WORKPLACE VIOLENCE TARGETING STUDENT NURSES IN THE CLINICAL AREAS

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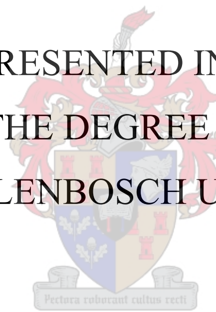
RESEARCH ASSIGNMENT PRESENTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF NURSING AT THE STELLENBOSCH UNIVERSITY



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DECEMBER 2010

DECLARATION

By submitting this research assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the authorship owner thereof and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

Workplace violence in health care is a worldwide phenomenon. In nursing, the nature of workplace violence is predominantly non-physical in nature. Literature reveals the devastating consequences for the individual nurse, both physically and / or emotionally, depending on the nature of the violence. The consequences for the organisation / institution and the profession are equally devastating, manifesting in reduced standards of patient care and increased attrition from the profession. The pervasiveness of this problem indicates that to date, remedial and protective measures have been unsuccessful.

However, most of the research done on workplace violence in nursing has been conducted amongst qualified nurses. The purpose of this study was to investigate the extent of workplace violence, targeting student nurses in clinical areas. The setting was the Western Cape College of Nursing and the population was second, third and fourth-year, pre-registration students. The research objectives addressed various aspects, for example, type, prevalence, perpetrators, consequences and management of workplace violence.

A quantitative research design, utilising a survey, was chosen for the study. A probability sample of n = 255 students was selected, using stratified, random sampling as the sampling method. The variables selected for stratification were gender and year of study. A self reported, anonymous questionnaire, guided by the literature review and by the research objectives, was utilised for data generation.

Summary statistics were used to describe the variables, whilst distributions of variables were presented in the form of histograms and frequency tables. Where appropriate, the relationships between demographic and research variables were described, using suitable statistical analyses.

The findings revealed that the perpetration of non-physical violence against student nurses is widespread, particularly that perpetrated by co-workers, more specifically registered, staff- and assistant nurses. The under reporting of workplace violence was a common finding.

Student nurses suffer grave emotional consequences as a result of workplace violence. Almost half of the respondents admitted that they had considered leaving

nursing due to workplace violence and that it had negatively affected their standard of patient care. The overall conclusion was that, in accordance with a worldwide trend amongst all categories of nurses, student nurses are targets of workplace violence in the clinical areas.

These findings have particular implications for the management of nursing education institutions. The fact that student nurses are targeted to the extent revealed in this study indicates that existing preventive measures in the clinical areas have not been effective. The recommendations arising from this study therefore focus on equipping the vulnerable trainee with the tools to withstand workplace violence. As such, the recommendations are directed at the management of the nursing education institution, to create awareness around the problem, to empower students to confront and cope with workplace violence and to support students traumatised by workplace violence.

Finally, this study suggests avenues for further research, for example, research in the same setting after implementation of the recommendations, or further research into the dynamics of workplace violence, targeting student nurses from the perspective of qualified nursing staff or patients.

OPSOMMING

Geweld in die gesondheidsdienste werksplek is ‘n wêreldwye verskynsel. In verpleging is geweld in die werksplek oorwegend nie-fisies van aard. Die literatuur wys op die ingrypende fisiese en / of emosionele gevolge vir die individuele verpleegkundige, afhangend van die aard van die geweld. Die gevolge vir die organisasie of instelling, asook vir die verpleegberoep, is eweneens ingrypend en manifesteer in verlaagde standaarde in pasiëntsorg en ‘n toename in verpleegkundiges wat die beroep verlaat. Die algemene verskynsel van die problem dui aan dat regstellende en beskermende maatreëls tot dusver onsuksesvol was.

Die meeste navorsing oor geweld in verpleging is egter tot dusver onder gekwalifiseerde verpleegkundiges gedoen. Die doel van hierdie studie was om die omvang van werksplek-geweld, met studenteverpleegkundiges as teikengroep, in die kliniese areas na te vors. Die studie is by die Wes-Kaap Kollege van Verpleging uitgevoer en die populasie was al die tweede, derde en vierde-jaar, voor-registrasie studente. Die geformuleerde navorsingsdoelwitte vir die studie het verskeie aspekte aangespreek, soos byvoorbeeld, tipe, frekwensie, die uitvoerders van geweld, gevolge en die hantering van werksplek-geweld.

‘n Kwantitatiewe navorsingsontwerp, met gebruikmaking van ’n opname, is vir die studie geselekteer. ‘n Waarskynlikheidsteekproef van n = 255 studente is deur middel van gestratifiseerde, ewekansige steekproefneming geselekteer. Geslag en jaar van studie was as die veranderlikes vir stratifikasie gekies. Die instrument vir data-insameling was ‘n self-voltooide vraelys, gebaseer op die literatuurstudie en gerig deur die navorsingsdoelwitte.

Opsommende statistieke is aangewend om die veranderlikes te beskryf, terwyl die verspreidings van veranderlikes in die vorm van histogramme of frekwensie-tabelle aangebied is. Waar toepaslik, is die verhoudings tussen demografiese en navorsingsveranderlikes met behulp van toepaslike statistiese analises beskryf.

Die bevindinge het onthul dat die pleeg van nie-fisiese geweld teenoor studenteverpleegkundiges algemeen voorkom, veral daardie deur mede-personeel, meer spesifiek geregistreerde, staf– en assistent verpleegundiges. Die onder-rapportering van werksplek-geweld was ‘n algemene bevinding.

Studenteverpleegkundiges ly aan erge emosionele gevolge, as gevolg van werksplek-geweld. Byna die helfte van die respondente het erken dat hulle oorweeg het om die beroep te verlaat en dat sodanige geweld hul standaard van pasiëntsorg negatief beinvloed het. Die oorkoepelende gevolgtrekking was dat studenteverpleegkundiges, in ooreenstemming met 'n wêreldwye neiging onder alle kategorieë van verpleegkundiges, die teiken van werksplek-geweld in die kliniese areas is.

Hierdie bevindinge hou spesifieke implikasies vir die bestuur van verpleegonderrig-inrigtings in. Die feit dat studenteverpleegkundiges tot die mate, soos in die studie onthul, geteiken word, het aangetoon dat bestaande voorkomende maatreëls in die kliniese areas oneffektief is. Die voorstelle vanuit hierdie studie is dus daarop gerig om die ontvanklike nuweling toe te rus om werksplek-geweld teë te staan. As sulks is die voorstelle gemik op die bestuur van die verpleegonderrig-inrigting, om bewustheid rondom die probleem te skep, om studente te bemagtig om geweld te konfronteer en te hanteer, en om studente, wat as gevolg van werksplek-geweld getraumatiseer is, te ondersteun.

Laastens word moontlikhede vir verdere navorsing voorgestel, soos byvoorbeeld, navorsing in dieselfde omgewing na die implementering van die voorstelle, of verdere navorsing in die dinamika van werksplek-geweld teenoor studenteverpleegkundiges, vanuit die perspektief van gekwalifiseerde verpleegpersoneel of pasiënte.

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CHAPTER 1

SCIENTIFIC FOUNDATION OF THE STUDY

1.1 INTRODUCTION

In this chapter, the scientific foundation of this study is presented. The rationale is discussed in-depth, followed by the problem statement, research question and research objectives. A short overview is given of the research methodology followed during this study, with a detailed discussion of the ethical considerations underpinning the study. Thereafter, relevant functional definitions are provided. The chapter concludes with a brief explanation of the study framework, an indication of the duration of the study, and a summary of the study layout.

1.2 RATIONALE FOR THE STUDY

Multidirectional workplace violence in health care settings is becoming more and more prevalent and the need to address such violence increasingly urgent. In the United States of America (USA), the likelihood of non-fatal assaults is almost four times higher in health care than in all other private sector industries combined (Clements, DeRanieri, Clark, Manno & Douglas, 2005:119). In South Africa, incidents cited in the Sunday Times (Rank, 2008:2), report hospital staff being held at gunpoint in elevators, a senior doctor at the Johannesburg hospital being robbed at gunpoint as he was coming off night shift, the stabbing of a young doctor at the Dora Nginza hospital in Port Elizabeth, the rape of an intern at Pretoria Academic hospital and the killing of four hospital managers at the Seshego hospital in Limpopo, all within the previous year. In an article in the Daily News, Cassim Lekhoathi from the nurses' trade union, Denosa, refers to two incidents at clinics in Hammarsdale and Mooi River, where nurses were threatened at gunpoint by patients under the influence of alcohol (Peters, 2008:3). More recently, a young dentist was repeatedly stabbed in the neck by an unknown attacker at a hospital in Khayelitsha in the Western Cape (De Bruin, 2010:2). A local study on workplace violence in three provincial health services in the Western Cape revealed that 61.1% of the sampled

health workers had reported that they frequently had to contend with violence, or crime in the workplace (Marais, Van der Spuy & Röntsch, 2002:9).

Although the above are examples of actual or threatened, extreme, physical violence, there is general consensus that workplace violence also comprises non-physical aggression, such as verbal abuse, harassment, bullying, intimidation, and incivility, as well as physical assault (World Health Organization, 2002:4; Hegney, Eley, Plank, Buikstra & Parker, 2006:22; Felblinger, 2008:234). However, in nursing, non-physical forms of violence appear to be far more common than actual physical assaults (Ferns, 2005:184).

Workplace violence may be committed by outsiders, known or unknown, who enter the workplace, or by recipients of the particular services offered in the workplace, or even by worker to worker (National Institute for Occupational Safety and Health, 2006:4). In nursing, it appears that nurses are more likely to be targeted by patients and, disturbingly, by other nurses (Le Blanc & Kelloway, 2002:444; McPhaul & Lipscomb, 2004:168; Kahlil, 2009:207).

Workplace violence in nursing has individual and organisational consequences (Camerino, Estryn-Behar, Conway, van Der Heijden & Hassehorn, 2008:36). Clearly, an individual can suffer physical injury following physical assault. However, it may be the psychological or emotional consequences of workplace violence that are more damaging and lasting. Kisa (2008:204) found that anger, hurt, shock, embarrassment, powerlessness, fear, shame, hostility and intimidation are some of the more common emotional responses to verbal abuse. Felblinger (2008:237) found that intimidation and incivility towards nurses had led to negative self evaluation and increased potential for re-victimisation.

All of these emphasise the destructive consequences of such behaviour for the individual nurse. According to the Royal College of Nursing in London (2002, cited in Randle, 2003:399), one third of nurses who had been bullied intended to leave the workplace, or profession. Such intentions are undoubtedly of great significance to any given organisation and to the nursing profession, specifically. Workplace violence also has serious implications for patient safety. A survey of 1,565 nurses by the Institute of Safe Medication Practices (2004) revealed that 49% had

acknowledged that intimidation had affected the way that they had clarified medication orders.

Students experiencing, or witnessing lateral violence (nurse on nurse), reported feelings of humiliation, dissonance, powerlessness and a firm resolve not to accept future employment in an area, institution, or unit, where they had been abused in this fashion (Curtis, Bowen & Reid, 2007:161). Distressingly, in a longitudinal study in the United Kingdom, Randle (2003:400) found that at the end of their three year pre-registration course, students were venting their frustrations on subordinates and were working in ways that they had initially found to be anxiety provoking at the start of their course.

The researcher, a lecturer at a nursing education institution, has become increasingly concerned about the nursing students being exposed to workplace violence, after hearing of several alarming accounts of student nurses being exposed to workplace violence in clinical areas. One student, for example, was pulled onto a bed by a male orthopedic patient. Other students described incidents where they had experienced verbal, and to a lesser extent, physical aggression from patients and co-workers. The fact that workplace violence in nursing is typically under reported (Rippon, 2000:454; Marais, Van der Spuy & Röntsch, 2002:11; Ferns, 2005:184), was further cause for concern.

Although a growing body of literature reveals that workplace violence is a well documented and virtually universal phenomenon in nursing (Ferns, 2005:184; Beech, 2008:94; Whelan, 2008:130), not many studies have specifically been directed at the occurrence of workplace violence targeting student nurses. Nau, Dassen, Needham and Halfens (2009:197) reported that a literature review in December 2007 had only located ten articles for the previous fifteen years, dealing with this topic. Consequently, it is unclear whether student nurses enjoy a certain degree of protection from workplace violence by virtue of their student status.

Finally, any study that directly, or indirectly, contributes towards the retention of nurses is of immeasurable value to the country in general and to the Western Cape in particular.

1.3 PROBLEM STATEMENT AND RESEARCH QUESTION

The potentially devastating consequences of workplace violence for the individual student nurse, the possible negative implications for patient safety and the possibility of increased attrition from the profession, convinced the researcher that a methodical investigation into the prevalence and nature of workplace violence, as experienced by student nurses in the clinical placement areas of the Western Cape College of Nursing, was justified.

The alarming possibility that student nurses may be socialised into an acceptance of a *status quo* regarding modes of interaction, the probable rampant under reporting of workplace violence and the need to create awareness and to institute strategies that would combat the phenomenon of workplace violence, before irreparable damage occurs, were further motivations for this study.

As a result, the research question underpinning this study was: "*What is the extent and nature of workplace violence, targeting student nurses in clinical areas?*"

1.4 AIM AND OBJECTIVES OF THE STUDY

The aim of this study was to determine and describe if, and to what extent, student nurses are targeted by workplace violence in the clinical environment. While the nature and frequency of physical and non-physical workplace violence were established during this study, almost all further data collected related to the students' exposure to non-physical violence. This was in line with evidence from literature suggesting that in nursing, violence of a non-physical kind is more prevalent than physical violence (Ferns, 2005:184). The study was conducted amongst student nurses from the Western Cape College of Nursing.

The specific objectives of the study, with reference to the second, third and fourth-year student nurses of the Western Cape College of Nursing, and to their clinical placement areas, were to:

- Identify the nature / type of workplace violence;
- Establish the frequency of workplace violence;
- Distinguish between the prevalence of non-physical violence in hospital and community (for example, clinics and day-hospitals) settings;

- Reveal the perpetrators of non-physical violence;
- Identify the type and frequency of consequences of non-physical violence;
- Determine whether workplace violence was reported;
- Establish reasons for not reporting workplace violence;
- Determine whether students were aware of any policies addressing workplace violence in the clinical areas;
- Determine the students' recommendations regarding the management of workplace violence; and
- Investigate any relationship between the demographic variables of age, gender, year of study, and frequency, nature, perpetrator, consequences and reporting of workplace violence.

1.5 RESEARCH METHODOLOGY

1.5.1 Research design

A quantitative-descriptive survey design was utilised, because the purpose of the research was predominantly explorative (Mouton, 2001:152). The quantitative approach enables the acquiring of information by means of a systematic and objective research process (Burns & Grove, 2007:24), whilst the numerical nature of the collected data was best suited to the specific objectives of this study. The exploratory and predominantly a-theoretical nature of the study prompted the researcher to direct the research by means of a research question and specific objectives, rather than by means of testing hypotheses (Mouton, 2001:152). A descriptive design was appropriate, as the variables were examined in natural environments and were not manipulated in any way (Burns & Grove, 2007:240). Where applicable, associations between variables were established.

1.5.2 Population and Sampling

The context within which the study was conducted was the Western Cape College of Nursing. The population was all the second, third and fourth-year student nurses (n = 729, comprising 287 second-year, 272 third-year and 170 fourth-year students), registered at the Western Cape College of Nursing for the Diploma in nursing

(general, psychiatric and community) and midwifery. First-year students were not considered for inclusion, because of their limited exposure to clinical areas. The method used to select a 35% representative sample (n = 255) was stratified, random sampling. This sampling method was used to ensure the representativeness of certain variables in the population (Burns & Grove, 2007:333). In this study, the variables were gender and year of study.

1.5.3 Instrumentation and Data collection

A questionnaire (annexure 3), compiled with the assistance of a statistician, was utilised to gather data from the respondents. The questionnaire (paper and pen format) was in English, the official and only language of instruction and academic expression at the institution where the study was conducted. It was administered to the respondents during class placements at the College, hence facilitating an acceptable response rate. Items to be included in the questionnaire were guided through insights obtained from an analysis of the literature. The majority of the questions were Likert-type in nature, although one open ended question was included at the end of the questionnaire.

1.5.4 Pilot study

A pilot study, comprising almost 10% of the total number of the selected sample (19 respondents in total), was done before the main study, in order to identify any problems related to the content and understanding of the questionnaire, to refine the data collection instrument and to improve methodological aspects, like the reliability and validity of the research instrument (Burns & Grove, 2007:38). An equal proportion of respondents were included from each of the second, third and fourth years of study. The participants and the data obtained during the pilot study were excluded from the main empirical study.

1.5.5 Validity and Reliability

Content and face validity of the instrument were ensured by basing the questionnaire on the reviewed literature, by subjecting it to the scrutiny of colleagues in the nursing

profession and by analysis of the pre-test results and feedback obtained during the preliminary pilot study.

Reliability was enhanced by the fact that the self administered questionnaire minimised the possibility of inconsistent management of the process by field workers, and by the fact that only the researcher distributed and collected the completed questionnaires.

1.5.6 Data analysis

Microsoft Excel was used to capture the data, which was analysed using the Statistica Version 9 data analysis software system. Summary statistics were used to describe the variables, whilst distributions of variables were presented in the form of histograms and frequency tables. Appropriate measurements, for example, chi-square tests, analyses of variance (ANOVA) and Pearson product moment correlations, with 95% confidence intervals, were used to describe relationships.

1.5.7 Ethical considerations

Researchers generally agree that voluntary participation, doing no harm (i.e. non-maleficence), privacy, anonymity and confidentiality are the most important ethical considerations that should prevail in any kind of social research (Babbie, 2007:62-68; Burns & Grove, 2007:203-219).

Voluntary participation is vitally important, considering the fact that participation in research, even when limited to the completion of a questionnaire, is an intrusion on someone else's life, or time. This infringement is further intensified by the fact that respondents are often required to reveal personal information (Babbie, 2007:62). Special attention was given to the fact that students may be regarded as an example of what Mouton (2001:245) refers to as a "vulnerable" population. In this instance the researcher was a lecturer at the institution where the study was conducted and could conceivably coerce respondents to participate in the research. As such, respondents were informed that participation in the study was entirely voluntary and that refusal to participate would have no negative consequences (Burns & Grove, 2007:217). Furthermore, written informed consent (annexure 4) was obtained from each individual participant beforehand.

Informed consent means that respondents are able to base their decision to voluntarily participate in a study, on a complete understanding of what their participation would involve, including any anticipated risks or discomforts that may ensue (Babbie, 2007:64; Burns & Grove, 2007:217). Apart from being informed that their participation was voluntary, respondents were informed of the purpose of the research, the manner in which the sample had been selected, the nature of their involvement, i.e. completing a questionnaire in about ten to fifteen minutes, the assurance of anonymity and confidentiality and the intended way in which the results would be used and disseminated. The possibility of any distress, due to recalling past incidences of workplace violence, was addressed by extending an invitation to respondents to contact the researcher, should that happen, so that an appropriate intervention could be arranged. Alternatively, respondents were reminded that they could consult the student counselor on the establishment of the College. Hence, adherence to the important principle of non-maleficence, or doing no harm, was ensured.

According to Burns and Grove (2007:209), the ethical principle of privacy relates to the amount of freedom people have regarding the extent to which their private information is shared, or withheld from others. Clearly, this is closely aligned with the principles of anonymity and confidentiality. Anonymity, i.e. when neither the researcher, nor the people who read the research outcomes can link a given response to a given subject (Babbie, 2007:64), was guaranteed by not including any kind of identification on the questionnaire. Additionally, respondents posted their completed questionnaires into a sealed container. To further ensure upholding of anonymity, the receipt of the signed consent forms by the researcher was separate from the receipt of the sealed completed questionnaires, thus making it impossible to connect any completed questionnaire with an individual subject.

Confidentiality refers to the way in which the researcher manages the private information disclosed by the subjects (Burns & Grove, 2007:212). Accordingly, all completed questionnaires were stored in sealed containers in a locked storage area, thereby preventing any unauthorised access to the data. Besides these measures to protect anonymity and confidentiality, privacy was also respected in that the completion of questionnaires did not necessarily intrude on the respondents' private time at home, as they could exercise the option to complete the questionnaires during breaks between lectures, or if they wished, during tea and lunch times.

Apart from protecting the rights of respondents as discussed above, Mouton (2001:238–243) claims that ethical requirements for research are met when compliance is demonstrated with professional ethics around integrity in research, and when accountability to society is expressed in the intention to disseminate the research findings. In this study, every effort was made to comply with all the requirements around scientific integrity. Regarding the dissemination of results, it was planned to submit a report, summarising the results and containing recommendations for modifications, or additions to the curriculum, to the head of the College. A similar report, containing appropriate recommendations, would be submitted to the heads of the clinical areas where students are placed. Furthermore, the study would be submitted for possible publication in an accredited professional nursing journal.

Before commencing the study, written ethical approval was obtained from the Ethics Research Committee, Faculty of Health Sciences of the University of Stellenbosch (annexure 2). Written consent for the study was also obtained from the Head of the Western Cape College of Nursing (annexure 1).

The researcher was available for any queries relating to the study and respondents were informed that she could be contacted on the cell number that had been provided on the letter of consent.

1.6 STUDY FRAMEWORK

A study framework is the theoretical base for a study and spells out the logic that is used in planning the study (Burns & Grove, 2007:34,165). There was no elaborate theoretical framework underpinning this study, since exploratory studies, including this one, are mainly inductive and a-theoretical (Mouton, 2001:152). However, aspects of established and relevant typologies of perpetrators and types of workplace violence contributed to the formulation of some of the objectives of the study, informed pertinent sections of the questionnaire (annexure 3), and featured in the discussion of the findings in chapter 4.

1.7 FUNCTIONAL DEFINITIONS

1.7.1 Workplace violence

For the purpose of this study, workplace violence was defined as aggressive behaviour towards another person, or object of that person, finding expression in physical assault, sexual harassment and non-physical violence, such as verbal abuse, incivility, bullying and intimidation.

1.7.2 Student nurse

A person registered as a student with the South African Nursing Council to follow a course of study leading to registration as a nurse (general, psychiatric and community) and midwife.

1.7.3 Assistant nurse

A person who has successfully completed a one year training program and is enrolled with the South African Nursing Council as a nursing auxiliary.

1.7.4 Staff nurse

A person who has successfully completed a two year training program and is enrolled with the South African Nursing Council as a staff nurse.

1.7.5 Registered nurse

A person who has successfully completed at least a three year, but since 1988 a four year training program and is registered with the South African Nursing Council as a registered / professional nurse.

1.7.6 Clinical educator / mentor

A registered nurse, primarily employed on behalf of the Nursing College, to accompany the student nurses during their clinical placements.

1.8 DURATION OF THE STUDY

The research proposal for this study was submitted for ethical approval to the Ethics Research Committee, Faculty of Health Sciences of the University of Stellenbosch, in September 2009, and the final research report was submitted for examination at the end of August 2010.

1.9 STUDY LAYOUT

The research outcomes are presented as follows:

Chapter 1: Scientific foundation of the study

In this chapter the background and rationale for the research, the problem statement, the research question and research objectives, and an overview of the research methodology are presented. The ethical considerations for the research are discussed in depth.

Chapter 2: Literature review

This chapter contains an in-depth analysis of relevant literature and a review of recent research and research findings on the topics of workplace violence in health care settings in general, and in nursing, specifically.

Chapter 3: Research methodology

In this chapter the research design, sampling methods and data collection are discussed in detail. A plan for the organisation and analysis of the data is also presented.

Chapter 4: Data analysis, Interpretation and Discussion

In this chapter the analysis and interpretation of data are presented, along with an in-depth discussion of each of the variables being investigated.

Chapter 5: Conclusions and Recommendations

The final chapter focuses on the conclusions and recommendations, based on the outcomes of this research study. These are guided by the purpose, research question and objectives of the study.

1.10 CONCLUSION

The scientific foundation for the proposed study was presented in this chapter.

The background to the problem was drafted by consulting relevant literature and the formulated problem statement was contextualised within the specific research setting and target group.

The rationale for the research, the research question and the aim and objectives of the study were described. An overview of the research methodology that guided the research was provided, followed by an in-depth discussion of ethical considerations relevant to this study.

In the next chapter an in-depth analysis of the relevant literature, as well as a review of recent research and research findings on violence are presented.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, an analysis of the literature regarding workplace violence in health care in general, and in the nursing context, specifically, is presented. This includes a review of recent relevant research and research findings.

While there is a growing body of literature describing various aspects of workplace violence in the health care setting, not many studies are specifically directed at the experiences of student nurses. Hinchberger (2009:38) points out that student nurses have rarely been included in the sampled population of previous research into workplace violence. According to Nau *et al*. (2009:197), a literature review in December 2007, using multiple search terms, only located 10 articles for the previous 15 years, dealing with this topic. The purpose of the literature review was to explore and understand the issues regarding workplace violence that threaten nurses, so as to inform the exploratory research of the degree and nature of workplace violence experienced by student nurses.

2.2 REVIEW OF THE LITERATURE

The search terms utilised in several combinations were “workplace violence” / “aggression” / “incivility” / “disruptive behaviour” / “abusive behaviour” / “intimidation” / “bullying” / “nurs* student*” / “student nurs*” or, because of the paucity of research directed at student nurses, “nurs*. The search was conducted on the CINAHL, PUBMED, SABINET and GOOGLE SCHOLAR databases.

2.3 FINDINGS

This section will commence with an overview of the theoretical background to workplace violence, followed by a discussion of the difficulty of reaching consensus on a standard definition for workplace violence. After presenting various

classifications of workplace violence, attention is given to literature on studies dealing with various aspects of workplace violence in the nursing profession.

2.3.1 Theoretical background to workplace violence / aggression

The in-depth analysis of theories on aggression was outside the scope of this review. Suffice to state that historically, theories explaining violence and aggression can be divided into two broad streams, i.e. those explaining the phenomenon as arising from internal, biologically related factors, such as instinct or drive, and those explaining the phenomenon as a function of the external environment and the behaviour of others (Turnbull, 1999a:48). Mason and Chandley (1999:19-21) summarise the theoretical background to aggression under evolutionary, psychoanalytical, behavioural, socio-cognitive and sociological perspectives.

Neuman and Baron (2005:30) propose that the General Affective Aggression Model (GAAM) summarises the current state of thinking in this area. According to this model, aggression is triggered by situational variables, e.g. stressors, frustration and provocation, and by individual variables, e.g. type A behaviour pattern, pro-aggression values and low self esteem. All of these impacts on the psychological processes of arousal, affective states and cognitions and, depending on a person's appraisal, may result in an aggressive, or non-aggressive response (Neuman & Baron, 2005:31-32).

A popular theoretical framework used to explain lateral violence (nurse to nurse), is that of oppressed group behaviour (Matheson & Bobay, 2007:227). The domination of powerful groups, such as physicians and hospital administrators, are seen to have caused an identity crisis in nursing, manifesting in reluctance to confront the reigning group, with resultant passive-aggressive behaviour and self dislike (Roberts, 1983, cited in Matheson & Bobay, 2007:227). Hutchinson, Jackson, Vickers and Wilkes (2006a:118), however, suggest that the use of an 'oppressed group' theory is too simplistic and fails to recognise other important organisational attributes of lateral violence, or bullying in the workplace. In addition, changes in the nursing profession over the past twenty years have resulted in modern, contemporary, registered nurses, who may not agree that they fit into an 'oppressed group' category (Thomas & Burk, 2009:226).

According to Luck*,* Jackson and Usher (2006:255), these various perspectives are useful in that they increase understanding regarding the etiology and complexity of aggression, but fail in the sense that they do not provide predictive models to understand aggression towards nurses. In the researcher's opinion, though, this may be a somewhat limited point of view, since, even a basic understanding of the etiology of aggression and of individual and situational variables, associated with aggression or violence, has some predictive value when designing intervention strategies.

2.3.2 Working towards a definition of workplace violence

There is no consensus in the literature on the use of the term workplace violence, or workplace aggression. Violence and aggression are essentially synonymous terms, but the abuse of superlatives, particularly by the media, and the resultant desensitisation have resulted in the term, violence, replacing that of aggression in many circles (Rippon, 2000:456). Workplace violence and aggression are thus complex concepts, having many different meanings, or definitions associated with them.

Waddington, Badger and Bull (2005:158) further indicate that some of the definitions of workplace violence are so broad and inclusive that any kind of behaviour experienced by an employee, ranging on a continuum from disagreeable to frightening, is labeled as violent. They do acknowledge that people experience violence differently and that such experiences should be respected from an analytical and practical point of view. However, they point out that broad, inclusive definitions of workplace violence are problematic, in the sense that the same conceptual tools are used to describe distinctly different circumstances and events (Waddington, Badger & Bull, 2005:158).

Alternatively, definitions restricting workplace violence to, for example, intended or physical assault, excludes the harmful effects of non-physical actions or threats, such as verbal and emotional abuse. To demonstrate this, the World Health Organization's definition of violence is: "…the intentional use of physical force or power, threatened or actual against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (WHO, 2002:4). Although

helpful in recognising that violence occurs at individual, group and community level and in acknowledging the psychosocial consequences of violence, this definition, by limiting violence to actual or threatened physical assault, is not comprehensive enough to be suitable for research on workplace violence targeting student nurses. Instead, violence in the nursing context should be viewed as an overarching term comprising a wide range of behaviours (Luck, Jackson & Usher, 2006:252).

LeBlanc and Kelloway (2002:444) suggest that the term, workplace violence, be reserved for physical violence and threats of physical violence, and that the term, workplace aggression, be reserved for non-physical aggression, e.g. shouting and swearing. In yet another attempt at achieving conceptual clarity, the term, psychological violence, was used to denote verbal abuse, bullying, sexual or racial harassment, mobbing and threats, in an international comparative study on violence in the health industry in 2002 (Mayhew, 2004:110).

Fox and Spector (2005:5) express preference for the more global term, i.e. 'counterproductive workplace behaviour', which they regard as an umbrella term for a domain that deals with any kind of behaviour that is detrimental to an organisation. In defining workplace aggression as "any form of behaviour directed by one or more persons in a workplace towards the goal of harming one or more others in that workplace, in ways the intended targets are motivated to avoid", Neuman and Baron (2005:18) isolate intention as the critical factor that differentiates workplace aggression from other forms of counterproductive work behaviour. They make a strong case for the concept, aggression, to be the integrating construct around which work and research into workplace violence and aggression should be centered (Neuman & Baron, 2005:16). Bies and Tripp (2005:76) also prefer the use of the term workplace aggression, because it is a value-neutral concept, preferable to a manager centered concept, such as counterproductive work behaviour.

Hegney, *et al.* (2006:221) regard workplace violence in the nursing workplace as inclusive of aggression, harassment, bullying, intimidation and assault. Other researchers have used terms like disruptive behaviour (Rosentein & O'Daniel, 2005:55) and bullying (Jackson, Clare & Mannix, 2002:15; Randle, 2003:395; Hutchinson *et al.*, 2006a:118).

The lack of a clear definition presents conceptual difficulties for researchers attempting to study workplace violence in the nursing context and has contributed to difficulty in addressing such behaviour (Rippon, 2000:452). Luck, Jackson and Usher (2006:252) point out that a common definition of violence would enhance the comparability of data attained in research, and would enable nurses to recognise and confront episodes of violence and aggression more effectively. It could be argued however, that a universally shared definition may have an opposite, simplistic effect and would exclude, for example, some of the finer cultural distinctions of workplace violence, as experienced in different contexts.

In summary, the literature seems to indicate that intent to harm, with resultant physical or psychological consequences are fundamental to any definition of workplace violence (Rippon, 2000:456). There also seems to be consensus that workplace violence encompasses at least two subcategories of workplace violence, namely physical and non-physical violence (Luck, Jackson & Usher, 2006:252).

The formulation of a functional definition of workplace violence for the purpose of this study was further reliant on typologies / classifications of workplace violence and an analysis of the nature of workplace violence experienced by nurses.

2.3.3 Classification of workplace violence

Workplace violence may be classified as being one of four types, based on the perpetrator's relationship to the workplace (LeBlanc & Barling, 2005:42; National Institute for Occupational Safety and Health, 2006:4).

- Type 1 refers to violent acts committed by criminals who enter the workplace to commit a crime. These individuals do not have a legitimate reason to enter the workplace.
- Type 2 refers to violent acts committed by those who are the recipients of the services provided in the workplace. These individuals have a legitimate relationship with the workplace.
- Type 3 refers to violent acts by worker to worker, where current or past employees are the agents of violence.

- Type 4 refers to violence committed in the workplace by a non-employee who has a relationship with a worker.

Health care workers, including nurses, are particularly at risk of violence from recipients / clients of the services provided in the workplace, i.e. type 2 (LeBlanc & Kelloway, 2002:444; McPhaul & Lipscomb, 2004:168). However, as will be seen in chapter 4, the findings from this study revealed that worker to worker violence (type 3), targeting student nurses, had been distressingly prevalent.

Kgosimore (2004:60) describes what he calls “type V employer on employee workplace violence”. He claims that this type of violence, though under researched, is prevalent, particularly in the relatively secluded farming and domestic sectors in South Africa. According to Kgosimore, this type of violence can be ascribed in part to the legacy of the oppressive socio-political system of ‘apartheid’ and colonialism. Although this does not appear to have direct bearing on workplace aggression and violence in nursing, it is conceivable that this legacy may also be included in the authority structure of other areas of social functioning in South Africa, including the health care system.

A simplified, yet useful typology of workplace violence distinguishes between public initiated and co-worker initiated violence and aggression (LeBlanc & Kelloway, 2002:445).

A widely recognised and foundational typology for many studies on workplace aggression is that proposed by Buss (cited in Neuman & Baron, 2005:18-19), who classifies workplace aggression using three dichotomies, namely physical-verbal, active-passive, and direct-indirect. Physical aggression involves physical actions (e.g. pushing, assault) on the part of the perpetrator, while verbal aggression (e.g. yelling, gossip) inflicts harm through words, rather than deeds. Active aggression implies that the perpetrator does something to harm the target, either directly, e.g. obscene gestures or racist remarks, or indirectly, e.g. theft or spreading rumours, while passive aggression involves withholding something the target needs or values, e.g. ignoring the target, or failing to provide important feedback (Neuman & Baron, 2005:19-20).

2.3.4 Nature of workplace violence against nurses

The literature revealed that in nursing, non-physical forms of violence, for example, verbal aggression, incivility, bullying and intimidation, are far more common than actual physical assault, and that in the few instances where weapons are involved, weapon use is opportunistic, rather than premeditated (Ferns, 2005:184). A similar pattern was reported by Khalil (2009:211), when she asked nurse respondents in eight public hospitals in Cape Town to respond to questions regarding six levels of violence. From most to least frequent, these levels were psychological violence, vertical violence, covert violence, horizontal violence, overt violence and physical violence.

Violence committed by fellow colleagues (type 3) is usually, but not exclusively, emotional and non-physical (Longo & Sherman, 2007:35). Typically called horizontal or lateral violence, it relates to inter group conflict and is expressed as bullying and aggression (Curtis, Bowen & Reid, 2007:156).

Common examples of lateral violence include being undervalued, blocking of learning opportunities, emotional neglect, nonverbal manifestations, such as rolling eyes, verbal manifestations, such as rude or demeaning comments, actions, such as not being available to help with difficult care related issues, sabotage, such as withholding important information, disinterest, excessive criticism, scapegoating, gossiping, forming cliques, exclusion, intimidation and humiliation (McKenna, Smith, Poole & Coverdale, 2003:93; Griffin, 2004:259). These behavioural manifestations can be classified as overt or covert (Griffin, 2004:257, 258). The most common kinds of verbal aggression perpetrated by other nurses were found to be anger, judgment, criticism and condescension (Rowe & Sherlock, 2005:246). In a study targeting student nurses, Thomas and Burk (2009:228) found that the perceived injustices from abusive registered nurses included, on a continuum from least to most severe, being ignored or unwanted, distrusted or disbelieved, unfairly blamed or publicly humiliated.

The lack of definitional clarity is also apparent in the description of lateral violence. Most researchers refer to lateral violence as workplace violence committed by nurse against nurse, irrespective of the status of the perpetrator. Contrary, Thomas and Burk (2009:227) suggest a refinement of terminology that restricts lateral violence to violence among equals, and propose vertical violence as the term describing abusive

behaviour by a colleague in a superior position to a subordinate. Johnson (2009:34) is of the opinion that the terms, lateral or horizontal violence and bullying, are synonymous. Griffon (2004:257) holds the view that the concept, bullying, is replacing that of lateral or horizontal violence. In bullying, a definite power differential exists between the victim and the perpetrator(s), suggesting that the victim is unable to defend him / herself (Johnson 2009:35).

The vulnerability associated with power inequality, would be particularly relevant to student nurses.

Bullying has broadly been defined as "persistent, negative, interpersonal behaviour, experienced by people at work" (Rayner & Keashly, 2005:271). It refers to many, rather than isolated instances of behaviour, which undermines, or humiliates. It further refers to what is done, e.g. personal attacks on credibility and what is not done, e.g. not receiving needed information (Rayner & Keashly, 2005:273-274). Hutchinson, Wilkes, Vickers and Jackson (2008:24), by utilising a process of factor analysis, developed and validated a bullying inventory, which they regard as a valid construct of bullying in the nursing workplace. They suggest that this developing model, consisting of three factors and five or six items under each factor, is suitable for use in further research. The three factors forming the construct of bullying in the nursing contexts are (1) attack upon competence and reputation, (2) personal attack and (3) attack through work tasks.

Although most attempts to describe workplace violence emphasise the harmful intention of the perpetrator, an interesting development in recent years has been the tendency to utilise the concept, incivility, when studying aggression and violence towards nurses (Felblinger, 2008:234; Hutton & Gates, 2008:168). This follows the influential research by Andersson & Pearson (1999:457), who define workplace incivility as "low-intensity, deviant behaviour, with ambiguous intent to harm the target, in violation of workplace norms for mutual respect". They further state that "uncivil behaviours are characteristically rude and discourteous, displaying a lack of regard for others". They emphasise that incivility differs from other types of workplace aggression or violence, in its ambiguous intent to cause harm. According to Cortina *et al.* (cited in Pearson, Andersson & Porath, 2005:178), qualitative research has identified the content of uncivil behaviour as disrespect, dishonesty,

ignoring, exclusion, professional discrediting, silencing, gender belittling, threats, intimidation, unprofessional address and comments about appearance.

Its relevance to possible inclusion as a valid field of study when researching workplace violence, is to be found in these authors' explanation of how incivility, when left unaddressed, can potentially spiral into increasingly intense aggressive behaviours.

It is evident that conceptually, there is no clear distinction between incivility, lateral violence and bullying. However, the undisputed fact that these behaviours occur is more important than being able to place them in neat, mutually exclusive categories. The researcher attempted to summarise the general nature of non-physical violence directed at nurses in table 2.1. On the one hand it illustrates the lack of conceptual clarity, but on the other hand, perhaps more significantly, it reflects the high degree of consensus, irrespective of terminology, regarding the nature of non-physical workplace violence in nursing.

Table 2.1: Summary of non-physical violence directed at nurses

Non-physical violence	Manifestation / General nature
Lateral violence	Rude or demeaning comments; anger; judging; excessive criticism; condescension; rolling eyes; disinterest; withholding information; exclusion / clique formation; undervaluing; blocking of learning opportunities; emotional neglect; scapegoating; gossiping; intimidation; humiliation; withholding help in difficult care related issues
Bullying	Persistent, negative, interpersonal behaviour; undermining or humiliating behaviour; attacks on credibility, competence and reputation; personal attacks; attack through work tasks
Incivility	Disrespect; dishonesty; ignoring; exclusion; professional discrediting; gender belittling; threats; intimidation; unprofessional address; comments about appearance

For the proposed study among student nurses, workplace violence was defined as '*aggressive behaviour towards another person, or object of that person, finding expression in physical assault, sexual harassment and non-physical violence, such as verbal abuse, incivility, bullying and intimidation*'.

2.3.5 Prevalence of workplace violence in health care and nursing

A high prevalence of aggression and violence against health care workers, throughout the world, is revealed in the literature. In the USA, the likelihood of non-fatal assaults was found to be almost four times higher in health care than in all other private sector industries combined (Clements *et al.*, 2005:119). A local study on workplace violence in three provincial health services in the Western Cape revealed that 61.1% of the sampled health workers had reported that they frequently had to contend with violence, or crime in the workplace (Marais, Van der Spuy & Röntsch, 2002:9).

Violence against nurses is an escalating, worldwide problem, despite growing awareness of the phenomenon (Beech, 2008:94). A survey in 2008 of the registered nurse workforce in the United States (US) indicated that, despite improvements (compared to surveys in 2002, 2004 and 2006) in several areas of the hospital workplace environment, areas in which the environment was perceived to have deteriorated, included sexual harassment, hostility and physical violence (Buerhaus, DesRoches, Donelan & Hess, 2009:289).

According to Turnbull (1999b:11), a study, the largest of its kind to date, carried out by the Health Services Advisory committee in five Area Health Authorities in England and yielding a 60% response rate, found that nurses were the group of health service workers with the greatest risk of being assaulted. Similarly, between 40 - 60% of nurse respondents in a study, targeting public, private and aged care services in Queensland Australia, had experienced workplace violence in the previous three months (Hegney *et al.*, 2006:223). In another study in a hospital in South Eastern USA, Spector, Coulter, Stockwell and Matz (2007:123) found that 28% of the nurses had experienced physical violence in the past year and 39% of them had experienced injury as a result of this violence. A total of 58% had experienced verbal aggression. Hader (2008:13) also undertook a survey in the USA and in seventeen other countries and found that almost 80% of nurse leaders had

experienced a form of workplace violence. In Turkey, a prevalence rate of 80.3% for verbal abuse against nurses was reported (Öztunc, 2006:361). Khalil (2009:210) found that in 2005, 54% of nurses, sampled from eight public hospitals in Cape Town, agreed that violence existed among nurses. However, the latter research only focused on lateral violence and did not address the issue of violence from other professional groups, patients, visitors, etc.

Nurses working in emergency care departments and psychiatric units are particularly vulnerable (McPhaul & Lipscomb, 2004:7; Ferns, 2005:180; Chapman & Styles, 2006:246; Wand & Coulson, 2006:163). Some of the reasons for the increased prevalence of aggression and violence in emergency department settings are thought to be a combination of emotional factors, such as fear, anger, disorientation and frustration, due to excessive pain, long waiting periods and lack of privacy, in addition to other situational factors, such as easy access to emergency departments (Turnbull, 1999b:19; Wand & Coulson, 2006:164-165). The restriction of personal freedom and geographical isolation in residential psychiatric units also seem to contribute to a higher level of violence (Turnbull, 1999b:20).

Although not well researched, the perception exists that student nurses, often younger and inexperienced, are also vulnerable to workplace violence (Rippon, 2000:453; Beech, 2008:95). According to Hinchberger (2009:37), 100% of student nurses (admittedly a small sample, n = 126) responding to an online survey, reported having been exposed to workplace violence. Also, Curtis, Bowen and Reid (2007:159) found that 57% of students in a particular study had experienced, or observed lateral violence in their clinical placements. Even more concerning, Beech (2008:101), in his study targeting student nurses, found that student nurses had often, to an undesirably high extent, been directly engaged in the management of violent incidents.

Although the prevalence of workplace violence in health care is already consistently and disconcertingly high, this may only be the tip of the iceberg, due to the under reporting of violence, especially violence of a non-physical kind. Marais, Van der Spuy and Röntsch (2002:11) found for example, that 50% of respondents had not reported verbal abuse. Similarly, in a large New Zealand study, investigating horizontal violence among registered nurses in their first year of practice, Mckenna *et al*. (2003:90) reported that less than half of lateral violence episodes had been

reported. Potentially rampant under reporting was also reported by other researchers (Rippon, 2000:454; Ferns, 2005:184). Nurses may tend to under report episodes of aggression and violence for many reasons, e.g. lack of confidence that management will do anything, a perception that, due to emotional or physical reasons, patients are not really responsible for their actions, fear of reprisal and cumbersome reporting procedures (Luck, Jackson & Usher, 2006:260).

2.3.6 Perpetrators of workplace violence against nurses

As was discussed, nurses are most often the targets of type 2 (committed by the recipient of the service provided by the health care institution) and type 3 (committed by an employee or former employee of the workplace) workplace violence (LeBlanc & Barling, 2005:42).

Specifically, the most common sources of workplace violence were found to be patients, visitors or relatives, other nurses, nursing management and doctors (Rippon, 2000:453; Rowe & Sherlock, 2005:245; Hegney *et al.*, 2006:220). Hader (2008:17) reported that patients (53.2%) were most often the perpetrators of violence, followed by nursing colleagues (51.9%), physicians (49%), visitors (47%) and other health care workers (37.7%). These percentages indicate that most respondents had been exposed to violence from more than one source. In one of the few studies targeting student nurses, Hinchberger (2009:42) found that the perpetrators were most commonly staff members, with patients coming a close second. In a study conducted in a single hospital in South Eastern USA, Spector *et al.* (2007:123) found that 28% of nurses had been the target of physical violence in the previous year. Most of the physical violence had been caused by patients (91%) and only 9% by colleagues or supervisors. They found that 58% of nurses had experienced verbal aggression in the previous year, 85% from patients and 33% from colleagues or supervisors.

Interestingly, Rowe and Sherlock (2005:245) found that 19% of registered and licensed practical nurse respondents had reported verbal abuse from sources other than the above, for example housekeeping, radiology, volunteers and pharmacy.

2.3.7 Antecedents / predictors of workplace violence

There is a fairly general consensus about job related risk factors for workplace violence. Of the 28 job characteristics identified by LeBlanc and Kelloway (2002:449) that may increase the risk for workplace violence, 14 are directly applicable to nursing, namely:

- Physical care of others;
- Emotional care of others;
- Decisions that influence other people's lives;
- Denying the public a service or request;
- Working alone during the evening / night, dispensing drugs;
- Exercising physical control over others;
- Supervising others;
- Interacting with frustrated individuals;
- Disciplining others;
- Working evenings / nights;
- Contact with individuals under the influence of alcohol;
- Contact with individuals under the influence of illegal drugs; and
- Contact with individuals under the influence of medication.

Marais, Van der Spuy and Röntsch (2002:11), for example, found that at the three health services being studied in the Western Cape, frustration, as a result of lengthy waiting periods, and substance abuse were primary reasons for aggressive behaviour.

Rayner and Keashly (2005:283) suggest that antecedents of workplace violence should be examined at the individual and organisational level. Some established precipitators of type 2 workplace violence in health care contexts, at individual level, are emotional stressors, such as depression, grief and death, mental health illnesses, confusion and disorientation related to age or medication, and

psychosocial or socio-economic factors, such as financial burdens and anxiety (Luck, Jackson & Usher 2006:253).

Other individual antecedents precipitating workplace violence have been summarised by Mason and Chandler (1999:24), i.e. those related to parenting factors, lack of ability to trust, poor self esteem, poor social skills and substance abuse. An obvious individual characteristic of nurses is gender, with women comprising the vast majority. The question can be asked whether this is related to the risk of workplace violence in nursing. Feminists argue that violence is a gendered construct, particularly in societies where women are the non-dominant cultural group (Yodanis in Luck, Jackson & Usher, 2006:255). However, the literature shows that escalating violence against nurses is a worldwide, universal problem, also in societies recognised as being egalitarian. Rippon (2000:453), in fact, reports that proportionally more male nurses are assaulted, or threatened with assault, than female nurses.

Unfortunately, organisational and industry factors may also contribute to the perpetuation and acceptance of a culture of workplace violence in nursing. When management, for example, does not respond appropriately when abuse occurs and / or is reported, nurses are disempowered, stop reporting incidents and start accepting abuse as an inevitable part of the job. This perception is often strengthened by the 'patient is never wrong' philosophy (Turnbull, 1999b:9; Sofield & Salmond, 2003:281). Historically, tolerance for lateral violence in nursing has been perpetuated as a "right of passage", or by the acceptance of the practice, because of the notion "this is how people were to me, when I was learning" (Griffon, 2004:258).

Organisational factors that contribute to workplace violence include weak or non-existent policy measures to address workplace violence, deficient employee supervision and retention procedures, insufficient violence prevention training, weak or non-existent measures for reporting workplace violence and failure to take immediate action against episodes of workplace violence (Chavez in Clements *et al.*, 2005:120). It will become clear that some of these organisational antecedents also function as barriers to the implementation of workplace violence prevention strategies.

2.3.8 Consequences of workplace violence for nurses

Workplace violence obviously has consequences for the individual and the workplace or organisation (Camerino *et al*., 2008:36). Victims of violence experience immediate, short, or long term trauma, which is exacerbated by an increased frequency and severity of incidents (Rippon, 2000:453). Clearly, the individual may experience actual physical injury, following physical assault. As has been noted, non-physical abuse is the most common type of workplace violence experienced by nurses and may result in physical and emotional distress. The results of a survey yielding 303 registered nurse respondents across the US, showed that bullying resulted in significant emotional and physical distress. In this particular study, 95% of respondents had experienced anxiety, whilst 72% had experienced headaches, or gastrointestinal symptoms as a result of bullying (Vessey, Demarco, Gaffney & Budin, 2009:303).

Emotional responses to verbal abuse from most to least common were found to be anger, sadness or hurt, shock or surprise, embarrassment or humiliation, powerlessness, fear, shame, hostility and intimidation (Kisa, 2008:204). Nurses taking part in a study on verbal abuse in a hospital in Turkey also reported feelings of dejection, confusion, hopelessness, hatred and anxiety (Öztung, 2006:362). Similarly, in a large survey in a multihospital system in the North East USA, Sofield and Salmond (2003:278) reported that emotional response to verbal abuse were anger, feelings of powerlessness, harassment and embarrassment.

Felblinger (2008:237) found that nurses often respond to intimidation and incivility with self directed feelings of shame and anger, leading to negative self evaluation and an increased potential for re-victimisation. Students experiencing, or witnessing lateral violence, reported feelings of humiliation, dissonance, powerlessness and a firm resolve not to accept future employment in an area, institution, or unit, where they had been abused in this fashion (Curtis, Bowen & Reid, 2007:161).

Rosenstein and O'Daniel (2005:55-64) conducted a large survey on the perceptions of nurses and physicians regarding clinicians' disruptive behaviour in 50 hospitals along the West coast of America. They define disruptive behaviour, as "any inappropriate behaviour, confrontation, or conflict, ranging from verbal abuse to physical and sexual harassment" (Rosenstein & O'Daniel, 2005:55). Most nurse

respondents indicated that disruptive behaviour by clinicians had significantly negative effects on selected behavioural and psychological variables, namely, workplace relationships (92% of respondents), information transfer (89%), team collaboration (91%), communication (94%), concentration (85%), frustration and stress (95%). Although the results of this study may have been biased by the fact that a convenience sample was used (Rosentstein & O'Daniel, 2005:62), it does reflect an almost unanimous perception by the nurse respondents of the destructive consequences of workplace aggression.

Organisations have been facing increased absenteeism and staff turnover, increased sick leave, increased security and litigation costs and decreased productivity (Jackson, Clare & Mannix, 2002:17; Ramos, 2006:37; Vessey *et al.*, 2009:303). Intent to leave the profession as a result of workplace violence was demonstrated by Mckenna *et al.* (2003:95), in a study on the experiences of registered nurses regarding lateral violence in their first year of practice. In this study, one in three respondents considered leaving the profession as a consequence of an abusive incident. Sofield and Salmond (2003:282) also reported that 33.4% of respondents had considered resigning, following verbal abuse.

These findings have serious implications for a profession already crippled by a shortage of staff.

Organisations suffer from losses in productivity, due to strained professional relationships and below standard patient care (Kisa, 2008:201). A survey of 1,565 nurses by the Institute of Safe Medication Practices (2004) revealed that 49% had acknowledged that intimidation had affected the way that they had clarified medication orders. In their survey, Rosenstein and O'Daniel (2005:60) asked respondents to indicate any link between disruptive behaviour and negative clinical outcomes. Many nurse respondents indicated a strong link between disruptive behaviour and adverse events (68% of respondents), medical errors (73%), compromised patient safety (54%), diminished quality of care (73%) and reduced patient satisfaction (77%). Rowe and Sherlock (2005:245) reported that 13% of the respondents admitted that verbal abuse had resulted in them making a caregiving error. Vessey *et al.* (2009:303) also reported an increased potential for below standard care as a result of bullying. Thus, workplace violence has serious implications for patient safety.

A distressing consequence of exposure to workplace violence is the 'normalisation' of the experience. Students are socialised into the antisocial behaviour, whilst those who have been victims, subject new nurses to the same treatment (Ramos, 2006:37), possibly in an attempt to protect their self esteem (Rowe & Sherlock, 2005:243). In a three year longitudinal study, Randle (2003:400) found that at the end of their training program, students were exhibiting the same bullying behaviour that had caused themselves stress and anxiety at the start of their course.

2.3.9 Barriers to the implementation of strategies to prevent workplace violence

At a conference held in Baltimore in 2004, under the auspices of the National Institute for Occupational Safety and Health, and incorporating a diverse group of representatives from various disciplines and organisations, common barriers to the implementation of workplace violence prevention were identified. Some of these were related to the particular organisation itself, whilst others were related to the type of workplace violence. The barriers, identified by participants, were corporate denial of workplace violence, a culture of violence that permeates society, lack of worker empowerment, lack of incentives to implement strategies, lack of awareness of the extent of the problem, lack of evidence based information to formulate prevention strategies, lack of training regarding management of workplace violence, lack of resources (particularly where prevention strategies are seen as costly and unjustified), lack of effective follow-up to reported incidents, under reporting of incidents of workplace violence, lack of written prevention of workplace violence policies, and lack of teamwork to sustain such programs (National Institute for Occupational Safety and Health, 2006:8-11).

Under reporting of workplace violence is a major barrier to successful management of the problem in nursing (Rippon, 2000:454; McKenna *et al.*, 2003:90; Ferns, 2005:184). Understandably, student nurses are loath to report incidents of lateral violence, because of the relative powerlessness they experience when having to confront the behaviour of, for example, registered nurses / superiors (Thomas & Burk, 2009:230). According to Rippon (2000:454) also, student nurses do not report incidents of assault, because of breaches in confidentiality and because they feel unsupported by senior staff.

2.3.10 Strategies to address workplace violence

Strong support is found in the literature that managerial intent, buy-in and commitment to addressing workplace violence are fundamental to the success of any violence prevention / management program (Clements *et al.*, 2005:121; National Institute for Occupational Safety and Health, 2006:14; Gallant-Roman, 2008:452). General strategies, formulated at the conference on workplace violence prevention in Baltimore (National Institute for Occupational Safety and Health, 2006:14-16), included a multidisciplinary approach to workplace violence prevention, a written workplace violence policy, tailored to an organisation's particular profile, training in the implementation of policies regarding the reporting of lateral violence, and continuous evaluation of programs and strategies adopted to address workplace violence.

There is strong support for the application of a zero tolerance policy for all forms of workplace violence (Gallant-Roman, 2008:452). In contrast, Duxbury and Whittington (2005:471) are of the opinion that different kinds of workplace violence necessitate different management strategies. They feel that zero tolerance policies, aimed at managing patient aggression, would result in patient blaming and intolerance on the part of health workers (Wand & Coulson, 2006:164), and that it may have the regrettable consequence that the training of nurses in more proactive, de-escalation strategies of violence prevention, would be neglected. It thus seems as if zero tolerance policies may be very effective against lateral violence and bullying (type 3 workplace violence), but less effective against violence committed by patients (type 2 violence). Training in de-escalation techniques, early recognition of potentially volatile situations and sound interpersonal skills is therefore the preferred way of managing most expressions of patient aggression (Wand & Coulson, 2006:166). In this regard, Beech (2008:100) noted a definite trend in the recent past towards interventions emphasising prevention and de-escalation strategies.

Generally, the training and education of nurses to recognise and defuse potential episodes of workplace violence and to report incidences of workplace violence, are widely recommended (Beech, 2008:94; Gallant-Roman, 2008:452-453). As far as nursing students are concerned, Nau *et al.* (2009:198) reported that training in violence and aggression management is very rare. In view of this, they implemented a three days training course to increase student nurses' confidence to cope with

patient aggression. They found that as a result of this intervention, confidence levels were significantly increased. However, a limitation to this study was that the students' self reported capacities to deal with patient aggression were measured only two weeks after the training course. The proximity to the received training may thus have produced false positive results. The actual efficacy of workplace violence prevention programs, however, is still a relatively under researched area.

A specific strategy identified to address type 2 workplace violence, is to ensure an adequate staffing and skills mix (National Institute for Occupational Safety and Health, 2006:14-16). It has been noted earlier, for example, that working alone, or working with clients under the influence of alcohol, increases the risk for workplace violence. Student nurses, by virtue of their inexperience, can be expected to be even more vulnerable to inadequate staffing and skills mix.

Hutchinson (2009:149) provides an insightful typology regarding approaches to combat bullying in the nursing workplace, by distinguishing between an individual focus and an organisational focus. Strategies with an individual focus include a remedial approach, centered on counseling and mediation, while a corrective approach applies discipline and ensures aggression de-escalation training. Strategies with an organisational focus comprise regulatory measures, such as policy and legislation, and value group restorative measures, centering on shared responsibility and shared concern.

An institutionally supported, group restorative approach to bullying, actualised through the intervention of restorative circles and conferencing, where group members are encouraged to expose and discuss the problem, admit culpability and commit to changed behaviour, is seen by Hutchinson (2009:150-153) as the vehicle to address the prevalent organisational climate that fosters and normatively sanctions bullying (Randle, 2003:399; Hutchinson, Jackson, Vickers & Wilkes, 2006b: Discussion ¶ 1).

With reference to student nurses, Hutchinson (2009:150-151) strongly advocates the use of restorative interventions in pre-registration training programs, to create awareness of and commence moral discourse about bullying behaviour. Such interventions could conceivably interrupt the socialisation process that perpetuates

bullying in nursing. However, participation in such restorative programs presupposes a high level of emotional maturity, the very characteristic often lacking in a bully.

Griffin (2004:262) found that the use of confrontation techniques, conveyed during education sessions to newly licensed nurses, caused the cessation of lateral violence by all nurse perpetrators. These findings have obvious positive implications for the training of student nurses.

2.4 CONCEPTUAL FRAMEWORK

As mentioned in chapter 1 (paragraph 1.6), the exploratory nature of this study precludes a comprehensive theoretical framework. However, typologies regarding the classification of workplace violence underpinned some of the research objectives, suggested items for inclusion in the questionnaire and guided the formulation of a functional definition of workplace violence.

2.5 CONCLUSION

Escalating workplace violence is a worldwide, inter-disciplinary problem. Nurses have been found to be particularly vulnerable to type 2 (committed by recipients of services provided in the workplace) and type 3 (violent acts by worker to worker) workplace violence. It is obvious that workplace violence has serious consequences for the individual employee (nurse), the quality of patient care and the organisation in which the violence occurs.

The reported lack of studies on the extent and nature of workplace violence, as experienced by student nurses, specifically, is a serious gap in research to date. Enabling student nurses to recognise, report and deal with workplace violence should occur before students are socialised into the acceptance of violence as an inherent part of nursing. Research in this area may contribute to student nurse retention, prevent serious emotional, psychological and even physical harm, and ultimately contribute to a safer workplace and improved patient care.

In the next chapter the attention is focused on a discussion of the research methodology used during this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

As indicated in chapter 1, the well documented frequency of workplace violence, directed at nurses worldwide, and the potentially devastating consequences of such violence formed the background to this study. The literature review revealed that, while nurses are definitely at risk of physical violence, it is particularly the perhaps less obvious, non-physical violence, that is widespread in nursing. Most studies, however, were done among trained / registered nursing staff. The relative lack of such studies among student nurses, the importance of retaining staff in an already threatened profession and the possibility of the negative socialisation of student nurses into acceptance or perpetration of workplace violence, prompted the researcher to undertake a descriptive study, by investigating the experiences of student nurses regarding workplace violence.

The research design and associated methodology utilised to achieve the objectives of this study are discussed in this chapter. Mouton (2001:55) describes the research methodology as a process in which the research design is systematically, methodically and accurately implemented, in a manner similar to the way in which a house is built according to its particular architectural design or blueprint. Therefore, attention was paid to all the vital components of the research methodology, including the overall research design, population, sampling, data gathering and processing, and its interpretation.

3.2 RESEARCH DESIGN

The research design guides the research methodology, provides a blueprint for the study and increases the validity of the findings by maximising control of the study (Mouton, 2001:55; Burns & Grove, 2007:237). A quantitative, descriptive design, employing a survey, was deemed most appropriate to achieve the objectives of the study. Burns and Grove (2007:24) regard a quantitative, descriptive research design as particularly suitable when describing what exists in real life situations. In this

study, there was no manipulation of variables, since respondents were merely required to report their experiences related to workplace violence, as they had occurred during real life clinical placements. A further justification for the choice of a quantitative design was the fact that the Likert-type scale, predominantly used in this study, is a form of instrumentation yielding quantifiable data, commonly employed to measure attitudes, feelings or opinions of respondents (Brink, 2006:153; Burns & Grove, 2007:388).

According to Mouton (2001:152), a survey is also suitable when a representative sample is utilised to gain a broad overview of a topic in a large population. Babbie (2007:244) too, identifies survey research as the best method for describing a population too large for gathering data through direct observation. In this study the population, comprising 729 student nurses, was too large to observe directly. Surveys are furthermore eminently appropriate when individual people, in this case student nurses, are the unit of analysis (Babbie, 2007:244). Surveys can vary from inductive, a-theoretical type surveys to analytical, theory driven surveys (Mouton, 2001:152). The inductive, a-theoretical type of survey was more appropriate for the exploratory nature of this study.

Although survey research has obvious strengths regarding the amount and standardisation of data that can be collected, it is relatively inflexible, and in-depth understanding of social dynamics in their natural settings is difficult to attain (Babbie, 2007:281). While it can therefore be argued that a qualitative research design promotes in-depth understanding of human experiences and emotions (Burns & Grove, 2007:18), it was not considered an appropriate design, due to the stated intention to obtain a broad overview of the nature and extent of workplace violence among the under researched population of student nurses.

3.3 POPULATION AND SAMPLING

According to Burns and Grove (2007:324) the population, also called target population, includes every element or subject that meets the sampling criteria, while the accessible population is that section of the target population to which the researcher has reasonable access. The target population selected for this study was all the second, third and fourth-year nursing students, registered at the Western

Cape College of Nursing for the R425 Diploma, leading to registration as a nurse (general, psychiatric and community) and midwifery. The entire population was readily accessible, due to the fact that the researcher was a lecturer at the Western Cape College of Nursing. The size of the total population was 729 (n = 729).

Sampling is the process of selecting respondents from the population, with the purpose of obtaining information about a phenomenon in such a way that the respondents (or sample) represent the population of interest (Brink, 2006:124; Burns & Grove, 2007:324). A representative sample resembles the population in as many ways as possible (Burns & Grove, 2007:327). Representativeness is vitally important when the researcher, by means of generalisation, draws conclusions about the population (Brink, 2006:125). Although the whole population was accessible by the researcher, time and money constraints made the study of every subject impractical. However, the compilation of a sampling frame, i.e. a list of every subject in the population (Burns & Grove, 2007:330), was relatively simple, because of the accessibility of the population. Respondents were then selected *via* probability, or random sampling.

Probability sampling methods increase the representativeness of the sample (Babbie, 2007:189; Burns & Grove, 2007:330) and imply that every person on the sampling frame has an equal chance of inclusion in the sample (Brink 2006:126; Babbie 2007:189). This is obviously advantageous, as researcher bias is reduced and findings can be generalised to the population (Brink, 2006:126). Particularly significant is that it avoids conscious, or unconscious biases by the researcher in the selection of respondents for study, by ensuring a non zero probability of selection for each subject (Babbie, 2007:215). This kind of control was especially relevant to this study, due to the researcher being a lecturer at the institution where the study was conducted. Non-probability sampling methods were not considered for this study, because of the risk of bias being introduced by available and willing respondents. Students, who had encountered workplace violence, may conceivably have been more eager to take part in the study, than those who had little or no exposure to such behaviour. Using a random sampling process therefore reduced the possibility of systematic variation or bias (Burns & Grove, 2007:328).

The sampling design utilised to select the sample was stratified, random sampling. Stratified sampling reduces the sampling error on identified variables (Babbie,

2007:206). This sampling design is chosen when, in the opinion of the researcher, certain variables in the population are regarded as critical for achieving representativeness (Burns & Grove, 2007:333). Instead of selecting a sample from the total population at large, the population is divided into strata or subgroups, according to those variables (Brink 2006:130; Babbie 2007:206). In this research study, gender and year of study were regarded as variables of such potential significance, that steps had to be taken to ensure adequate representation. Also, as was mentioned, one of the objectives of the study was to establish any relationships between elements of workplace violence, year of study and gender.

The final selection of respondents was done with the help of a statistician, using a computer program that provided a random selection of sampling units, i.e. the elements considered for selection during sampling (Babbie, 2007:191). The name and student number of every subject on the sampling frame was supplied to the statistician and a random sample, comprising 35% of the population, was selected from each subgroup or stratum (year of study and gender), according to the population proportions of each stratum.

A sample size of 35% (n = 255) was chosen, because descriptive and correlation studies typically require larger samples, especially when survey questionnaires are used (Burns & Grove, 2007:341). Sample size should also increase in accordance with the number of demographic variables included in the data analyses (Burns & Grove, 2007:342). According to Polit and Hungler (1995, cited in Brink, 2006:136), most researchers are of the opinion that there should be at least 10, but preferably 20 to 30 respondents per demographic variable. According to these guidelines, the sample size of n = 255 for this study was more than adequate, with the only three demographic variables utilised in the data analyses being age, year of study and gender.

Some of the other factors affecting sample size are measurement sensitivity, expected response rate and the planned methods of statistical analyses (Brink, 2006:137; Burns & Grove, 2007:342). The relatively large sample size was justified by the fact that the measurement of psychosocial variables tend to be less precise than the measurement of physiological variables, and therefore a bigger sample size would assure significance (Burns & Grove, 2007:342). Furthermore, a response rate of 70% by a selected sample is regarded as more than adequate for analysis and

reporting (Babbie, 2007:262). For this study, the response rate was expected to be fairly high, due to the relatively easy and direct access to the respondents by the researcher, and by the fact that during the pilot study (paragraph 3.5) a response rate of over 80% was recorded. A sample size of 35% was therefore regarded as adequate in ensuring that, ultimately, at least 30% of the total population would be surveyed. Finally, the planned method of statistical analyses affects sample size. Larger samples are required when the power of the statistical analysis is expected to be weak (Burns & Grove, 2007:342). This was applicable, because of the imprecise measurements associated with psychosocial variables (Burns & Grove, 2007:342). Furthermore, the planned utilisation of the chi-square test of independence to investigate relationships between nominal variables meant that a fairly large sample was required to reduce the risk of a type II error (Burns & Grove, 2007:420).

3.3.1 Inclusion criteria

The researcher was particularly interested in describing the nature and extent of workplace violence, as experienced by the relatively inexperienced, pre-registration students. Therefore, the inclusion sampling criteria was registration as a second, third, or fourth-year student nurse. Sampling criteria are the list of attributes which qualify respondents for inclusion in the target population (Burns & Grove, 2007:324).

3.3.2 Exclusion criteria

As there were no exclusion sampling criteria, the whole target population was eligible for selection as respondents. First-year students were not considered, due to their limited exposure to the clinical areas, whilst post-basic program students were not considered, because of their pre-program nursing experience ranging from 2 - 30 years.

3.4 INSTRUMENTATION

A self completed paper questionnaire was chosen as the instrument to elicit information from the research respondents. This form of instrumentation is highly suitable for use in descriptive studies, such as this one, where the objective is to

gather a broad spectrum of information, ranging from facts about the subject to beliefs, attitudes, opinions and knowledge of the subject (Burns & Grove, 2007:382). It is also an instrument which is specifically designed to facilitate analysis of information (Babbie, 2007:245). In addition, the higher sense of anonymity maintained in a self completed questionnaire is associated with higher levels of honesty (Brink, 2006:147), particularly amongst student nurses who may feel vulnerable in a face to face situation, for example during an interview, particularly with a lecturer. Although the first languages of some of the respondents were Xhosa and Afrikaans, the questionnaire was only constructed in English, due to English being the only language of instruction and academic expression at the College where the study was conducted. Having reached at least their second year of study, respondents had demonstrated an acceptable proficiency in English and were deemed competent to answer the questionnaire.

The questionnaire (annexure 3) contained 5 sections. Section A inquired about demographic information, namely gender, age and year of study, in order to describe the sample and to establish any relationships with other research variables. Sections B - E specifically focused on aspects of workplace violence. In section B the questions addressed the frequency of different types of workplace violence under three main headings, namely non-physical violence (intimidation, bullying and verbal abuse), physical abuse and sexual abuse. Section C investigated only non-physical violence, specifically as to who the perpetrators were, the most common locations (hospital or community placements) where violent incidences occurred, and the consequences of workplace violence. Section D dealt with the reporting of any kind of workplace violence. Section E gave respondents the opportunity to make any suggestions regarding the management of workplace violence. Respondents were also required to indicate whether they had ever reported any kind of workplace violence.

The measurement of variables was done at two levels, namely nominal and ordinal. Nominal scale measurement is used when data can be organised into categories which differ in quality, but not in quantity, and that can therefore not be compared (Burns & Grove, 2007:363). Data measured at this level was gender, year of study, and two Yes / No items towards the end of the questionnaire. The rest of the quantitative variables (i.e. all the other questions, except for the final open ended question) were measured at the ordinal level. Ordinal scale measurement is used

when data is assigned to categories that can be ordered or ranked, but differs from interval scale measurement in that ordinal data is regarded as having unequal intervals (Burns & Grove, 2007:363).

The construction of the questionnaire and the succession of items were strictly directed by the research objectives formulated for the study. The literature review provided guidelines for question formulation, particularly the outcomes by Anderson (2002:359). The questionnaire contained questions and statements, a technique which increases flexibility of design and which makes a questionnaire more interesting (Babbie, 2007:246). Closed ended questions were used to establish facts about the respondents, namely year of study, age, gender, whether they had ever reported any kind of workplace violence and whether they were aware of any policy addressing workplace violence in the clinical areas. In addition to these closed ended questions, one open ended question was included at the end of the questionnaire, asking the respondents to provide suggestions regarding the management of workplace violence, targeting student nurses in the clinical areas.

In the remainder of the questionnaire, Likert-type statements, consisting of predominantly four scaling categories, required respondents to select a response from a list of four options, in order to establish the type and frequency of workplace violence, most common perpetrators of workplace violence, most common consequences of workplace violence and most common reasons for not reporting workplace violence. A Likert-scale contains declarative statements and generally has response choices that address agreement, frequency, or evaluation (Burns & Grove, 2007:388). This was a suitable option for this study, as the researcher was particularly interested in establishing the frequency of different aspects of workplace violence, and associated consequences. At the end of each subsection in sections B, C and D, provision was made for options not included by the researcher, by adding an option, “Other”, with an instruction to specify and tick the appropriate response box. This flexibility of the questionnaire attempted to obtain accurate, comprehensive and across-the-board information regarding a particular variable.

A matrix question format was selected for those sets of questions that had the same response categories. According to Babbie (2007:254), this format facilitates the answering of the questions by enabling respondents to complete a set of questions faster than with other formats.

One contingency question was asked, intended only for some respondents and contingent, or dependent on their answer to a previous question (Babbie, 2007:253). The intention of such a question is to facilitate the completion of a questionnaire by ensuring that respondents do not need to answer questions irrelevant to them (Babbie, 2007:253). This technique was applied in section D in the statement aimed at exploring reasons for never having reported an episode of workplace violence. Respondents, who in the previous question had indicated that they had reported an episode(s) of workplace violence, were directed to skip this question and to proceed to the next relevant question.

3.5 PILOT STUDY

A pilot study is a small scale version of the planned project, with the intention of refining the methodology to be used in the final / main survey (Burns & Grove, 2007:549). Information obtained during the pilot study can be used to improve a project, adjust the instrument, refine data collection plans and determine whether the proposed study is feasible (Brink, 2006:54; Burns & Grove, 2007:38). According to Mouton (2001:103), neglecting to do a pilot study is one of the most common sources of error in questionnaire construction.

In this study, 10% of the number of participants selected for the target population was invited to take part in the pilot study. Respondents who took part in the pilot study were not included in the sampling frame for the main study. The sampling method utilised for the selection of the sample for the pilot study was quota sampling. Quota sampling is a non-random, convenience sampling technique, similar to that of stratified, random sampling, in that the researcher also attempts to replicate the proportions of subgroups in the population that (s)he deems critical for representativeness (Burns & Grove, 2007:339). However, it differs from random sampling in that available respondents are simply requested to take part until the desired sample size, in this case 22 respondents for the pilot study, is reached. In accordance with the main study, the subgroups out of which quotas were obtained, were the respective years of study and gender.

The decision to utilise a convenience sampling technique for the pilot study, although with the intention of reducing potential bias by adding the feature of quota sampling

(Burns & Grove, 2007:339), was not made lightly. Clearly, a pilot study should be as similar to the main study, as possible. However, severe student unrest at the onset of the study necessitated changes to their programs, including the dates of clinical placements. These program changes meant that accessing randomly selected students, unavailable for taking part in the pilot study due to clinical placements all over the Western Cape, would have significantly delayed the actual project. A modification of the sampling method for the pilot study was thus essential, so that data collection for the actual project could be planned for a time when randomly selected respondents would be easily accessible. This protocol had been stipulated in the research proposal and had been in harmony with the time and financial constraints confronting the researcher.

A total of 22 respondents, representing just below 10% of the sample size of the actual project and proportionate to the subgroups regarding year of study and gender, declared that they were willing to complete the questionnaire. A total of 19 (86.4%) completed questionnaires were returned.

The instrument being employed for data collection during this study was hence pre-tested during the pilot study, to ensure clarity of content and to ensure that questions were relevant, understandable and could be answered by the respondents. Subsequent to the pilot study, minor changes were made to the wording and succession of some of the questions.

3.6 RELIABILITY AND VALIDITY

Reliability is the degree to which an instrument consistently measures a variable, or concept (Burns & Grove, 2007:40). According to Brink (2006:163), this means that an instrument can be depended upon to yield similar results if used by two researchers on one person. Reliability is associated with the characteristics of “dependability” and “comparability” (Burns & Grove, 2007:365). The fact that the questions were based on the literature review and other research on workplace violence, facilitated comparison, increased dependability and generally enhanced reliability. The potential of generating unreliability, by having more than one research worker (Babbie, 2007:146), was effectively negated by the fact that only the researcher distributed the questionnaires and supervised the collection of the questionnaires. According to the statistician involved at this stage of the study, the

statistical estimation of instrument reliability was unnecessary, since most of the questions measured occurrence of events, rather than, for example, attitudes (Kidd, 2010).

Validity is the extent to which an instrument indeed measures the abstract concepts it is designed to measure (Burns & Grove, 2007:365). Content and face validity assesses the representativeness of the questions to the phenomenon being studied (Brink, 2006:160). Stated differently, it means that the instrument should provide an adequate sample of all the elements of the phenomenon in question (de Vos, Strydom, Fouche & Delport, 2005:161). The face and content validity of the instrument was secured by ensuring that all of the relavent components of workplace violence, as exposed by the literature review, were represented by the questions. Furthermore, the instrument was submitted to nurse and research experts, who pronounced that they were satisfied that the content was appropriate, clear and easy to understand.

3.7 DATA COLLECTION

Data collection is the "precise, systematic gathering of information relevant to the research purpose, or the specific objectives, questions, or hypotheses of a study" (Burns & Grove, 2007:41). The data being collected in this particular study was relevant to the specific objectives formulated in response to the research question. The methodology employed to collect data is vitally important, as the accuracy of research conclusions is strengthened by high quality data collection (Brink, 2006:141).

Written permission was obtained beforehand from the Head of the College to approach the respondents at the selected setting. Consent (annexure 4), as discussed in chapter one, was obtained from all the research respondents, prior to them completing the questionnaire.

Distribution of the questionnaires to the randomly selected respondents occurred over a period of approximately two months, from the second week of March to the first week of May 2010. The setting within which the study was conducted, employ a 'block system' where students attend the College for predetermined periods of tuition, varying from two - five weeks at a time. The total research population

attended the College at varying times during the abovementioned period and was therefore easily accessible by the researcher, who personally collected all the data. The purpose of the study was explained to each respondent, prior consent was obtained and questionnaires were handed out to the selected respondents. Respondents were encouraged to complete the questionnaires on that same day during breaks from lectures, or during tea breaks, but were not prevented from taking them home if they preferred to do so. The consent forms were returned separately from the questionnaires and placed in a specific container made available for that purpose. Completed questionnaires were placed in sealed containers provided by the researcher, thereby ensuring the upholding of complete anonymity.

3.8 DATA ANALYSIS

Data analysis refers to the reduction, organisation and interpretation of data, with the methodology employed contingent upon the research objectives and the level at which the variables are measured (Burns & Grove, 2007:41-42). The fact that all the variables were measured at a nominal or ordinal level, meant that descriptive statistics (or summary statistics) were used to describe the sample, to prepare frequency distributions and to establish measures of central tendency. The relationships between continuous and nominal response variables were examined, using appropriate analysis of variance (ANOVA) tests. The relationship between two continuous variables was examined, using Pearson product moment correlations, while the chi-square test of independence was utilised to examine relationships between two nominal variables. ANOVA is used to test for differences in means and is expressed as an F statistic (Burns & Grove, 2007:430). The Pearson produce moment correlation determines the nature and strength of relationships between variables, whilst the chi-square test of independence establishes whether variables are related, or independent of each other (Burns & Grove, 2007:420, 423).

3.9 CONCLUSION

In this chapter, the selected research design, sampling methods and choice of instrumentation was discussed and justified. The preliminary pilot study was described, as were measures to enhance the validity and reliability of the instrument. Finally, an overview was given on data management and interpretation.

The research methodology used in this study is often employed in quantitative studies and has a proven track record for yielding reliable, valid and functional data for further analysis.

The quality of the data collected for this study was limited by the fact that the respondents, by virtue of their year of study and the nature of their clinical placements, did not have equal exposure to hospital and community settings. Second-year students, for example, would have had less exposure to community settings than third and fourth-year students. However, all students were exposed to both hospital and community settings in the year prior to them completing the questionnaire. Furthermore, the timing of clinical placements meant that the experience of workplace violence in specific nursing disciplines, e.g. psychiatric nursing science, could not be investigated.

In the next chapter the data analysis, results and interpretation are presented and discussed.

CHAPTER 4

RESULTS, DATA ANALYSIS, INTERPRETATION AND DISCUSSION

4.1 INTRODUCTION

The purpose of this study was to explore the extent of workplace violence, targeting student nurses in clinical areas. Questionnaires were handed out to 35% of the selected target population (n = 255), namely, second, third and fourth-year nursing students, registered at the Western Cape College of Nursing for the R425 Diploma, leading to registration as a nurse (general, psychiatric and community) and midwifery. The variables controlled by the sampling method were year of study and gender.

Accordingly, questionnaires were handed out to 35% randomly selected female students and 35% randomly selected male students, registered for each of the second, third and fourth years of study. In this manner, 100 questionnaires were handed out to second-year students (84 females and 16 males), 95 to third-year students (82 females and 13 males) and 60 (52 females and 8 males) to fourth-year students. This represented the gender distribution of the population, namely 86% females and 16% males. A total of 218 of the 255 (86%) questionnaires were completed and returned by respondents.

In this chapter, the raw data is presented, analysed and interpreted. Thereafter, the results are discussed and integrated with the findings from the literature review.

4.2 PRESENTATION AND ANALYSIS OF DATA

Data analysis is the organisation of data so as to derive meaning from it (Burns & Grove, 2007:41). The quantitative data, generated by all the questions, except for the last one (no. 66), were measured at a nominal or ordinal level. Microsoft Excel was used to capture the raw, quantitative data on computer. The data was then analysed, using the Statistica Version 9 data analysis software system. Descriptive statistics were used to describe the variables. Distributions of variables were

represented in histograms and frequency tables. Means were used as the measure of central tendency for ordinal responses, whilst standard deviations were used as the measure of spread. Measures of central tendency describe the most typical, or representative value in a distribution (Brink, 2006:177). The standard deviation, a measure of dispersion, is commonly used to indicate how the scores are spread around the mean (Brink, 2006:178).

The relationship between continuous response variables and nominal input variables were analysed, using appropriate analysis of variance (ANOVA). Where indicated, the Fisher Least Significant Difference (LSD), post-hoc test was conducted on individual means. The relationship between two nominal variables was investigated with the chi-square test. The relationship between two continuous variables was analysed with correlation analysis and the strength of the relationship measured with the Pearson product moment correlation. A p-value of $p < 0.05$ represented statistical significance.

ANOVA tests for differences in means between two or more groups and is reported as an F statistic (Burns & Grove, 2007:430). The chi-square test of independence establishes whether two nominal variables are related, or independent (Burns & Grove, 2007:420). Pearson product moment correlation is a test determining the relationship between two continuous variables. It reflects the nature (positive or negative) and strength of a relationship and is expressed as r, a correlation coefficient (Burns & Grove, 2007:423).

According to Maltby, Day and Williams (2007:114), probability (p) is used in combination with a criterion (significance testing) by researchers to establish confidence in their findings. In this study, the criterion set for confidence was at the 0.05 significance level, i.e. $p < 0.05$ represented statistical significance. Stated differently, this level of significance means there is only a 5% probability of error, or that the researcher is 95% confident of the findings.

The statistician rounded off all the percentages to the nearest whole number, which explains why some of the frequency distributions reflect percentages of 99 or 101. Statisticians from the Centre for Statistical Consultation at the University of Stellenbosch, consulted independently by the researcher, advised that this was entirely acceptable practice (Kidd, 2010; Nel, 2010).

4.3 RESULTS OF THE STUDY

This section of the chapter presents the raw data generated during the questionnaire survey. The responses to each question (variable) in the questionnaire (annexure 3) were summarised in frequency tables and histograms and discussed individually. Where deemed appropriate and helpful, some of the responses were summarised in a composite frequency table.

This section starts with frequency distributions of the demographic variables. Thereafter, descriptive statistics (frequency distributions and where appropriate, measures of central tendency and dispersion) of all other quantitative variables are presented in accordance with the specific research objectives (chapter 1.4) and questionnaire layout (annexure 3) of this study. The responses to the open-ended question (no. 66) were grouped, quantified and presented with the aid of a frequency distribution table.

4.3.1 Section A: Demographic data

Question 1: Gender (n = 218)

Table 4.1: Gender of respondents

Gender	Frequency (*f*)	Percentage (%)
Female	185	85
Male	33	15
Total	**n = 218**	**100**

As indicated in table 4.1 the majority of the respondents were female. However, the gender distribution of 85% females and 15% males represented the gender distribution of the target population, and was one of the variables being controlled by the sampling method.

Question 2: Age (n = 206)

Table 4.2: Age of respondents

Age	Frequency (*f*)	Percentage (%)
15 - 19	14	7
20 – 24	99	48
25 – 29	47	23
30 – 34	30	15
35 – 39	11	5
40 – 44	04	2
45 - 49	01	0
Total	**n = 206**	**100**

Twelve respondents did not answer this question. Table 4.2 shows that 99 (48%) of the respondents were in the age group 20 – 24. A total of 176 respondents (86%) were aged between 20 - 34 years. Five respondents were 40 and older. The mean age was 25.6 years and the standard deviation was 5.52.

Question 3: Year of study (n = 218)

The year of study was the second variable controlled by the sampling method. The distribution of respondents according to year of study (table 4.3), largely represented the distribution of year groups in the target population. The number of 2nd year respondents (89) represented 41% of the total number of respondents, whilst 2nd year students represented 39% of the population. The number of 3rd year (72) and 4th year (57) respondents represented 33% and 26% of the total number of respondents, respectively, whilst 3rd and 4th year students represented 37% and 24% of the population, respectively.

Table 4.3: Year of study

Category	Frequency (*f*)	Percentage (%)
2nd year	89	41
3rd year	72	33
4th year	57	26
Total	**n = 218**	**100**

4.3.2 Section B: Data related to form and frequency of workplace violence

In this section, the data related to the following two objectives of the research study are presented:

- Identify the nature / type of workplace violence; and
- Establish the frequency of workplace violence.

The frequency of different types of workplace violence, as experienced by respondents in the previous year, was established. In line with the functional definition of workplace violence (chapter 1.7.1), questions 4 – 15 investigated the frequency of various types of non-physical violence, such as intimidation, bullying and verbal abuse, questions 16 – 23 investigated the frequency of various forms of physical abuse, whilst questions 24 – 29 investigated the frequency of sexual abuse.

The respondents were instructed to use the following response key:

- 1 = Never;
- 2 = Occasionally (1 – 2 times);
- 3 = Sometimes (3 – 5 times); and
- 4 = Often (>5 times).

4.3.2.1 Form and frequency of non-physical violence (questions 4 - 15)

Questions 4 - 14 were arranged in a matrix, within which respondents had to indicate his / her level of exposure to various forms of non-physical violence. Question 15

afforded the respondents an opportunity to identify and report on a form of non-physical violence not included in the given matrix. Accordingly, it was titled ‘Other’. The questions were prefaced by the statement: “In the past year in the clinical areas, I have been intimidated, bullied, or verbally abused in the following ways”.

Question 4: Non-verbally, e.g. raised eyebrows, rolling eyes (n = 216)

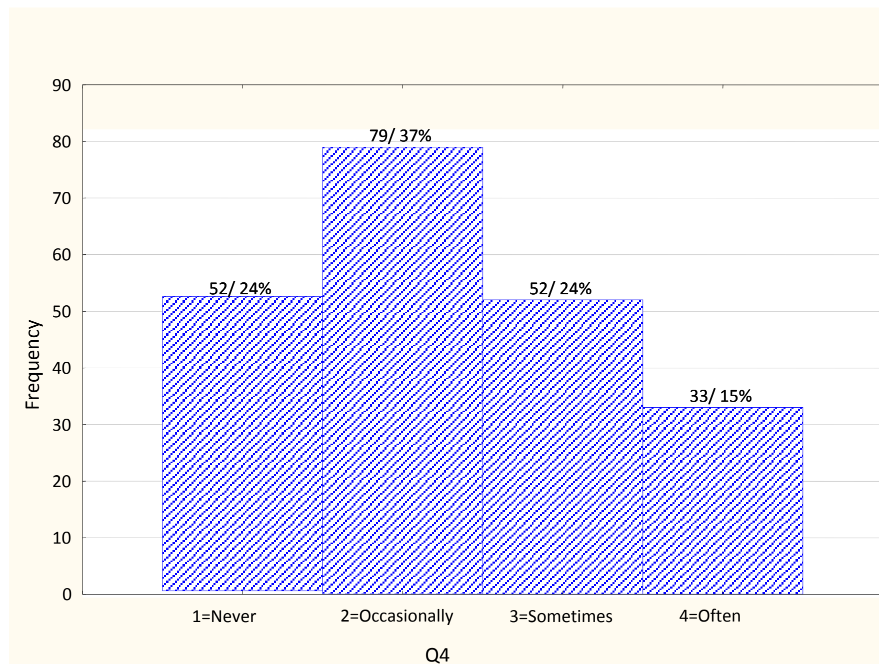

Figure 4.1: Nursing students’ experience of non-verbal violence (e.g. raised eyebrows, rolling eyes).

Two respondents did not answer this question. Figure 4.1 shows that non-verbal workplace violence was a common experience, with 76% (n = 164) reporting that they had experienced such behaviour *occasionally* (37% or n = 79), *sometimes* (24% or n = 52), or *often* (15% or n = 33).

Question 5: Sworn, shouted or yelled at (n = 216)

Two respondents did not answer this question. According to figure 4.2, 67% (n = 145) of respondents had been sworn, shouted or yelled at in the previous year, with 39% (n = 85) reporting that this had occurred *occasionally*, 17% (n = 36) *sometimes* and 11% (n = 24) *often*.

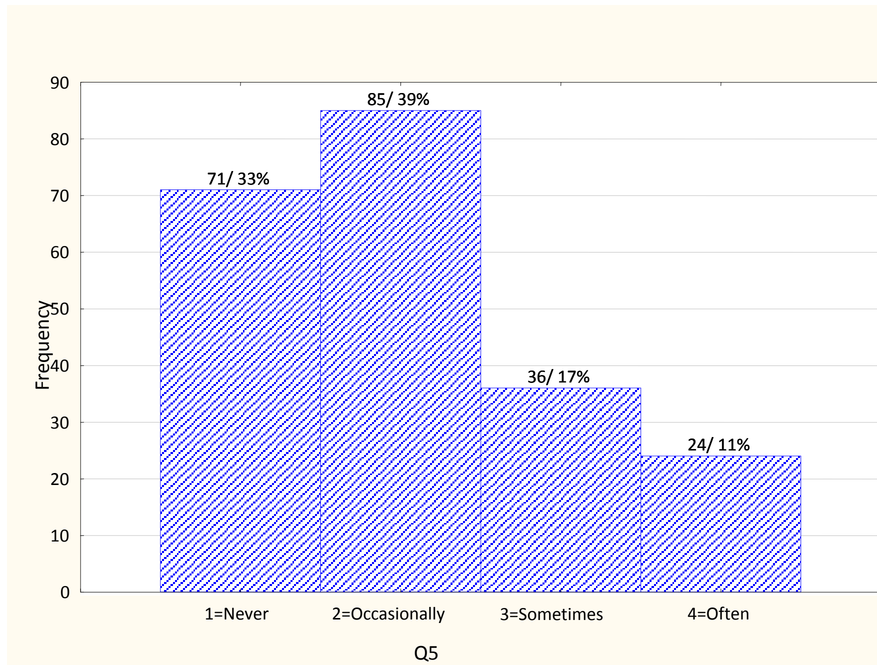

Figure 4.2: Nursing students' experience of being sworn, shouted or yelled at.

Question 6: Harshly judged / criticised (n = 215)

Three respondents did not answer this question. Figure 4.3 indicates that 68% (n = 147) had been harshly judged or criticised *occasionally* (35% or n = 75), *sometimes* (22% or n = 48), or *often* (11% or n = 24) in the previous year.

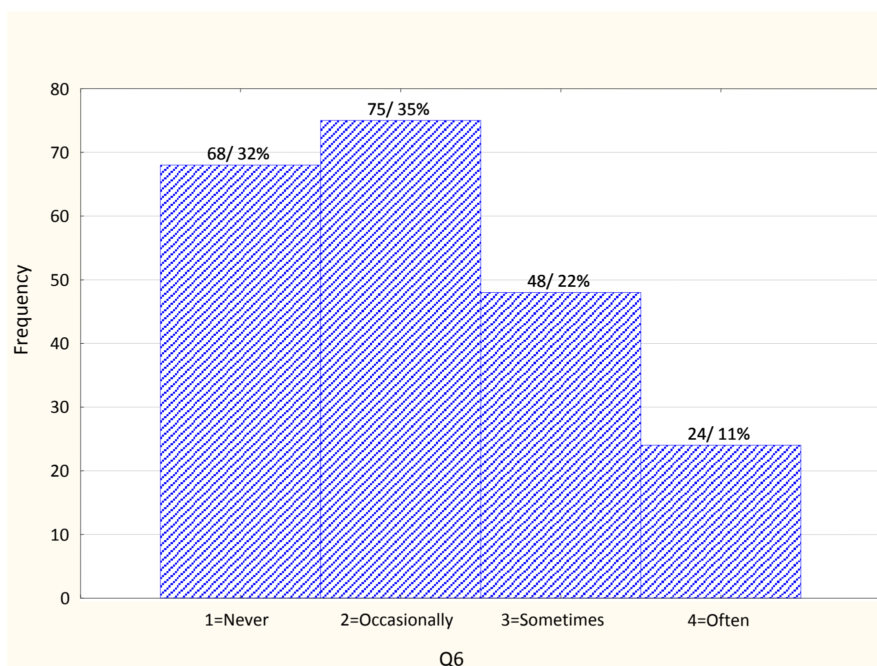

Figure 4.3: Nursing students' experience of being harshly judged / criticised.

Question 7: Ignored or neglected (n = 214)

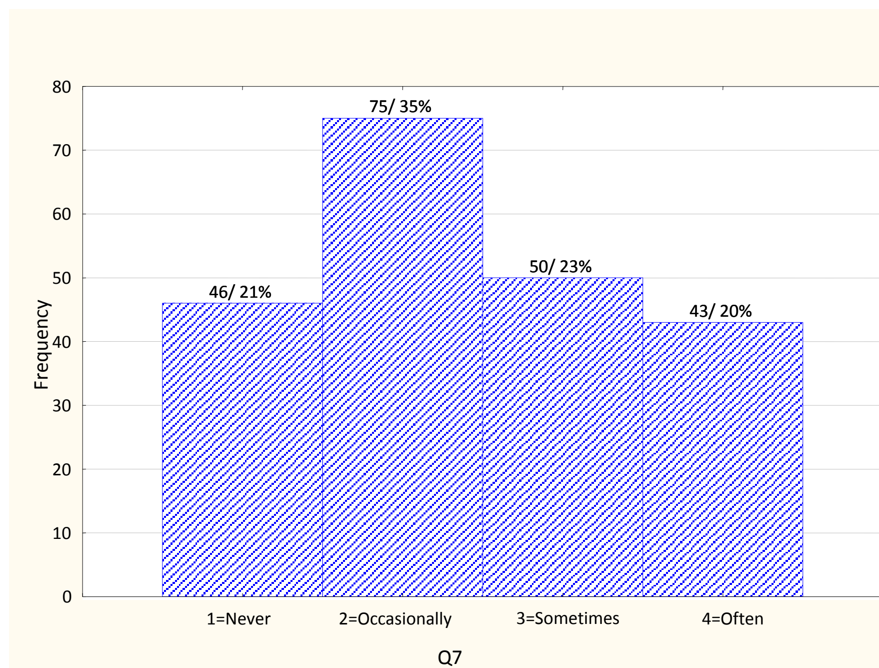

Figure 4.4: Nursing students' experience of being ignored or neglected.

Four respondents did not answer this question. As indicated in figure 4.4, a large majority (78% or n = 168) of the respondents had felt ignored or neglected *occasionally* (35% or n = 75), *sometimes* (23% or n = 50), or *often* (20% or n = 43) during the previous year. More than half of this number (n = 93) reported that such behaviour had occurred *sometimes*, or *often*, i.e. three or more times.

Question 8: Ridiculed or humiliated (n = 212)

Six respondents did not answer this question. Figure 4.5 demonstrates that a total of 61% (n = 130) respondents reported having been ridiculed or humiliated in the previous year. A total of 35% (n = 75) indicated that this had happened *occasionally*, 18% (n = 39) *sometimes* and 8% (n = 16) *often*.

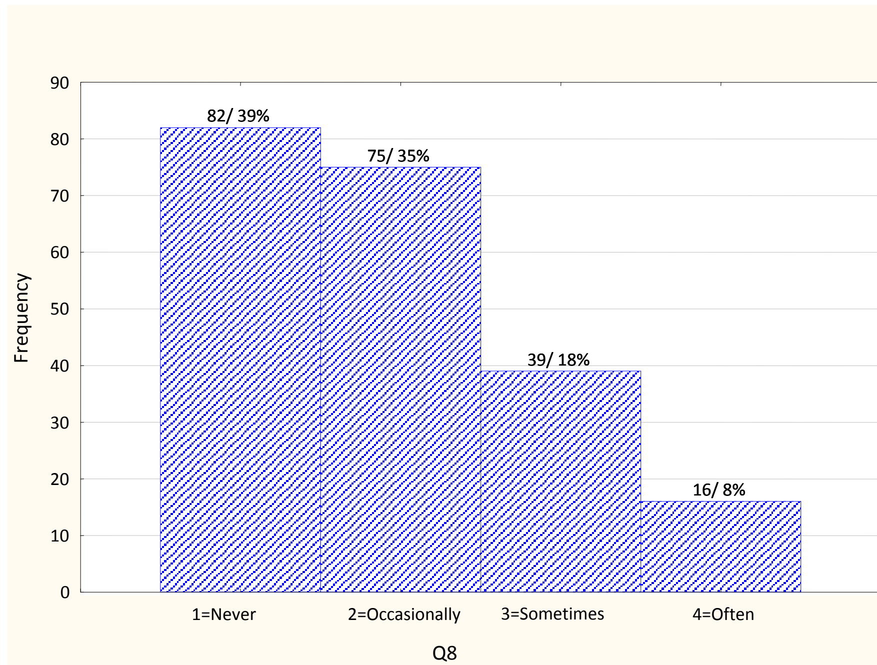

Figure 4.5: Nursing students' experience of being ridiculed or humiliated.

<u>Question 9: Being unfairly treated regarding on / off duty schedules (n = 216)</u>

Two respondents did not answer this question. From figure 4.6 it can be seen that 66% (n = 141) of respondents had been the target of such behaviour, with 30% (n = 65) reporting *occasionally*, 17% (n = 36) *sometimes* and 19% (n = 40) that they had *often* been unfairly treated regarding duty schedules.

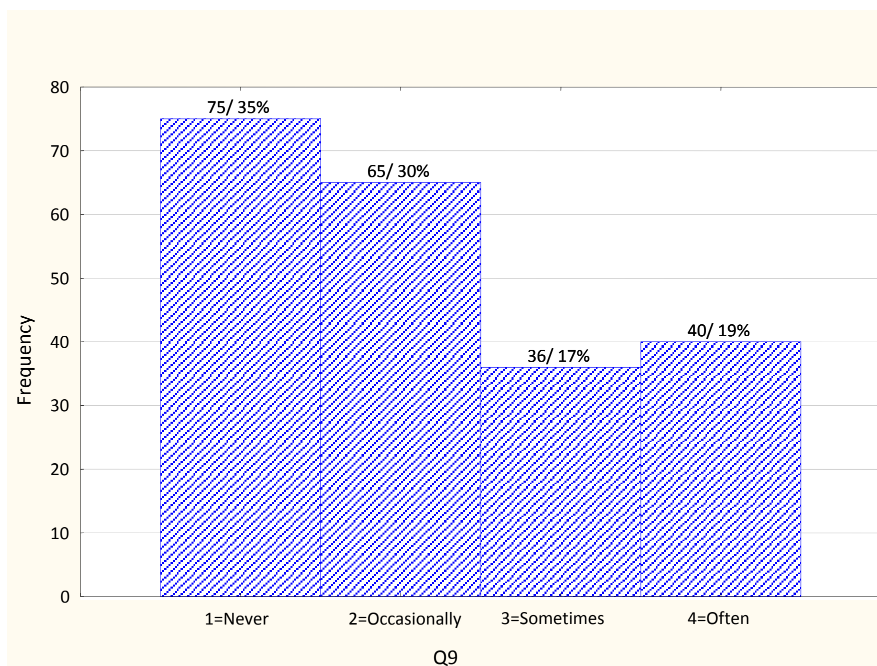

Figure 4.6: Nursing students' experience of being unfairly treated regarding on / off duty schedules.

Question 10: Given unfair work allocation (n = 216)

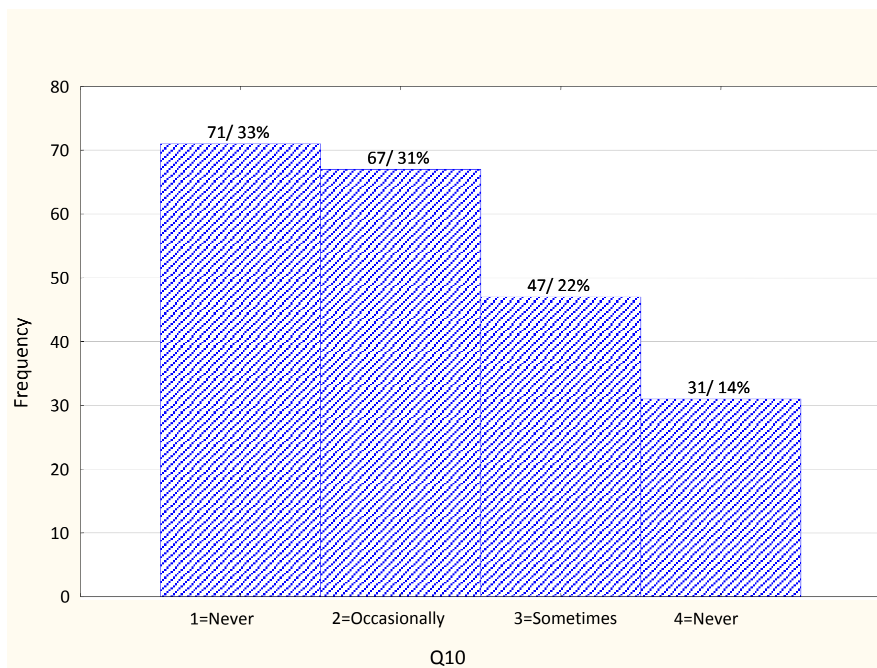

Figure 4.7: Nursing students' experience of unfair work allocation.

Two respondents did not answer this question. Figure 4.7 depicts that a total of 67% (n = 145) were of the opinion that they had *occasionally* (31% or n = 67), *sometimes* (22% or n = 47), or *often* (14% or n = 3) been given unfair work allocation in the previous year. Of these, more than half (n = 78) had experienced this three or more times.

Question 11: Not received acknowledgement for good work (n = 215)

Three respondents did not answer this question. Figure 4.8 shows that a large majority of 75% (n = 161) of respondents felt that there were times that they had not received acknowledgement for good work. Of the total number of respondents, 33% (n = 72) reported that it had *occasionally* happened, 20% (n = 42) *sometimes* and 22% (n = 47) *often.*

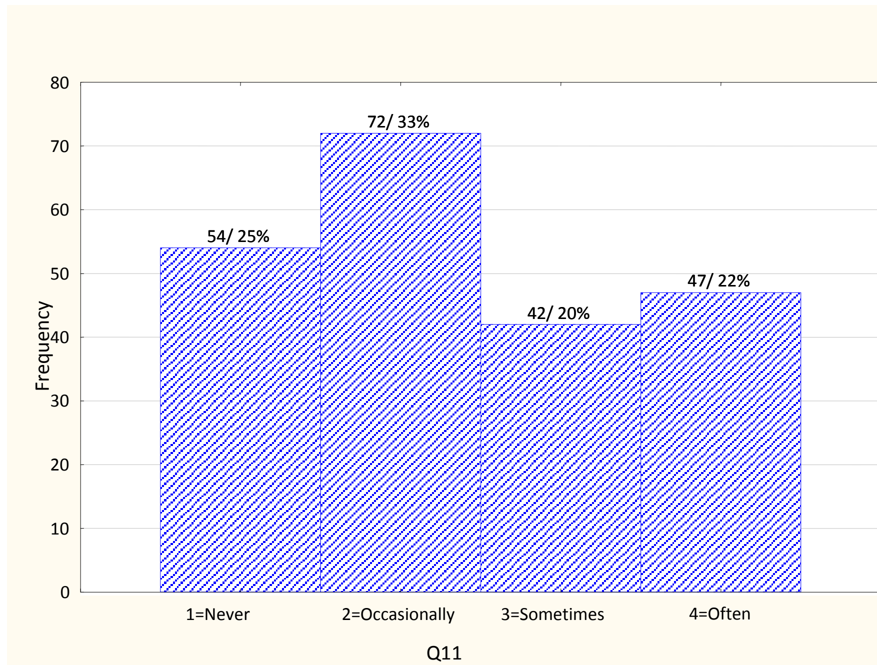

Figure 4.8: Nursing students' experience of not receiving acknowledgement for good work.

Question 12: Denied learning opportunities (n = 212)

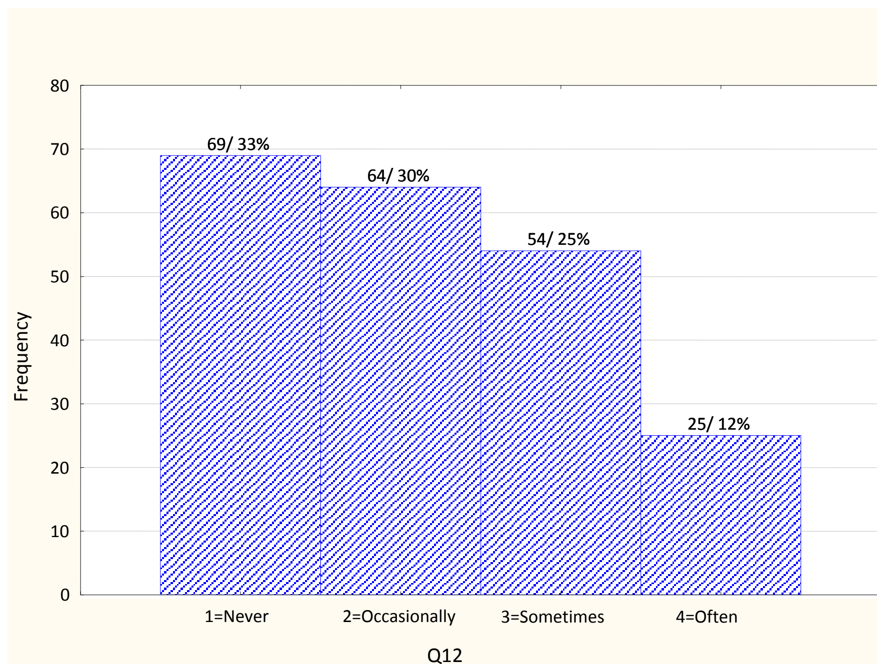

Figure 4.9: Nursing students' experience of being denied learning opportunities.

Six respondents did not answer this question. Of the 67% (n = 143) who responded that they had been denied learning opportunities, more than half (n = 79), representing 37% of the respondents, reported that it had occurred three or more times in the previous year, and 30% (n = 64) reported that it had occurred *occasionally* (figure 4.9).

Question 13: Had a racist remark directed at me (n = 217)

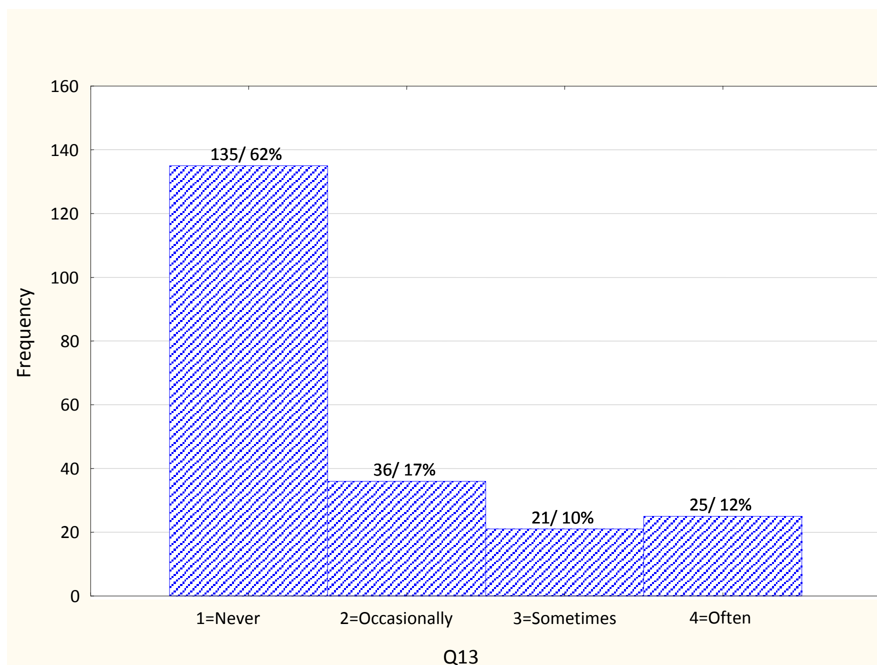

Figure 4.10: Nursing students' experience of racist remarks.

One respondent did not answer this question. The majority 62% (n = 135) had *never* experienced a racist remark. Of the remaining 38%, 17% (n = 36) *occasionally*, 10% (n = 21) *sometimes* and 12% (n = 25) had *often* experienced a racist remark.

Question 14: Not being treated as part of the multidisciplinary team (n = 218)

As depicted in figure 4.11, the majority (61% or n = 134) of the respondents had experienced not being treated as part of the multidisciplinary team. Of the total number of respondents, 36% (n = 80) had been targeted by this behaviour three or more times in the previous year and 25% (n = 54) reported being *occasionally* not treated as part of the multidisciplinary team.

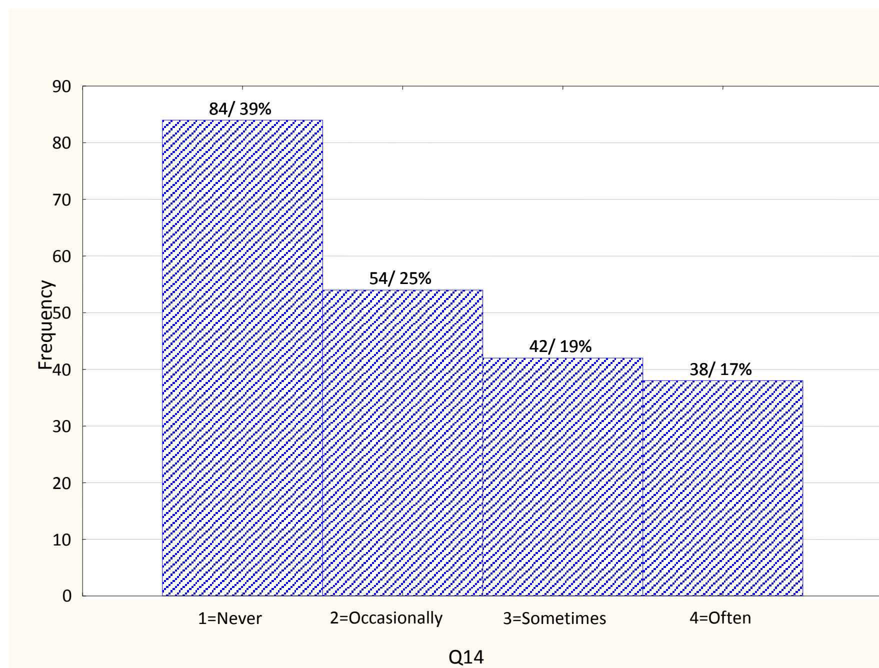

Figure 4.11: Nursing students' not being treated as part of multidisciplinary team.

Question 15: Other (n = 4)

Four respondents answered this question. Two responses were related to unfair work allocation, e.g. being put in charge of a ward, because the permanent staff had left early, due to transport problems. Two responses amounted to discrimination based on language, namely, "*no-one willing to translate*" and "*they gossip about me not knowing I can understand the language*".

Table 4.4 depicts the mean and standard deviation for each of the variables depicted in questions 4 - 14. They were arranged from the most to the least frequently occurring variables. A confidence interval of 0.95 was established for the mean of each variable. Although table 4.4 indicates that being ignored or neglected had been the most frequently experienced form of non-physical workplace violence, the small difference in the means of the first eight variables indicated little difference in the frequency of these behaviours.

Table 4.4: Means and standard deviations of variables regarding form and frequency of non-physical violence

Kind of non-physical violence		Mean	Confidence -95%	Confidence 95%	Standard deviation
Q07	Ignored or neglected	2.42	2.28	2.56	1.04
Q11	Not received acknowledgement for good work	2.38	2.24	2.53	1.09
Q04	Non-verbally, e.g. raised eyebrows, rolling eyes	2.31	2.17	2.44	1.00
Q09	Being unfairly treated regarding on / off duty schedules	2.19	2.04	2.34	1.11
Q10	Given unfair work allocation	2.18	2.04	2.32	1.05
Q12	Denied learning opportunities	2.17	2.03	2.30	1.02
Q14	Not being treated as part of the multidisciplinary team	2.16	2.01	2.31	1.12
Q06	Harshly judged / criticised	2.13	2.00	2.26	0.99
Q05	Sworn, shouted or yelled at	2.06	1.93	2.19	0.97
Q08	Ridiculed or humiliated	1.95	1.82	2.08	0.94
Q13	Had a racist remark directed at me	1.71	1.57	1.85	1.05

4.3.2.2 Form and frequency of physical violence (questions 16 – 23)

Questions 16 – 22 were arranged in a matrix, within which respondents had to indicate his / her level of exposure to various forms of physical violence. Question 23 afforded the respondents an opportunity to identify and report on a form of physical violence not included in the given matrix. Accordingly, it was titled ‘Other’. Table 4.5 represents a composite summary of the responses to questions 16 - 22. The

questions were prefaced by the statement: "In the past year, in the clinical areas, I have been physically abused in the following ways".

Table 4.5: Form and frequency of physical violence experienced by nursing students

Form of physical violence		Frequency (*f*)				n
		Never	Occasionally 1–2 times	Sometimes 3–5 times	Often >5 times	
Q16	Pushed or shoved	203 (93%)	13 (6%)	1 (0%)	1 (0%)	218 (99%)
Q17	Kicked	216 (99%)	1 (0%)	0	1 (0%)	218 (99%)
Q18	Slapped or punched	212 (97%)	4 (2%)	1 (0%)	1 (0%)	218 (99%)
Q19	Hit with something	214 (98%)	4 (2%)	0	0	218 (100%)
Q20	Had a gun or knife pulled on me	218 (100%)	0	0	0	218 (100%)
Q21	Threatened with physical violence	202 (93%)	11 (5%)	3 (1%)	2 (1%)	218 (100%)
Q22	Had something deliberately damaged	203 (93%)	12 (6%)	3 (1%)	0	218 (100%)

Question 16: Pushed or shoved (n = 218)

Table 4.5 shows that the majority of the respondents (93% or n = 203) had *never* been pushed, or shoved in the clinical area in the previous year. A relatively small number (6% or n = 13) of respondents had *occasionally* been pushed or shoved.

Question 17: Kicked (n = 218)

According to table 4.5, 99% (n = 216) of respondents had *never* been kicked.

Question 18: Slapped or punched (n = 218)

Again, a majority (97% or n = 212) of respondents had *never* been slapped or punched in the clinical areas in the previous year (table 4.5).

Question 19: Hit with something (n = 218)

Continuing the trend, table 4.5 depicts the majority of respondents (98% or n = 214) as *never* having been hit with something in the clinical areas in the previous year.

Question 20: Had a gun or knife pulled on me (n = 218)

As table 4.5 shows, none of the respondents had had a gun or knife pulled on them in the clinical areas during the previous year.

Question 21: Threatened with physical violence (n = 218)

Table 4.5 shows that the majority (93% or n = 202) of respondents had *never* been threatened with physical violence. However, 7% (n = 16) had been threatened once or more with physical violence.

Question 22: Had something of mine deliberately damaged (n = 218)

Similar to threats of physical violence, table 4.5 shows that although 93% (n = 203) of respondents *never* had something of theirs deliberately damaged, 7% (n = 15) had been subject to such behaviour in the previous year.

As can be seen in table 4.5, the vast majority of subjects had *never* experienced any form of physical violence in the previous year. The notable exceptions were with regards to question 16, where 6% (n = 13) reported that they had *occasionally* been pushed or shoved; question 21, where 5% (n = 11) indicated that they had *occasionally* been threatened with physical violence, and question 22, where 6% (n = 12) of respondents indicated that *occasionally* something belonging to them had been deliberately damaged.

Question 23: Other (n = 0)

No respondents answered this question.

Table 4.6 shows the mean and standard deviation for every variable, each representing a form of physical violence being described. They were arranged from the most to the least frequently occurring variable. A confidence interval of 0.95 was established for the mean of each variable.

Table 4.6: Means and standard deviations of variables regarding form and frequency of physical violence

Kind of physical violence		Mean	Confidence -95%	Confidence 95%	Standard deviation
Q21	Threatened with physical violence	1.11	1.05	1.16	0.42
Q16	Pushed or shoved	1.08	1.04	1.13	0.34
Q22	Had something deliberately damaged	1.08	1.04	1.13	0.32
Q18	Slapped or punched	1.04	1.00	1.08	0.28
Q17	Kicked	1.02	0.99	1.05	0.21
Q19	Hit with something	1.02	1.00	1.04	0.13
Q20	Had a gun or knife pulled on me	1.00			0.00

4.3.2.3 Form and frequency of sexual abuse (questions 24 - 29)

Questions 24 -28 were arranged in a matrix, within which respondents had to indicate his / her level of exposure to various forms of sexual abuse. Question 29 afforded the respondent an opportunity to report on a form of sexual abuse not included in the given matrix. Accordingly, it was titled ‘Other’. Table 4.7 represents a composite summary of the responses to questions 24 -28. All the questions were prefaced by the statement: “In the past year, in the clinical areas, I have been sexually abused in the following ways”.

Table 4.7: Form and frequency of sexual abuse experienced by nursing students

Form of sexual abuse		Frequency (*f*)				n
		Never	Occasionally 1–2 times	Sometimes 3–5 times	Often >5 times	
Q24	Inappropriately touched	193 (89%)	21 (10%)	1 (0%)	3 (1%)	218 (100%)
Q25	Threatened with sexual assault	211 (97%)	6 (3%)	1 (0%)	0	218 (100%)
Q26	Sexist remarks	174 (80%)	35 (16%)	5 (2%)	4 (2%)	218 (100%)
Q27	Suggestive sexual gestures	189 (87%)	22 (10%)	4 (2%)	3 (1%)	218 (100%)
Q28	Request for intimate sexual contact	191 (88%)	20 (9%)	2 (1%)	3 (1%)	216 (99%)

Question 24: Inappropriately touched (n = 218)

Table 4.7 shows that although 89% (n = 193) of respondents had *never* been inappropriately touched, 10% (n = 21) had *occasionally* been subjected to such behaviour.

Question 25: Threatened with sexual assault (n = 218)

As depicted in table 4.7, being threatened with sexual assault had not been commonly experienced, with 97% (n = 211) of respondents *never* experiencing such behaviour.

Question 26: Sexist remarks (n = 218)

Table 4.7 illustrates that in the previous year, 16% (n = 35) had *occasionally*, 2% (n = 5) *sometimes* and 2% (n = 4) *often* experienced sexist remarks directed at them.

Question 27: Suggestive sexual gestures (n = 218)

Table 4.7 shows that 13% (n = 29) of respondents had been subjected to suggestive sexual gestures in the previous year.

Question 28: Request for intimate sexual contact (n = 216)

Two respondents did not answer this question. In keeping with the trend, table 4.7 shows that 11% (n = 25) had been asked to engage in intimate sexual contact during the previous year.

In all, but one, of the categories of sexual abuse, approximately 10% of respondents had experienced *occasional* abuse. More specifically, on at least one or two occasions in the previous year, 10% (n = 21) of respondents had been inappropriately touched, 16% (n = 35) had been subjected to sexist remarks directed at them, 10% (n = 22) had been subjected to suggestive sexual gestures and 9% (n = 20) had received a request for intimate sexual contact on one or two occasions in the previous year. The exception to this trend was with being threatened with sexual assault, where only 3% (n = 6) of respondents had *occasionally* experienced such behaviour.

Question 29: Other (n = 1)

One respondent stated that she had been "cornered".

Table 4.8 summarises the mean and standard deviation for every variable, each representing a form of sexual abuse being described above. They were arranged from the most to the least frequently occurring variable. A confidence interval of 0.95 has been established for the mean of each variable.

Table 4.8: Means and standard deviations of variables regarding form and frequency of sexual violence

Kinds of sexual violence		Mean	Confidence -95%	Confidence 95%	Standard deviation
Q26	Sexist remarks	1.26	1.18	1.34	0.59
Q27	Suggestive sexual gestures	1.18	1.11	1.25	0.52
Q28	Request for intimate sexual contact	1.15	1.09	1.22	0.48
Q24	Inappropriately touched	1.15	1.08	1.21	0.47
Q25	Threatened with sexual assault	1.04	1.01	1.07	0.21

4.3.3 Section C: Data related to non-physical violence only (intimidation, bullying or verbal abuse)

In this section, the questions generated information related to non-physical violence only, and data related to the following three objectives of the research study are presented:

- Distinguish between the prevalence of non-physical violence in hospital and community settings;
- Reveal the perpetrators of non-physical violence; and
- Identify type and frequency of consequences of non-physical violence.

Questions 30 - 31 asked the respondents to identify the frequency with which workplace violence occurred in hospital and in community settings. Questions 32 - 44 aimed at identifying the perpetrators of non-physical violence in the clinical areas. The effect of workplace violence on the work performance of the respondents was investigated through questions 45 - 49. Finally, in questions 50 - 57, the personal consequences of workplace violence was examined.

The respondents were instructed to use the following response key:

- 1 = Never;
- 2 = Occasionally (1 – 2 times);
- 3 = Sometimes (3 – 5 times); and
- 4 = Often (>5 times).

4.3.3.1 Prevalence of non-physical violence in hospital and community settings (questions 30 - 31)

These two questions were arranged in a matrix, within which respondents had to indicate his / her level of exposure to non-physical workplace violence in hospital and community settings. The results are presented in table 4.9. The questions were prefaced by the statement: "In the past year I have experienced intimidation, bullying or verbal abuse in the following clinical areas".

Table 4.9: Prevalence of workplace violence directed at student nurses in hospital and community settings

Clinical setting		Frequency (*f*)				n
		Never	Occasionally 1–2 times	Sometimes 3–5 times	Often >5 times	
Q30	Hospital	28 (13%)	106 (49%)	44 (20%)	38 (18%)	216 (100%)
Q31	Community	141 (69%)	36 (18%)	17 (8%)	10 (5%)	204 (100%)

Question 30: Hospitals (n = 216)

Two respondents did not answer this question. Table 4.9 shows that a large majority of 87% (n = 188) of respondents experienced workplace violence *occasionally* (49% or n = 106), *sometimes* (20% or n = 44), or *often* (18% or n = 38) in hospital settings.

Question 31: Community settings, e.g. day hospitals / clinics (n = 204)

Fourteen respondents did not answer this question. Table 4.9 shows that the majority of respondents (69% or n = 141) had *never* experienced workplace violence in community settings. Of the remaining respondents, 18% (n = 36) had *occasionally*, 8% (n = 17) *sometimes* and 5% (n = 10) *often* experienced workplace violence in community settings.

Table 4.10 shows the means and standard deviations for both variables, each representing a setting in which workplace violence had occurred. A confidence interval of 0.95 was established for the mean of each variable.

Table 4.10: Means and standard deviations of variables regarding setting of workplace violence

Setting of workplace violence		Mean	Confidence -95%	Confidence 95%	Standard deviation
Q30	Hospital	2.43	2.30	2.55	0.93
Q31	Community	1.49	1.37	1.61	0.85

4.3.3.2 Perpetrators of non-physical violence (questions 32 – 44)

The results of questions 32 - 43 are presented in figures 4.12 - 4.23. These questions were arranged in a matrix and respondents had to indicate the level of workplace violence they had experienced from selected categories of people. Question 44 afforded respondents the opportunity to identify and report on a perpetrator of workplace violence not included in the given matrix. Accordingly, question 44 was titled 'Other'. All the questions were prefaced by the statement: "In

the past year I have experienced intimidation, bullying, or verbal abuse in the clinical areas from the following sources".

Question 32: Patients (n = 217)

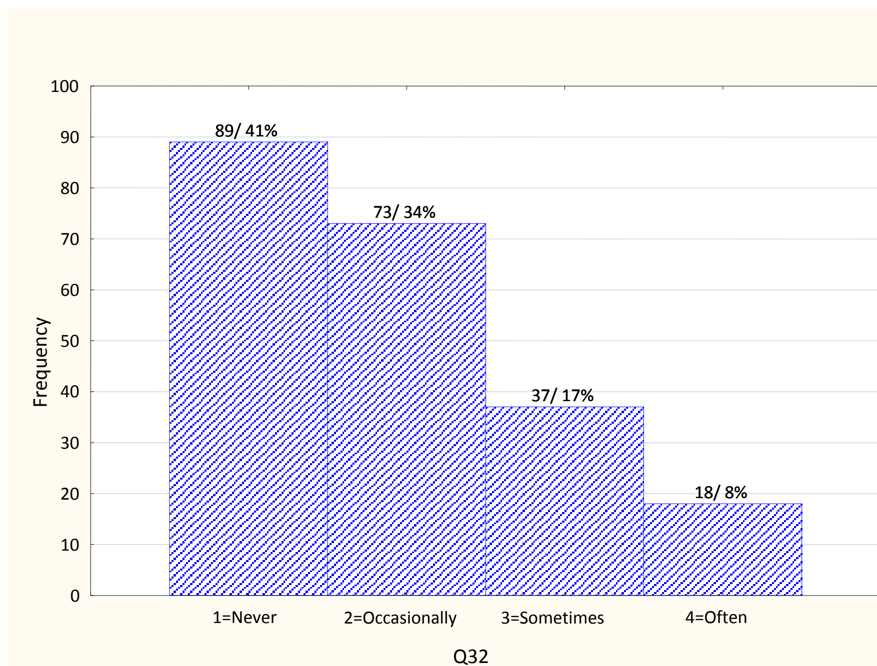

Figure 4.12: Nursing students' experience of non-physical violence from patients.

One respondent did not answer this question. According to figure 4.12, the majority of respondents (59% or n = 128) had experienced workplace violence from patients *occasionally* (43% or n = 73), *sometimes* (17% or n = 37), or *often* (8% or n = 18).

Question 33: Doctors (n = 216)

Two respondents did not answer this question. Figure 4.13 shows that a majority of 62% (n = 133) of respondents had *never* experienced workplace violence from doctors. Of the remainder, 24% (n = 52) *occasionally*, 10% (n = 22) *sometimes* and 4% (n = 9) *often* had been subjected to workplace violence from doctors.

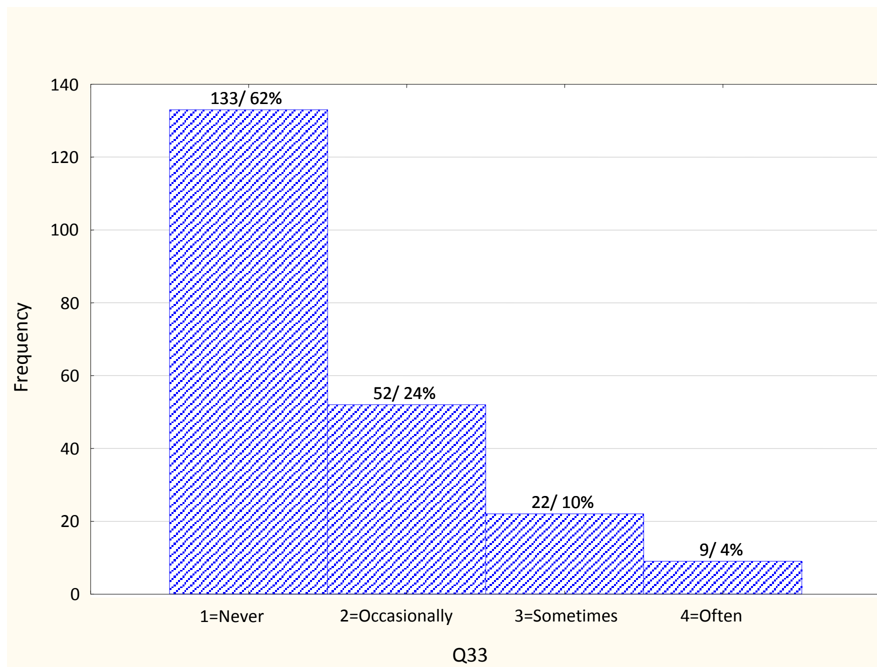

Figure 4.13: Nursing students' experience of non-physical violence from doctors.

<u>Question 34: Patients' relatives or friends (n = 218)</u>

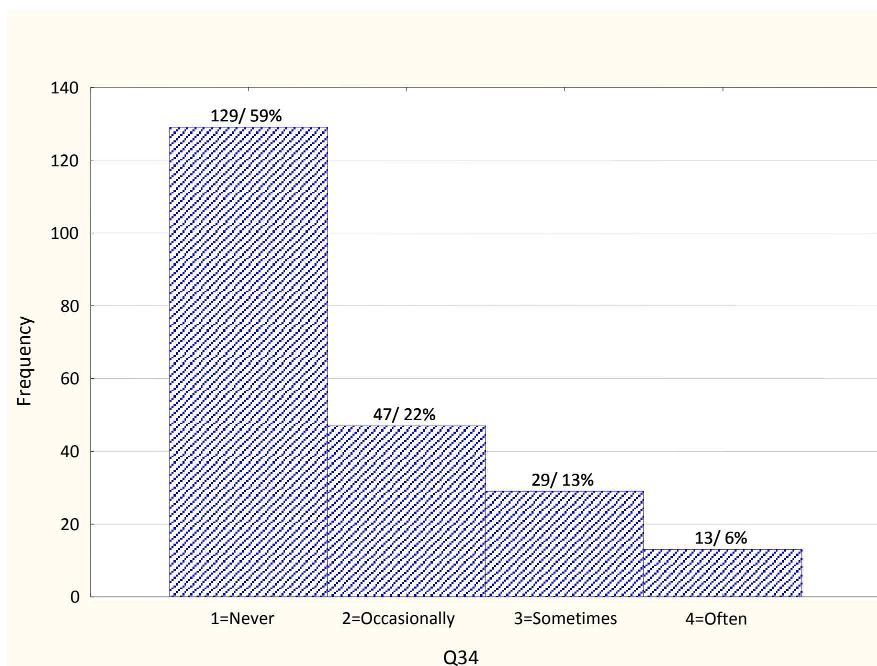

Figure 4.14: Nursing students' experience of non-physical violence from patients' relatives or friends.

Figure 4.14 illustrates that 59% (n = 129) had *never* experienced workplace violence from patients' relatives and friends. Of the remaining respondents, 22% (n = 47)

occasionally, 13% (n = 29) *sometimes* and 6% (n = 13) had *often* experienced violence from patients' relatives and friends.

Question 35: Matrons / nurse managers (n = 218)

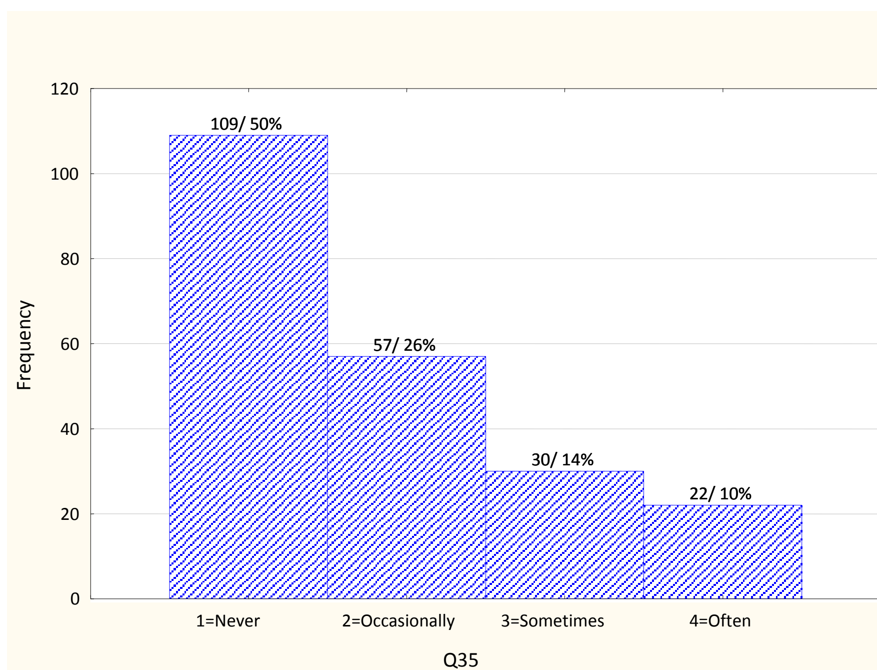

Figure 4.15: Nursing students' experience of non-physical violence from matrons / nurse managers.

Figure 4.15 shows that half of the respondents *occasionally* (26% or n = 57), *sometimes* (14% or n = 30 or), or *often* (10% or n = 22) had experienced violence from matrons / nurse managers in the previous year. The remaining 50% (n = 109) had *never* experienced violence from matrons / nurse managers.

Question 36: Registered nurses (n = 216)

Two respondents did not answer this question. Figure 4.16 shows that 33% (n = 71) of respondents had *never* been subjected to workplace violence from registered nurses. Of the remaining 67% of respondents, 32% (n = 70) *occasionally*, 19% (n = 41) *sometimes* and 16% (n = 34) had *often* experienced violence from registered nurses.

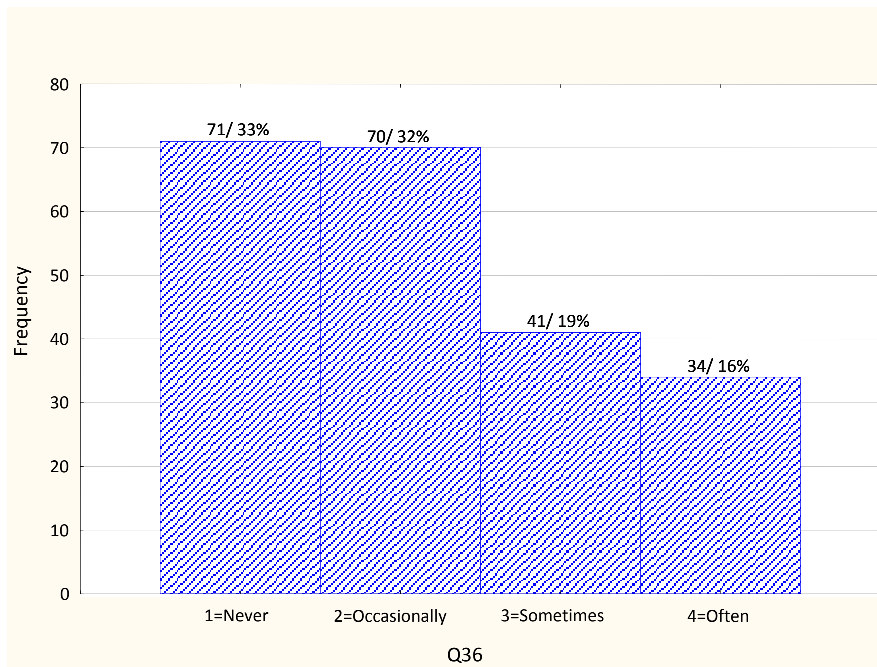

Figure 4.16: Nursing students' experience of non-physical violence from registered nurses.

<u>Question 37: Staff nurses (n = 217)</u>

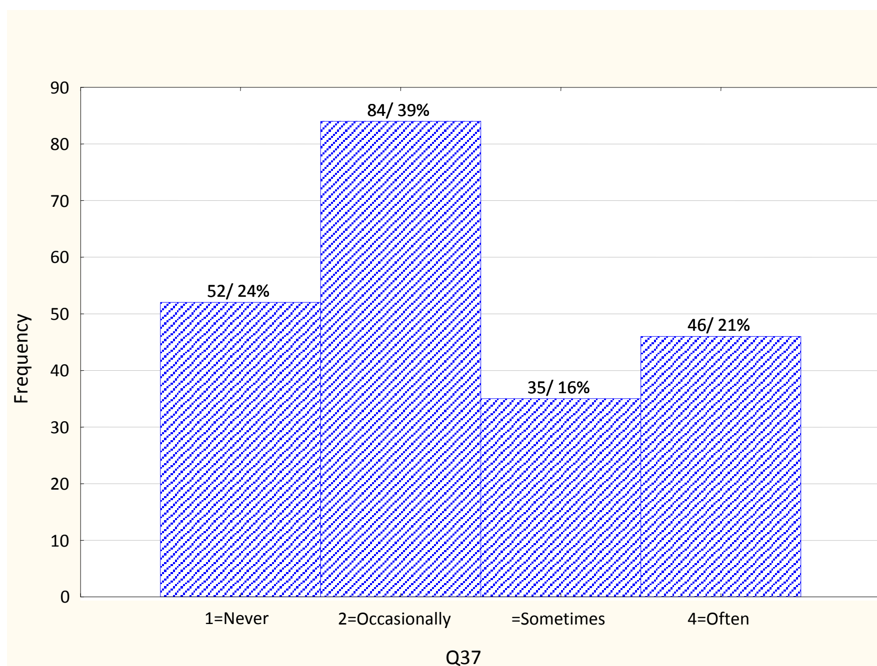

Figure 4.17: Nursing students' experience of non-physical violence from staff nurses.

One respondent did not answer this question. According to figure 4.17, a large majority (76% or n = 165) had been subjected to violence from staff nurses. Of

these, 39% (n = 84) *occasionally*, 16% (n = 35) *sometimes* and 21% (n = 46) had *often* experienced such behaviour. A minority (24% or n = 52) had *never* experienced workplace violence from staff nurses in the previous year.

Question 38: Assistant nurses (n = 218)

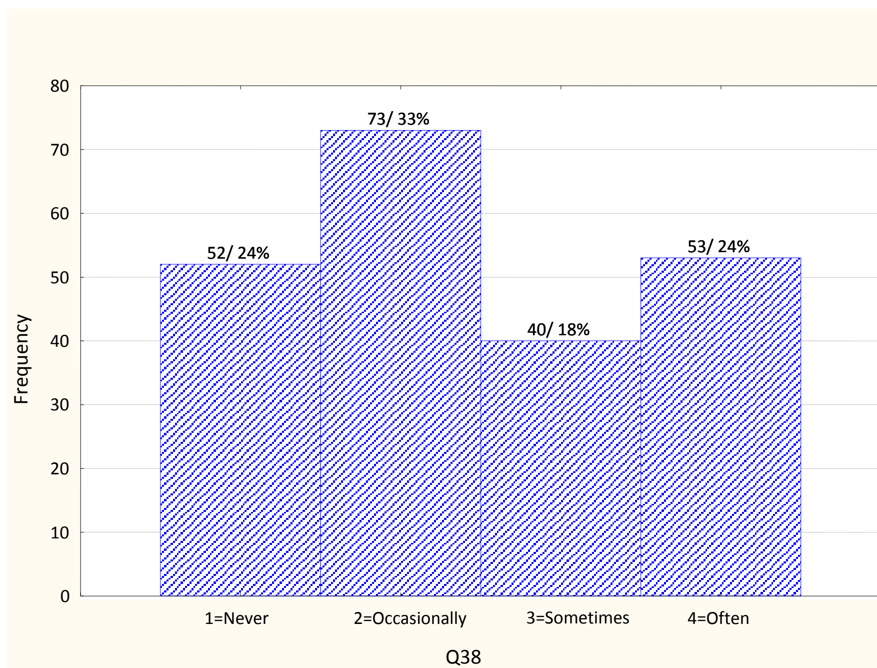

Figure 4.18: Nursing students' experience of non-physical violence from assistant nurses.

Figure 4.18 shows that, similar to registered and staff nurses, assistant nurses had regularly committed violence against the respondents. A minority (24% or n = 52) had *never* experienced violence from assistant nurses. Contrary, the majority had *occasionally* (33% or n = 73), *sometimes* (18% or n = 40), or *often* (24% or n = 53) experienced violence from assistant nurses.

Question 39: Other student nurses (n = 216)

Two respondents did not answer this question. Unlike the previous three categories of nurses, figure 4.19 shows that the majority (63% or n = 137) had *never* experienced violence from other student nurses. Of the remaining 37%, 26% (n = 57) had *occasionally*, 7% (n = 15) *sometimes* and 3% (n = 7) *often* experienced violence form other student nurses.

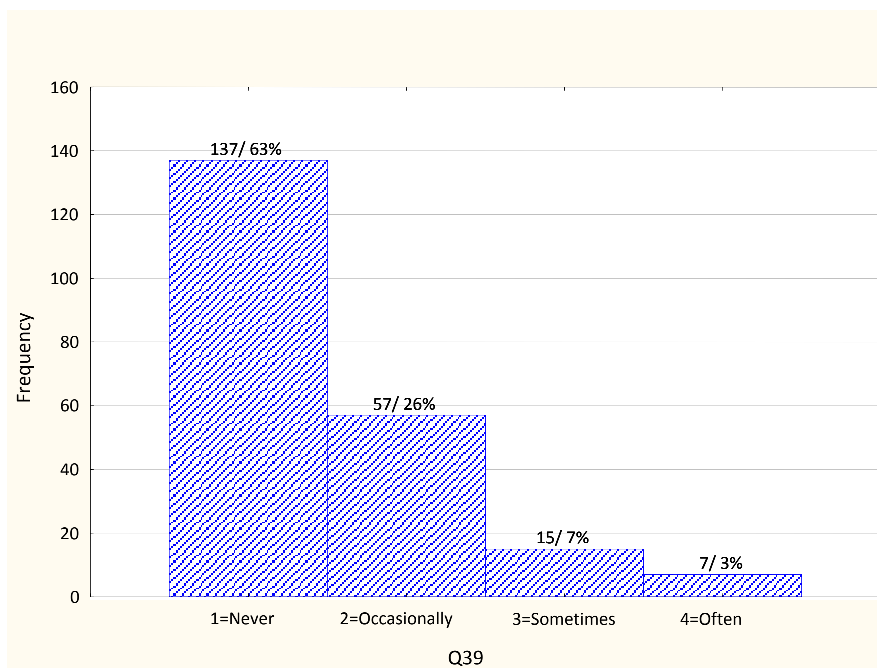

Figure 4.19: Nursing students' experience of non-physical violence from other student nurses.

Question 40: Clinical educators / mentors (n = 217)

One respondent did not answer this question. A large majority of 75% (n = 162) had *never* been subjected to violence from clinical educators / mentors, while 17% (n = 36) reported that they had *occasionally* experienced violence from this source. Only 5% (n = 11) and 4% (n = 8), respectively, had *sometimes* or *often* been subjected to violence from clinical educators / mentors.

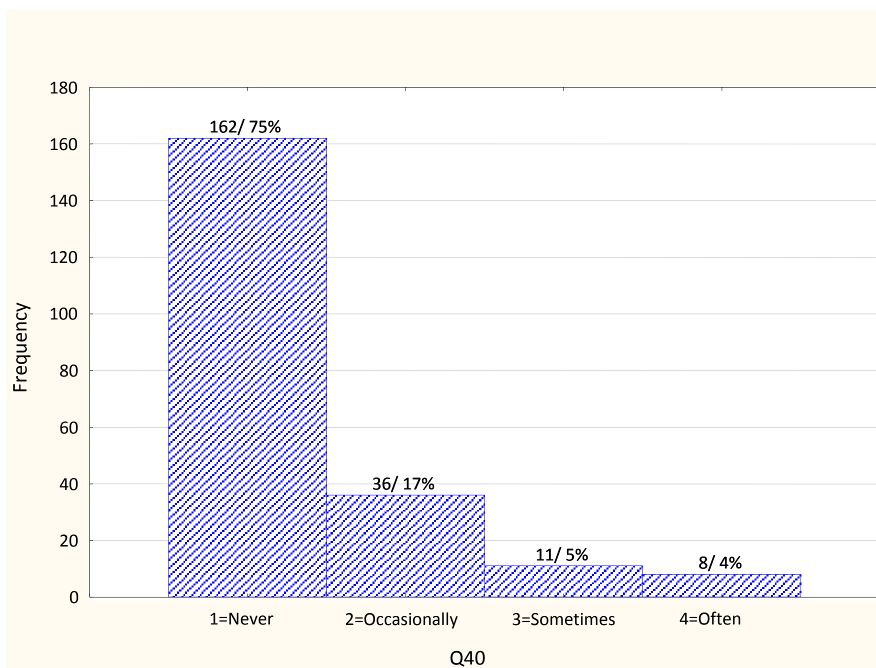

Figure 4.20: Nursing students' experience of non-physical violence from clinical educators.

<u>Question 41: Lecturers (n = 218)</u>

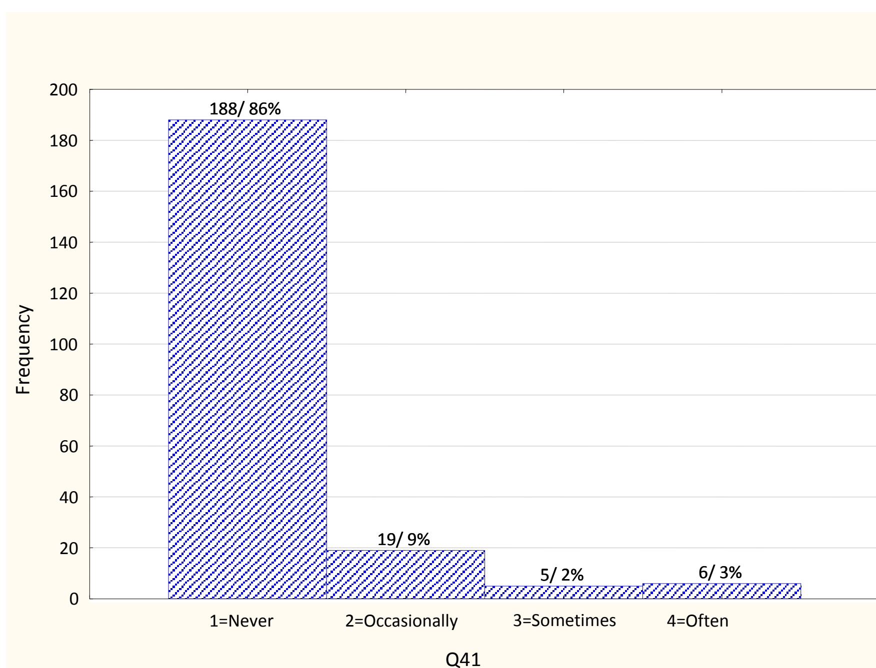

Figure 4.21: Nursing students' experience of non-physical violence from lecturers.

Similar to the findings related to clinical educators / mentors, a large majority (86% or n = 188) had *never* experienced violence from lecturers. A small minority of 9% (n =

19) had *occasionally*, 2% (n = 5) *sometimes*, or 3% (n = 6) *often* been subjected to violence from lecturers.

Question 42: Administrative staff (n = 216)

Two respondents did not answer this question. A small number had *occasionally (*11% or n = 23), *sometimes* (5% or n = 11), or *often* (2% or n = 4 or) experienced violence from administrative staff. The majority of 82% (n = 178) had *never* experienced violence from this source.

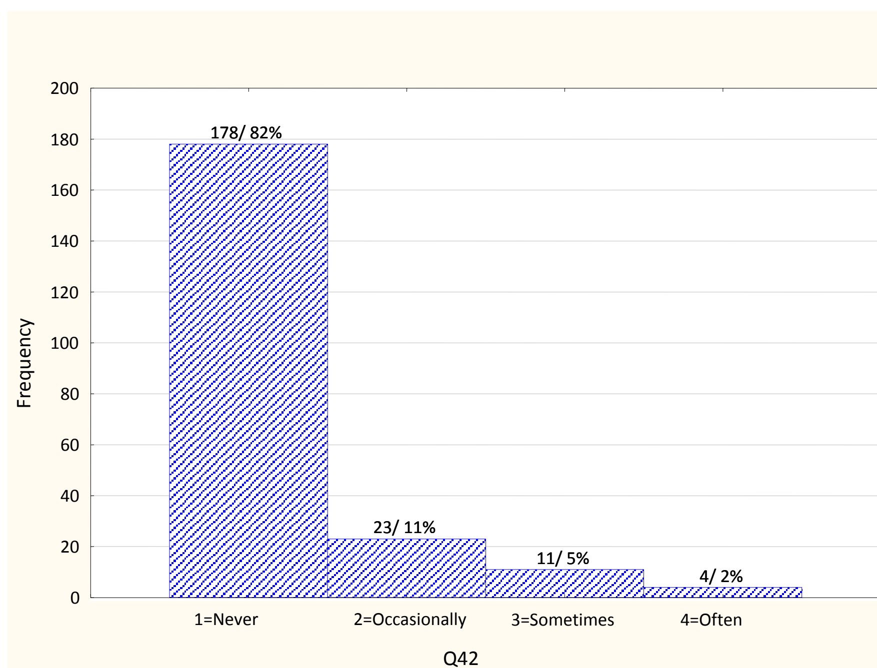

Figure 4.22: Nursing students' experience of non-physical violence from administrative staff.

Question 43: Housekeeping staff (n = 214)

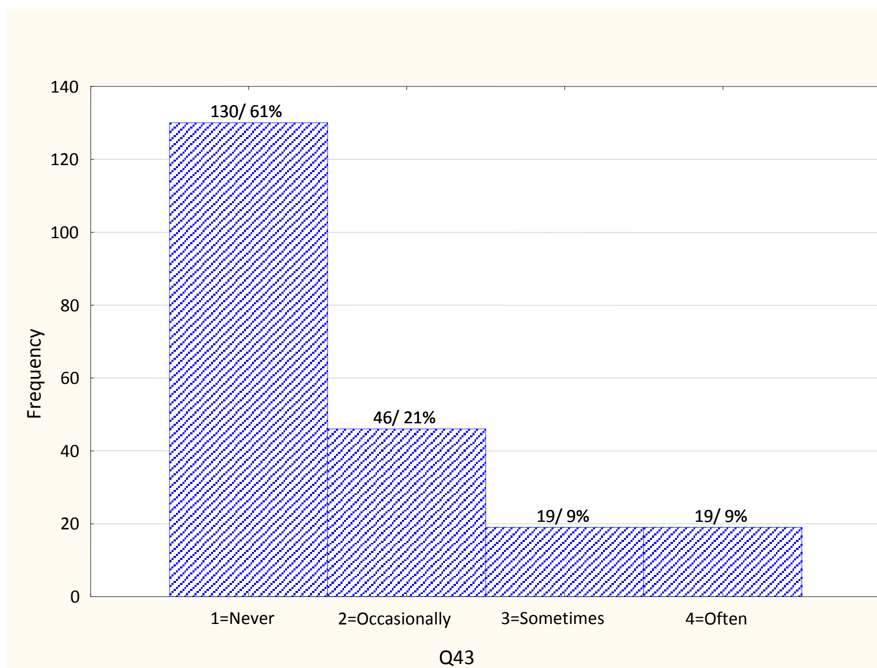

Figure 4.23: Nursing students' experience of non-physical violence from housekeeping staff.

Four respondents did not answer this question. Figure 4.20 shows that violence from housekeeping staff had been experienced *occasionally* by 21% (n = 46), *sometimes* by 9% (n = 19) and *often* by 9% (n = 19). The majority of 61% (n = 130) had never experienced violence from housekeeping staff.

Question 44: Other (n = 3)

All three respondents who answered this question reported that porters had been perpetrators of workplace violence in the clinical settings. One respondent also identified "electricians, builders, etc." as sources of workplace violence.

Table 4.11 summarises the mean and standard deviation for every variable, each representing a perpetrator of non-physical workplace violence, as described above. They were arranged from the most to the least frequently occurring variable. A confidence interval of 0.95 was established for the mean of each variable. It became evident from the means of the first three variables that assistants, staff and

registered nurses were clearly the main perpetrators of non-physical workplace violence to student nurses.

Table 4.11: Means and standard deviations of variables regarding perpetrators of workplace violence

Perpetrator of workplace violence		Mean	Confidence -95%	Confidence 95%	Standard deviation
Q38	Assistant nurses	2.43	2.28	2.58	1.10
Q37	Staff nurses	2.35	2.20	2.49	1.07
Q36	Registered nurses	2.18	2.03	2.32	1.06
Q32	Patients	1.93	1.80	2.05	0.95
Q35	Matrons	1.84	1.71	1.97	1.01
Q34	Patients' relatives	1.66	1.54	1.78	0.92
Q43	Housekeeping staff	1.66	1.53	1.79	0.97
Q33	Doctors	1.57	1.46	1.68	0.84
Q39	Student nurses	1.50	1.40	1.60	0.77
Q40	Clinical educators	1.38	1.28	1.48	0.75
Q42	Administrative staff	1.26	1.18	1.35	0.64
Q41	Lecturers	1.22	1.13	1.30	0.62

4.3.3.3 Type and frequency of consequences of non-physical workplace violence (questions 45 – 57)

Respondents were required to report the work related and personal consequences of workplace violence on themselves.

a. Consequences to work performance (questions 45 – 49)

These questions were arranged in a matrix and respondents had to indicate to what extent various work related consequences had been induced by workplace violence. Question 49 afforded the respondent the opportunity to identify and report on

consequences of workplace violence not included in the given matrix. Accordingly, question 49 was titled ‘Other’. Table 4.12 represents a composite summary of the results to questions 45 – 48. The questions were prefaced by the statement: “Intimidation, bullying, or verbal abuse in the clinical areas has influenced my work performance in the following ways”.

Question 45: Made me consider leaving nursing (n = 217)

One respondent did not answer this question. While table 4.12 shows that 54% (n = 118) of the respondents had *never* considered leaving nursing as a result of workplace violence, almost half (46% or n = 99) had *occasionally* (31% or n = 67), *sometimes* (10% or n = 21), or *often* (5% or n = 11) considered this option.

Question 46: Caused me to call in absent (n = 217)

One respondent did not answer this question. Table 4.12 shows that a majority 62% (n = 134) of respondents had *never* considered this course of action. Of the remainder, 27% (n = 59) had *occasionally*, 7% (n = 16) *sometimes* and 4% (n = 8) *often* called in absent as a result of workplace violence.

Question 47: Made me scared to check orders for patient care (n = 217)

One respondent did not answer this question. According to table 4.12, 64% (n = 139) of respondents claimed that they had *never* been scared to check orders for patient care, as a result of workplace violence. Contrary, 29% (n = 64) had *occasionally*, 3% (n = 7) *sometimes* and 3% (n = 7) *often* neglected to check orders for patient care, because of workplace violence.

Question 48: Negatively affected my standard of patient care (n = 215)

Three respondents did not answer this question. Table 4.12 shows that workplace violence had *occasionally* (32% or n = 68), *sometimes* (7% or n = 14 or), or *often* (6% or n = 12) negatively affected the standard of patient care. A total of 56% (n = 121) of respondents claimed that workplace violence had *never* affected their standards of patient care.

Table 4.12: Consequences of workplace violence on the work performance of nursing students

Consequence		Frequency (*f*)				n
		Never	Occasionally 1–2 times	Sometimes 3–5 times	Often >5 times	
Q45	Made me consider leaving nursing	118 (54%)	67 (31%)	21 (10%)	11 (5%)	217 (100%)
Q46	Caused me to call in absent	134 (62%)	59 (27%)	16 (7%)	8 (4%)	217 (100%)
Q47	Made me scared to check orders for patient care	139 (64%)	64 (29%)	7 (3%)	7 (3%)	217 (99%)
Q48	Negatively affected my standard of patient care	121 (56%)	68 (32%)	14 (7%)	12 (6%)	215 (101%)

<u>Question 49: Other (n = 2)</u>

One respondent reported "*I just did not want to be there anymore*". Another reported that she had "*lost focus / concentration*".

Table 4.13 shows the mean and standard deviation for every variable, each representing a work performance consequence of non-physical workplace violence. They were arranged from the most to the least frequently occurring variable. A confidence interval of 0.95 was established for the mean of each variable.

Table 4.13: Means and standard deviations of variables regarding work performance consequences of workplace violence

Work performance consequences of workplace violence		Mean	Confidence -95%	Confidence 95%	Standard deviation
Q45	Made me consider leaving nursing	1.65	1.54	1.77	0.85
Q48	Negatively affected my standard of patient care	1.61	1.50	1.73	0.84
Q46	Caused me to call in absent	1.53	1.42	1.64	0.79
Q47	Made me scared to check orders for patient care	1.46	1.36	1.55	0.71

b *Personal consequences (questions 50 – 57)*

Questions 50 to 57 investigated the personal consequences of workplace violence. The question matrix required respondents to indicate the level of personal consequences resulting from workplace violence. Question 57 afforded the respondent the opportunity to identify and report on personal consequences other than those appearing in the given matrix. Accordingly, it was titled ‘Other’. Table 4.14 represents a composite summary of the results to questions 50 - 56. The questions were prefaced by the statement: “Intimidation, bullying or verbal abuse in the clinical areas has resulted in me experiencing the following personal consequences”.

Table 4.14: Personal consequences of workplace violence for student nurses

Consequence		Frequency (*f*)				n
		Never	Occasionally 1–2 times	Sometimes 3–5 times	Often >5 times	
Q50	Anger	44 (20%)	103 (47%)	47 (22%)	24 (11%)	218 (100%)
Q51	Depression	94 (43%)	85 (39%)	27 (12%)	12 (6%)	218 (100%)
Q52	Humiliation / embarrassment	56 (26%)	111 (51%)	35 (16%)	16 (7%)	218 (100%)
Q53	Anxiety / fear	86 (40%)	93 (43%)	25 (12%)	12 (6%)	216 (101%)
Q54	Confusion	78 (36%)	88 (41%)	35 (16%)	15 (7%)	216 (100%)
Q55	Feelings of inadequacy	74 (34%)	87 (40%)	41 (19%)	14 (6%)	216 (99%)
Q56	Negative effect on personal relationships	121 (56%)	64 (30%)	19 (9%)	12 (6%)	216 (101%)

Question 50: Anger (n = 218)

Table 4.14 shows that the majority of respondents (n = 174 or 80%) had reacted to workplace violence with anger. Of these 47% (n = 103) had *occasionally*, 22% (n = 47) *sometimes* and 11% (n = 24) *often* experienced anger as a result of workplace violence. A mere 20% (n = 44) had *never* experienced anger as a result of workplace violence.

Question 51: Depression (n = 218)

According to table 4.14 a majority of 57% (n = 124) of respondents had experienced depression *occasionally* (39% or n = 85), *sometimes* (12% or n = 27), or *often* (6% or n = 12), as a result of workplace violence. The remaining 43% (n = 94) had *never* experienced depression as a result of workplace violence.

Question 52: Humiliation / embarrassment (n = 218)

Table 4.14 shows that this had been a common consequence of workplace violence, with 51% (n = 111) having *occasionally*, 16% (n = 35) *sometimes* and 7% (n = 16) *often* experiencing humiliation / embarrassment.

Question 53: Anxiety / fear (n = 216)

Two respondents did not answer this question. Table 4.14 demonstrates that anxiety and fear, resulting from workplace violence, had been experienced by a majority of 61% of respondents. Of these, workplace violence caused 18% (n = 37) to experience anxiety or fear, three or more times in the previous year.

Question 54: Confusion (n = 216)

Two respondents did not answer this question. Table 4.14 shows that a majority 64% (n = 138) of respondents had experienced confusion after episodes of workplace violence. Of these, 41% (n = 88) had experienced it *occasionally*, 16% (n = 35 *sometimes* and 7% (n = 15) *often*.

Question 55: Feelings of inadequacy (n = 216)

Two respondents did not answer this question. According to table 4.14, feelings of inadequacy as a result of workplace violence had been experienced *occasionally* by 40% (n = 87), *sometimes* by 19% (n = 41) and *often* by 6% (n = 14) of respondents.

Question 56: Negative effect on personal relationships (n = 216)

Two respondents did not answer this question. Table 4.14 shows that a small majority of 56% (n = 121) felt that workplace violence had *never* negatively affected their personal relationships. However, table 4.14 also shows that almost half of the respondents felt that it had *occasionally* (30% or n = 64), *sometimes* (9% or n = 19), or *often* (6% or n = 12) negatively affected their personal relationships.

Question 57: Other (n = 2)

One respondent reported having changed from an "extrovert kind of person" to an "introverted, shy and withdrawn person". Another respondent reported being "*unsure how to approach patients*", because *"they are rude*".

Table 4.15: Means and standard deviations of variables regarding personal consequences of workplace violence

Personal consequences of workplace violence		Mean	Confidence -95%	Confidence 95%	Standard deviation
Q50	Anger	2.23	2.11	2.35	0.90
Q52	Humiliation / embarrassment	2.05	1.94	2.16	0.84
Q55	Feelings of inadequacy	1.98	1.86	2.10	0.89
Q54	Confusion	1.94	1.82	2.06	0.90
Q53	Anxiety / fear	1.83	1.72	1.94	0.84
Q51	Depression	1.80	1.69	1.92	0.86
Q56	Negative effect on personal relationships	1.64	1.52	1.75	0.86

Table 4.15 summarises the mean and standard deviation for every variable, each representing a personal consequence of non-physical workplace violence. They were arranged from the most to the least frequently occurring variable. A confidence interval of 0.95 was established for the mean of each variable. Although table 4.15 shows that anger had been the most frequently experienced form of non-physical workplace violence, the small difference in the means of the first four variables indicated little difference in the frequencies of these consequences.

4.3.4 Section D: Reporting of workplace violence (of any nature)

In this section data related to the following research objectives are presented:

- Determine whether workplace violence had been reported;
- Establish reasons for not reporting workplace violence; and
- Determine whether students had been aware of any policies addressing workplace violence.

Question 58: Have you ever reported an episode of any kind of workplace violence in the clinical areas to the authorities? (n = 216)

Two respondents did not answer this question. Table 4.16 illustrates that most of the respondents (85% or n = 184) had *never* reported workplace violence to the authorities.

Table 4.16: Number of student nurses having reported workplace violence to authorities

Category	Frequency (*f*)	Percentage (%)
Yes	32	15
No	184	85
Total	**n = 216**	**100**

Questions 59 - 64

Questions 59 - 64 were contingent upon a 'No' response to question 58. Respondents, who had answered 'Yes' to question 58, were directed to question 65. By virtue of a 'No' answer to question 58, 184 respondents qualified to answer questions 59 - 64. Questions 59 - 63 were arranged in a matrix and respondents had to agree, or disagree, with possible reasons for not reporting workplace violence. Question 64 afforded the respondent an opportunity to identify and provide a reason not included in the given matrix. Accordingly, it was titled "Other". Table 4.17 represents a composite summary of the results to questions 59 - 63. All the

questions were prefaced by the statement: "I have never reported an episode of physical, or non-physical violence in the clinical areas to the authorities, because".

Table 4.17: Reasons for student nurses not reporting workplace violence

	Reason	Agree	Disagree	N
Q59	It is part of the job	28 (15%)	157 (85%)	185 (100%)
Q60	Nothing will get done about it	90 (49%)	92 (51%)	182 (100%)
Q61	I am afraid of victimisation	103 (57%)	78 (43%)	181 (100%)
Q62	It is not important enough	38 (21%)	144 (79%)	182 (100%)
Q63	I do not know where / how to report it	100 (55%)	82 (45%)	182 (100%)

Question 59: It is part of the job (n = 185)

Table 4.17 indicates that 185 respondents answered this question, meaning that one respondent who had answered 'Yes' to question 58, also answered question 59. The majority of respondents (85% or n = 157) *disagreed* that workplace violence was part of the job. Only 15% (n = 28) *agreed* that it was part of the job.

Question 60: Nothing will get done about it (n = 182)

Two respondents did not answer this question. Table 4.17 shows that respondents were fairly divided about this question, with 51% (n = 92) *disagreeing* and 49% (n = 90) *agreeing* that nothing would get done about workplace violence.

Question 61: I am afraid I will be victimised (n = 181)

Three respondents did not answer this question. Table 4.17 indicates that those who *agreed* with the statement (57% or n = 103) outnumbered those who *disagreed* (43% or n = 78).

Question 62: It is not important enough to me (n = 182)

Two respondents did not answer this question. According to table 4.17, 79% (n = 144) *disagreed* with the statement, while 21% (n = 38) *agreed* that they had not reported workplace violence, because it was not important enough.

Question 63: I do not know where / how to report it (n = 182)

Two respondents did not answer this question. Table 4.17 shows that just over half of the respondents (55% or n = 100) *agreed* that they had not known where to report workplace violence, while 45% (n = 82) *disagreed* that this had been the reason for them for not reporting workplace violence.

Question 64: Other (n = 39)

39 respondents answered this question. Many of their responses matched the options provided in question 60, namely: "nothing will get done about it", and question 61, namely: "I am afraid I will be victimised". The following are examples of student nurses' responses:

- "*scared to be ignored during working hours*";
- "*scared of the superiors*";
- "*scared of being shouted at*";
- "*it will only cause more trouble for you in the end*";
- "*it might lead to my practical not being signed and also not being taught how to do the procedures*";
- "*the managers or sister-in-charge take sides and their staff is always right*" and
- a "*waste of time, nothing will be done about it*".

Other responses were: "*I don't want to be labeled forward or a racist*" and "*I won't be trusted again*". Two respondents declared that they "*did not want anyone to be fired because of them*".

Question 65: Are you aware of any policy in the clinical areas addressing workplace violence? (n = 184)

Although all respondents qualified and had been requested to respond to this question, only 184 (84%) did so. Table 4.18 indicates that of these respondents, the majority (72% or n = 132 or) had been *unaware* of any policy in the clinical areas addressing workplace violence. However, 28% (n = 52) had been aware of such policy. Despite this knowledge, table 4.16 indicates that only 15% of respondents had reported episodes of workplace violence.

Table 4.18: Number of student nurses being aware of policy addressing workplace violence in the clinical areas

Category	Frequency (*f*)	Percentage (%)
Yes	52	28
No	132	72
Total	**n = 184**	**100**

4.3.5 Section E: Management of workplace violence

In this section, the data generated by the one open ended question related to the research objective of 'determining the students' recommendations regarding the management of workplace violence', is presented.

.Question 66: Do you have any suggestions regarding the management of workplace violence targeting student nurses in clinical areas? (n = 141)

A total of 65% (n = 141) of respondents answered this question. The responses were grouped and quantified and the most common proposals are presented in table 4.19.

Table 4.19: *Most common* recommendations by respondents to manage workplace violence targeting student nurses in clinical areas

Recommendations	Frequency (*f*)	Percentage of respondents
Education of permanent staff regarding student status and learning needs	32	23%
Empowering students to deal with workplace violence	31	22%
Greater visibility and advocacy from clinical educators / lecturers	23	16%
Prompt response to and disciplining of perpetrators	20	14%
Interpersonal skills workshops for permanent staff	16	11%
Dedicated staff member in unit to look after needs of students	12	9%

4.3.5.1 Recommendations by respondents related to permanent nursing staff at clinical facilities

Table 4.19 indicates that the most general suggestion (23% of respondents) was that permanent nursing staff should be educated about the learning needs and status of nursing students. As shown in table 4.19, another fairly common proposal related to permanent nursing staff, made by 11% (n = 16) of the respondents, was that registered, staff- and assistant nurses should be sent on interpersonal skills workshops so that they could learn "*how to treat student nurses*". One respondent suggested that "*staff should treat students as they would like their children to be treated as students*".

4.3.5.2 Recommendations by respondents related to clinical educators, lecturers, management

Many suggestions were related to the role that clinical educators or mentors should play in the management of workplace violence in the clinical areas. Table 4.19 shows that 16% (n = 23) of respondents suggested that clinical educators or mentors

should be more visible and available in the clinical areas and "not just enter the units when they had specific demonstrations or procedures scheduled for a particular time". As table 4.19 indicates, this was aligned with a further suggestion by quite a few respondents (9% or n = 12), namely that student nurses should have a dedicated person, for example a clinical educator, or suitable registered nurse, in whom they could confide and who would address student needs in every unit.

Four respondents said that lecturers should stand up for students' rights and another commented that "*lecturers should believe students*".

Some suggestions regarding the role of management in the prevention of workplace violence were that managers should be encouraged to "*take action in accordance with policy*", that "*matrons be offered professional help*", that managers should "*discipline their staff*" and that managers should "*undergo interpersonal skills training*".

4.3.5.3 Recommendations by respondents related to student awareness and student conduct regarding workplace violence

Several respondents suggested that policies relating to workplace violence should be widely disseminated amongst students. One respondent suggested that in every unit all new, or first-time students, should be orientated to the phenomenon of workplace violence, i.e. "*what it is and where to report it, etc*". Table 4.19 indicates that many respondents (22% or n = 31) suggested that students be "*taught*" and "*empowered*" to "*report*" and "*confront workplace violence*". A number of students suggested a workshop on workplace violence. A widespread suggestion was that students should not keep silent, but "*speak up*". Two respondents suggested that students be given training in physical self-defense measures.

4.3.5.4 Recommendations by respondents calling for a punitive response to workplace violence

Table 4.19 reflects that 14% (n = 20) of the respondents desired prompt disciplinary action when workplace violence occurred. One respondent commented that "*penalties must be enforced*" and two respondents, probably referring to physical violence, said that "*violent patients must be punished*".

Other interesting suggestions included the writing of anonymous reports by students about their experiences in this regard, an anonymous complaints box to report workplace violence and the installation of cameras to witness staff behaviour towards students. One respondent commented that "*students should change their attitudes, because it triggers abuse*".

4.4 STATISTICAL RELATIONSHIPS BETWEEN DEMOGRAPHIC AND RESEARCH VARIABLES

In this section, the nature of any relationships between the demographic variables of the respondents (age, gender and year of study) and relevant research variables are reported. Most of the research variables were considered relevant for such analyses, except for those characterised by a high percentage of '*never*' responses, for example, those investigating the form and frequency of physical and sexual workplace violence (tables 4.5 and 4.7).

Where appropriate, the scores were aggregated for the analyses. In section 4.4.6 and 4.4.7, however, only the relationship between the demographic variables and the two most common reasons (variables) for not reporting workplace violence, were examined.

4.4.1 Demographic variables of respondents and prevalence of non-physical workplace violence

4.4.1.1 Age

A Pearson product moment correlation was used to examine the relationship between age and the prevalence of non-physical violence. The probability value (p = 0.37) exceeded 0.05, indicating a statistically insignificant relationship between age and the prevalence of non-physical workplace violence (r = -0.07; p = 0.37).

4.4.1.2 Gender

An appropriate analysis of variance (ANOVA) was used to determine the relationship between gender and non-physical violence. The probability value (p = 0.44)

exceeded 0.05, indicating a statistically insignificant relationship between gender and the prevalence of non-physical workplace violence ($F[1,192] = 0.60131$; $p = 0.44$).

4.4.1.3 Year of study

An appropriate ANOVA was used to determine the relationship between year of study and non-physical violence. The probability value ($p = <0.01$) was below 0.05, indicating a statistically significant relationship between year of study and the prevalence of non-physical workplace violence ($F[2,191] = 5.3895$; $p = <0.01$). The Fisher Least Significant Difference (LSD) post-hoc test revealed that the only significant difference ($p = <0.01$) was that between the second (mean = 2.0057) and third-years (mean = 2.3824).

4.4.2 Demographic variables of respondents and perpetrators of non-physical workplace violence

4.4.2.1 Age

A Pearson product moment correlation was used to examine the relationship between age and the perpetrators of non-physical violence. The probability value ($p = 0.19$) exceeded 0.05, indicating a statistically insignificant relationship between the age of respondents and perpetrators of non-physical workplace violence ($r = -0.09$; $p = 0.19$).

4.4.2.2 Gender

An appropriate ANOVA was used to determine the relationship between gender and the perpetrators of non-physical violence. The probability value ($p = 0.91$) exceeded 0.05, indicating a statistically insignificant relationship between the gender of respondents and perpetrators of non-physical workplace violence ($F[1,212] = 0.01260$; $p = 0.91$).

4.4.2.3 Year of study

An appropriate ANOVA was used to determine the relationship between year of study and the perpetrators of non-physical violence. The probability value ($p = 0.49$) exceeded 0.05, indicating a statistically insignificant relationship between year of

study and the perpetrators of non-physical workplace violence (F[2,211] = 0.72516; p = 0.49).

4.4.3 Demographic variables of respondents and consequences of non-physical workplace violence on work performance

4.4.3.1 Age

A Pearson product moment correlation was used to examine the relationship between age and the consequences of non-physical workplace violence on work performance. The probability value (p = 0.06) exceeded 0.05, indicating a statistically insignificant relationship between age and the consequences of non-physical workplace violence on the work performance of respondents (r = -0.13; p = 0.06).

4.4.3.2 Gender

An appropriate ANOVA was used to determine the relationship between gender and the consequences of non-physical workplace violence on work performance. The probability value (p = 0.87) exceeded 0.05, indicating a statistically insignificant relationship between gender and the consequences of non-physical workplace violence on work performance (F[1,213] = 0.02818; p = 0.87).

4.4.3.3 Year of study

An appropriate ANOVA was used to determine the relationship between year of study and the consequences of non-physical workplace violence on work performance. The probability value (p = 0.38) exceeded 0.05, indicating a statistically insignificant relationship between year of study and the consequences of non-physical workplace violence on work performance (F[2,212] = 0.96638; p = 0.38).

4.4.4 Demographic variables of respondents and personal consequences of non-physical workplace violence

4.4.4.1 Age

A Pearson product moment correlation was used to examine the relationship between age and the personal consequences of non-physical workplace violence.

The probability value (p = 0.16) exceeded 0.05, indicating a statistically insignificant relationship between age and the personal consequences of non-physical workplace violence (r = -0.10; p = 0.16).

4.4.4.2 Gender

An appropriate ANOVA was used to determine the relationship between gender and the personal consequences of non-physical workplace violence. The probability value (p = 0.34) exceeded 0.05, indicating a statistically insignificant relationship between gender and the personal consequences of non-physical workplace violence (F[1,208] = 0.92839; p = 0.34).

4.4.4.3 Year of study

An appropriate ANOVA was used to determine the relationship between year of study and the personal consequences of non-physical workplace violence. The probability value (p = 0.37) exceeded 0.05, indicating a statistically insignificant relationship between year of study and the personal consequences of non-physical workplace violence (F[2,207] = 1.0085; p = 0.37).

4.4.5 Demographic variables of respondents and the reporting of workplace violence

4.4.5.1 Age

An appropriate ANOVA was used to determine the relationship between age and the reporting of workplace violence. The probability value (p = 0.35) exceeded 0.05, indicating a statistically insignificant relationship between age and the reporting of workplace violence (F[1,203] = 0.88522; p = 0.35).

4.4.5.2 Gender

A chi-square test of independence was done to determine the relationship between gender and the reporting of workplace violence. The probability value (p = 0.28) exceeded 0.05, indicating that the two variables were independent of each other, i.e. there was no statistically significant relationship (chi-square[df = 1] = 1.16; p = 0.28).

4.4.5.3 Year of study

A chi-square test of independence was done to determine the relationship between year of study and the reporting of workplace violence. The probability value (p = 0.40) exceeded 0.05, indicating that the variables were independent of each other, i.e. there was no statistically significant relationship (chi-square[df = 2] = 1.86; p = 0.40).

4.4.6 Demographic variables of respondents and not reporting workplace violence, because of fear of victimisation

4.4.6.1 Age

An appropriate ANOVA was used to determine any relationship between age and not reporting workplace violence, because of fear of victimisation. The probability value (p = 0.25) exceeded 0.05, indicating a statistically insignificant relationship between age and not reporting workplace violence, because of fear of victimisation (F[1,171] = 1.3419; p = 0.25).

4.4.6.2 Gender

A chi-square test of independence was done to determine any relationship between gender and not reporting workplace violence, because of fear of victimisation. The probability value (p = 0.11) exceeded 0.05, indicating that the variables were independent of each other, i.e. there was no statistically significant relationship (chi-square[df = 1] = 2.61; p = 0.11).

4.4.6.3 Year of study

A chi-square test of independence was done to determine any relationship between year of study and not reporting workplace violence, because of fear of victimisation. The probability value (p = 0.10) exceeded 0.05, indicating that the variables were independent of each other, i.e. there was no statistically significant relationship (chi-square[df = 2] = 0.03; p = 0.10).

4.4.7 Demographic variables of respondents and not reporting workplace violence, because of not knowing where to report it

4.4.7.1 Age

An appropriate ANOVA was used to determine any relationship between age and not reporting workplace violence, because of not knowing where to report it. The probability value (p = <0.01) was below 0.05, indicating a statistically significant relationship between age and not reporting workplace violence, because of not knowing where to report it (F[1,171] = 7.0552; p = <0.01). The mean age of respondents disagreeing that they had not known where to report workplace violence was 26.96, whilst the mean age of respondents agreeing with the statement was 24.75. As the age of respondents increased, there was a tendency to disagree with the statement.

4.3.7.2 Gender

A chi-square test of independence was done to determine any relationship between gender and not reporting workplace violence, because of not knowing where to report it. The probability value (p = 0.44) exceeded 0.05, indicating that the variables were independent of each other, i.e. there was no statistically significant relationship (chi-square[df = 1] = 0.59; p = 0.44).

4.4.7.3 Year of study

A chi-square test of independence was done to determine the relationship between year of study and not reporting workplace violence, because of not knowing where to report it. The probability value (p = 0.57) exceeded 0.05, indicating that the variables were independent of each other, i.e. there was no statistically significant relationship (chi-square[df = 2] = 1.12; p = 0.57).

4.4.8 Demographic variables of respondents and being aware of workplace violence policy

4.4.8.1 Age

An appropriate ANOVA was used to determine any relationship between age and being aware of workplace violence policy. The probability value ($p = 0.84$) exceeded 0.05, indicating a statistically insignificant relationship between age and being aware of workplace violence policy ($F[1,172] = 0.03965$; $p = 0.84$).

4.4.8.2 Gender

A chi-square test of independence was done to determine any relationship between gender and being aware of workplace violence policy. The probability value ($p = 0.07$) exceeded 0.05, indicating that the variables were independent of each other, i.e. there was no statistically significant relationship (chi-square[df = 1] = 3.25; $p = 0.07$).

4.4.8.3 Year of study

A chi-square test of independence was done to determine any relationship between year of study and being aware of workplace violence policy. The probability value ($p = 0.10$) exceeded 0.05, indicating that the variables were independent of each other, i.e. there was no statistically significant relationship (chi-square[df = 2] = 4.52; $p = 0.10$).

4.5 DISCUSSION OF RESULTS

In this section, the above findings are discussed and related to the outcomes of the literature review. The syntheses and clarification of findings are presented according to the order in which the specific research objectives, with reference to the second, third and fourth-year student nurses of the Western Cape College of Nursing, as well as to their clinical placement areas, were formulated (chapter 1.4). For the purpose of this discussion, the first two objectives of the study were combined.

4.5.1 Objective: Identify the nature / type of workplace violence and identify the frequency of workplace violence

The findings from this study indicated that student nurses had frequently encountered acts of non-physical violence (figures 4.1 - 4.11) in all, but one, of the eleven forms of non-physical violence being surveyed. The most common experiences were:

- Being ignored (figure 4.4);
- Being subjected to non-verbal aggression, such as rolling eyes (figure 4.1); and
- Not receiving acknowledgement for good work (figure 4.8).

The only act of non-physical workplace violence that had been experienced by less than half (39%) of the respondents, was being subjected to a racist remark (figure 4.10). Despite this still relatively high percentage of respondents having had a racist remark directed at them in the previous year, the findings showed that this had been the least prevalent form of non-physical violence being experienced by student nurses. It is possible that, because race is such a sensitive topic and racist remarks so severely sanctioned in South Africa, most people guard from exposing themselves to the serious consequences of such behaviour.

Regarding violence of a physical, or sexual nature, the findings (tables 4.5 and 4.7) clearly showed that this had occurred far less frequently than non-physical violence. Although there had been isolated incidences of more frequent exposures to physical violence, the principal trend was that respondents had been very rarely subjected to physical violence. Similarly, the relatively rare incidences of exposure to sexual abuse indicated that, for the majority of respondents, sexual abuse had not been a regular experience in the clinical areas.

The high number of students who had experienced non-physical workplace violence, matched the findings of Ferns (2005:184), Öztunc (2006:36), Spector *et al.* (2007:123) and Khalil (2009:210), all of whom had investigated the prevalence among qualified nurses. In a rare study done amongst student nurses, Hinchberger (2009:37) found that 100% of respondents reported having been exposed to workplace violence. These researchers similarly found that actual physical assault

had been a rare event in nursing. Conversely, Buerhaus *et al.* (2009:289) found that in 2008, the hospital workplace environment in the United States had been perceived by registered nurses to have deteriorated regarding sexual harassment and physical violence occurrences.

The most frequent kind of non-physical violence being experienced by respondents in this study, namely being ignored or neglected, was similarly found by Thomas and Burk (2009:228), who had researched workplace violence among junior nursing students at a public state university in the South Eastern United States. In actual fact, the various kinds of non-physical violence encountered by students in this study, matched the general consensus, as revealed by the literature about the nature of non-physical violence directed at nurses (table 2.1).

With reference to the foundational classification of workplace aggression by Buss (cited in Neuman & Baron, 2005:18-19) and referred to in chapter 2.3.3, the findings indicated that the most common acts of violence were grouped around the verbal end of the physical-verbal dichotomy, with physical violence occurring very rarely. The findings further suggested that the most common acts of violence, e.g. being ignored, or not receiving acknowledgment for good work, tended towards the passive end of the active-passive dichotomy, as postulated by Buss. However, an unacceptably high frequency of violent acts that could be interpreted as actively harmful, e.g. being sworn, shouted, or yelled at (figure 4.2), harshly judged, or criticised (figure 4.3) and ridiculed, or humiliated (figure 4.5), led to the conclusion that student nurses had been frequently subjected to violent acts that span the whole active-passive continuum, as described by Buss.

4.5.2 Objective: Distinguish between the prevalence of non-physical violence in hospital and community settings

None of the literature reviewed for this study pertinently differentiated between hospital and community settings. Generally, most of the studies were conducted in hospital settings. However, as students in the research population are placed in hospital and community settings, the researcher had expected this to be a relevant avenue of research. It is clear from the findings that respondents generally experienced hospitals as the location where they most often experienced workplace

violence. However, this finding may be affected by the limitation regarding the differing level of exposure to community settings reported in chapter 3.9.

4.5.3 Objective: Reveal the perpetrators of non-physical violence

Although many researchers, for example, Rippon (2000:453), Rowe and Sherlock (2005:245) and Hader (2008:17), found that patients had most often been the perpetrators of violence, thereby confirming the observation of LeBlanc and Kelloway (2002:444), and McPhaul and Lipscomb (2004:168), that nurses were particularly at risk of violence from recipients, or clients of the service provided in the workplace, the findings of this study, targeting student nurses, indicated otherwise.

Despite being identified by 59% of respondents as perpetrators of violence (figure 4.12), patients were not the biggest source of non-physical violence targeting student nurses. This number was exceeded by the high percentage of respondents (figures 4.16 - 4.18) who had experienced violence from registered (67%), staff (76%) and assistant (75%) nurses. With reference to the classification of workplace violence by the National Institute for Occupational Safety and Health (2006:4), this meant that type 3 (perpetrated by fellow-workers) had been the most common type of workplace violence experienced in the year preceding this study, followed by type 2 (perpetrated by recipients of the service, i.e. patients). As mentioned, registered, staff– and assistant nurses had commonly engaged in non-physical violent behaviour, targeting student nurses. Other categories of fellow-workers identified as perpetrators of non-physical workplace violence by more than one-third of the respondents, were matrons, doctors, other student nurses and housekeeping staff (figures 4.15, 4.13, 4.19 and 4.23).

Interestingly, Hinchberger (2009:42), whose focus of study was student nurses as well, also found that staff members had been the most common perpetrators of violence against student nurses, with patients coming a close second. The relatively high percentage of respondents (39%), who identified housekeeping staff as a source of non-physical violence (figure 4.23), compared to the 19% reported by Rowe and Sherlock (2005:245), becomes significant when one realises that Rowe and Sherlock’s study was done among registered and licensed, practical nurse respondents (i.e. qualified nurses). This finding emphasised the vulnerable position of student nurses in the workplace hierarchy.

4.5.4 Objective: Identify type and frequency of consequences of non-physical violence

The consequences of non-physical violence were investigated from two perspectives. Firstly, in accordance with previous studies, work performance consequences were examined, whilst secondly, personal consequences, related to workplace violence, were observed. Although these kinds of consequences mirrored those found in the literature, the actual percentages of respondents, reporting these consequences, were sometimes surprisingly different from those in the reported studies.

Regarding work performance consequences, it was found that for every type of consequence surveyed, more than 50% of the respondents denied ever experiencing that particular consequence (table 4.12). However, the 46% of respondents who admitted that workplace violence had made them consider leaving the profession, eclipsed by far the approximately 33%, as reported by Mckenna *et al.* (2003:95), and Sofield and Salmon (2003:282). Conversely, the 44% of respondents, who admitted that workplace violence had negatively affected their standard of patient care, was far less than the 73% reported by Rosenstein and O'Daniel (2005:60). Similarly, a smaller percentage (36%) of respondents in this study, compared to 49% in a survey by the Institute of Safe Medication Practices (2004), admitted that workplace violence had made them scared to check orders for patient care. Nevertheless, the findings still emphatically indicate that workplace violence had resulted in negative work related consequences.

Regarding personal consequences, the findings (table 4.14) indicated that workplace violence most commonly, in order of frequency, had resulted in anger, feelings of humiliation or embarrassment, feelings of inadequacy, confusion, anxiety / fear, depression and negative effects on personal relationships. Anger was also found to be the most common emotional response, in studies on verbal abuse in Turkey (Kisa, 2008:203), as well as in the North East USA (Sofield & Salmond, 2003:278). Interestingly, although 60% of respondents had felt anxiety following episodes of workplace violence, this was much lower than the 95% of respondents reporting anxiety during a survey on bullying amongst 303 registered nurses across the US (Vessey *et al.* 2009:303).

4.5.5 Objective: Determine whether workplace violence was reported

Table 4.16 indicates that 85% of the respondents had never reported an episode of workplace violence. This under reporting of workplace violence matched all the reported studies in the literature review, e.g. those of Marais, Van der Spuy and Röntsch (2002:11) and Mckenna *et al.* (2003:90). Other researchers, for example Rippon (2000:454), and Ferns (2005:184), also refer to the potentially rampant under reporting of workplace violence. A possibly significant difference between this study, focusing on student nurses, and the referred ones, primarily focusing on qualified nurses, was the fact that the rate of under reporting was much higher amongst the student nurses (85%), than among the trained / qualified staff (approximately 50%).

4.5.6 Objective: Establish reasons for not reporting workplace violence

The findings (table 4.17) suggested that the major reasons for not reporting workplace violence included fear of victimisation and ignorance about where, or how to report it. A third reason, namely that workplace violence had not been reported because nothing would get done about it, was supported by almost half of the respondents.

The fear of victimisation, as expressed by a majority of the respondents, was aligned with the conclusion by Thomas and Burk (2009:230) that the relative powerlessness, when having to confront the behaviour of senior staff, e.g. registered nurses, underpinned the reluctance of student nurses to report episodes of workplace violence. Similarly, Rippon (2000:454) and Jackson, Clare and Mannix (2002:19) deduced that student nurses had not reported incidents of workplace violence, because they felt unsupported by senior staff. The conviction expressed by 49% of respondents that nothing would be done about it, was similar to the 48.4%, as found by Pejic (2005:275), in a study conducted among pediatric nurses in Ontario.

The fact that 85% of the respondents disagreed that workplace violence had been ‘part of the job’ indicated that for them, the occurrence of workplace violence had not (yet) become ‘normalised’, as per the possibility suggested by Jackson, Clare and Mannix (2002:18) and Ramos (2006:37).

4.5.7 Objective: Determine whether students were aware of any policies in the clinical areas addressing workplace violence

Table 4.18 indicates that 72% of the respondents had been unaware (and consequently disempowered) of any policies addressing workplace violence. While one can only surmise about the reasons, the significance of this finding was emphasised by the fact that the National Institute for Occupational Safety and Health (2006:8-11) had identified factors such as lack of worker empowerment and lack of written policy, as common barriers to the implementation of strategies to prevent workplace violence.

4.5.8 Objective: Determine the students' recommendations regarding the management of workplace violence

It was apparent from the responses that for the vast majority of respondents, lateral or horizontal violence (i.e. perpetrated by co-workers) was uppermost in their minds when they addressed this question.

In view of the fact that the most common perpetrators of workplace violence had been registered, staff- and assistant nurses (figures 4.16 - 4.18), it was not surprising that some of the more common recommendations were that permanent nursing staff should be educated about the learning needs and status of nursing students and, in addition, be exposed to interpersonal skills training (table 4.19).

Some examples of comments accompanying this suggestion were: "*permanent staff must not see students as workforce*", "*inform staff we are not there to take their jobs*", "*permanent staff should be aware students are there to learn*", "*they should understand that we are human-beings with feelings and emotions*" and "*stop treating students as useless and stupid*".

These comments clearly suggested that respondents believed that misunderstanding of, or even resentment of their roles as students, had provoked hostility from permanent staff. Respondents indicated that permanent staff had regarded them as part of the workforce and had resorted to hostile actions when they had been frustrated by students' lack of ability, or when they had resented the seeming benefits of the student role, for example attending tutorials when the unit was busy.

Another widespread suggestion was that student nurses be empowered (table 4.19) to confront and report workplace violence. As a management strategy, empowerment of potential and actual victims of workplace violence resonates throughout the literature. Wand and Coulson (2006:166) call for training in de-escalation techniques, sound interpersonal skills and early recognition of potentially volatile situations. Griffin (2004:262) proposes that confrontation techniques be taught and employed to reduce lateral violence perpetrated by nurses. In a more conciliatory vein and recognising the possibility of co-culpability, Hutchinson (2009:150-151) pleads for the use of restorative (e.g. discussion and commitment to changed behaviour) interventions in pre-registration programs to create awareness and to commence moral discourse about workplace violence in nursing.

By suggesting that clinical educators, or mentors should be more visible and available in the clinical areas (table 4.19), respondents revealed that they had felt exposed and unsupported in the clinical areas and in need of protection.

One respondent suggested that clinical educators should "*advocate for the rights of students*". Other comments, although not specifying exactly what the role of the clinical educator should be, included "*clinical educators need to help*" and "*clinical educators should encourage students to express their feelings to them*". It was evident that respondents perceived clinical educators as potentially the most likely ally regarding protection from lateral violence.

However, a disturbing comment by one of the respondent's was that when she had reported verbal abuse to the clinical educator, she had been informed that "*this is nursing, just keep quiet or it might get worse*".

Another respondent pleaded for "*mentors to have more empathy with students in the clinical areas*" and yet another said that "*mentors should stand up for students, rather than take the side of hospital staff*". Worryingly, the perceived turning of a blind eye to workplace violence had not been confined to clinical educators or lecturers, as several respondents, by suggesting that "*management should treat student nurses fairly*", "*unit managers must stop protecting their staff*" and "*unit managers must not just overlook violence*" implied that management had also ignored workplace violence.

4.5.9 Objective: Investigate any relationship between the demographic variables of age, gender, year of study, and frequency, nature, perpetrator and reporting of workplace violence

As mentioned previously, research variables, characterised by a high percentage of '*never*' responses, namely those investigating the form and frequency of physical and sexual workplace violence, (tables 4.5 and 4.7), were only subjected to descriptive analyses.

Regarding the remainder of the research variables analysed, the findings generally revealed insignificant relationships between the demographic characteristics of respondents and workplace violence. Two exceptions, which yielded significant differences, were (1) year of study and prevalence of non-physical workplace violence (4.4.1.3), as well as (2) age and disagreeing with the statement that workplace violence had not been reported, because of not knowing where to report it (4.4.7.1). In the first case, respondents in the third year of study were more likely to experience non-physical workplace violence, than respondents in the second year of study. In the second instance, an increase in age was associated with a higher proportion of respondents disagreeing that they had not reported workplace violence, because they had not known where to report it. Age was not significantly associated with any other aspects of workplace violence.

In a review of research done in the United Kingdom and in North America on adult bullying at work, Rayner and Keashly (2005:281) found that neither age, nor gender had been significant factors in bullying. Similar findings were reported by Kisa (2008:204), and by Ozturk, Sokmen, Yilmaz and Cilinger (2008:438), and, with respect to gender, by Mckenna *et al.* (2003:94). On the contrary, however, Rippon (2000:453) reported that male nurses had been proportionately more at risk of workplace violence than female nurses.

Various studies have, however, demonstrated a significant relationship between age and experience of workplace violence, for example that of Celik and Bayraktar (2004:333), where an increase in age correlated positively with "academic" abuse, such as unfair work allocation. Mckenna *et al.* (2003:94) also found that respondents under the age of 30 more often reported feeling undervalued.

In spite of this, the predominant finding in the literature, as has been confirmed by this study, was that age and other demographic factors, such as gender, were insignificantly related to the prevalence of workplace violence. In this study it has been found that these same demographic factors were moreover insignificantly related to other aspects of workplace violence, such as the perpetrator (4.4.2), the consequences (4.4.3 and 4.4.4), or the actual reporting (4.4.5) of workplace violence.

4.6 CONCLUSION

This chapter presented the analysis of the data generated *via* a self administered questionnaire.

Frequency distributions, in the form of histograms and tables, were presented for each research variable. In each case, this was accompanied by a short description of the results. The mean, with confidence intervals of 95%, and the standard deviation were established as measures of central tendency and dispersion for each relevant research variable.

The responses to the one open ended question were grouped, quantified and the most common suggestions were presented with the aid of a frequency distribution table. The results of the correlation statistics applied to investigate any relationship between demographic and relevant research variables, were also reported.

Finally, a discussion of the findings followed, in which the results were linked with information revealed during the literature review.

In the following chapter, the conclusions and recommendations arising from the outcomes of this research are presented. Recommendations that were made for further studies are presented, whilst the limitations of the current study are discussed.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The purpose of this study was to describe the occurrence of workplace violence in clinical areas among student nurses. This was in response to the guiding research question, namely: 'What is the extent and nature of workplace violence, targeting student nurses in the clinical areas?'

In chapter 1 the researcher described the background and rationale for the study, showing why it was of significance to nursing. The researcher also established the fact that most studies in this regard had focused on qualified / registered nurses. Several specific research objectives, based on an extensive literature review, were formulated for the study. In chapter 2, a review of the relevant literature, pertaining to the study, was presented. Bearing in mind the exploratory nature of this study, a simple theoretical framework, outlining relevant typologies regarding types and perpetrators of workplace violence, was described and later utilised in the formulation of the questionnaire and the discussion of the research findings. In chapter 3, the research methodology was presented in detail and in chapter 4 the data was analysed, interpreted and discussed.

In this final chapter, the conclusions and recommendations, arising from the study, are presented. The recommendations, based on the conclusions and literature review, are condensed into four main interventional categories.

5.2 CONCLUSIONS FROM THE SURVEY OUTCOMES

Conclusions, largely drawn from the discussion of the results in chapter 4 (paragraph 4.5), were derived with reference to each research objective (paragraph 1.4). Overall, the aim of this study, namely, to determine and describe if and to what extent student nurses are being targeted by workplace violence in the clinical areas, was achieved. The conclusion for each stated study objective is now presented. For the purpose of the discussion, the first two objectives of the study were combined.

5.2.1 Objective: Identify the nature / type of workplace violence, and identify the frequency of workplace violence

The findings indicated that student nurses are not protected from workplace violence, by virtue of their novice status.

It can be concluded that in the clinical areas, student nurses of the Western Cape College of Nursing:

- Often encounter active and passive manifestations of workplace violence of a non-physical nature;
- Rarely encounter workplace violence of a physical nature; and
- Occasionally encounter workplace violence of a sexual nature. While sexual abuse was not commonly experienced by student nurses in the clinical areas, the fact that an average of 11.3% of respondents had occasionally experienced sexual abuse in all, but one, of the types of sexual abuse listed in the questionnaire (annexure 3), is worrying and warrants intervention.

5.2.2 Objective: Distinguish between the prevalence of non-physical violence in hospital and community settings

As mentioned previously, none of the reviewed literature pertinently differentiated between hospital and community settings. The reasons for the large difference in the prevalence of non-physical violence in hospital and community settings are unknown. It may be that the hospital environment is fast paced and intolerant of learners.

It can be concluded that student nurses of the Western Cape College of Nursing:

- Frequently experience non-physical workplace violence in hospitals; and
- Rarely experience non-physical workplace violence in community clinical settings.

5.2.3 Objective: Reveal the perpetrators of non-physical violence

This study revealed that nursing colleagues, particularly registered, staff– and assistant nurses were the most common perpetrators of workplace violence.

It can be concluded that regarding students of the Western Cape College of Nursing:

- The most common perpetrators of non-physical violence are the professional (registered nurses) and sub-professional (staff - and assistant nurses) categories of trained nursing staff; and
- Patients and other categories of staff, more specifically, matrons, doctors, other student nurses and housekeeping staff, are also significant sources of workplace violence.

5.2.4 Objective: Identify the type and frequency of consequences of non-physical violence

Many respondents acknowledged suffering debilitating emotional and personal consequences after episodes of workplace violence.

It can be concluded that workplace violence has a harmful effect on the work performance of the students at the Western Cape College of Nursing, as evidenced by their:

- Intent to consider leaving the profession; and
- Reduced confidence to provide safe patient care of a high quality.

Regarding personal consequences, it can further be concluded that:

- Workplace violence has an intensely detrimental personal effect on student nurses at the Western Cape College of Nursing. With the exception of a negative effect on personal relationships, each of the personal consequences surveyed, was acknowledged as being experienced by more than half of the respondents.

5.2.5 Objective: Determine whether workplace violence was reported

The level of under reporting of workplace violence by the respondents matched and in reality exceeded the equally problematic level of under reporting revealed in the literature.

It can be concluded that student nurses of the Western Cape College of Nursing:

- Are particularly reluctant to report episodes of workplace violence.

5.2.6 Objective: Establish reasons for not reporting workplace violence

The reasons for not reporting workplace violence were similar to those revealed in the literature. In addition to a lack of confidence that management would do anything, fear of reprisal and cumbersome reporting procedures, the findings in the current study indicated that ignorance, related to the process of reporting workplace violence, is a further reason for the non-reporting of workplace violence.

It can be concluded that student nurses of the Western Cape College of Nursing do not report workplace violence because of:

- Fear of reprisal;
- Procedural ignorance; and
- Lack of confidence that anything will be done about the problem.

5.2.7 Objective: Determine whether students were aware of any policies in the clinical areas addressing workplace violence

The researcher was alert to the possibility that the multi-setting nature of students' clinical placements might hinder their awareness of policies in the clinical areas, dealing with workplace violence. Although awareness of policy does not guarantee compliance, it is a minimum prerequisite for the formal management of workplace violence. The evidence revealed that, for unknown reasons, a majority of

respondents had been unaware of such policies, effectively neutralising the possibility of students activating institutionally sanctioned preventative measures.

It can be concluded that:

- The majority of the students at the Western Cape College of Nursing are unaware of any policies addressing workplace violence in the clinical areas.

5.2.8 Objective: Determine the students' recommendations regarding the management of workplace violence

The student generated suggestions for the management of workplace violence understandably focused on immediate situational remedies, rather than on broader, institutional initiatives. With reference to Hutchinson's (2009:149) typology, categorising interventional approaches to bullying in the nursing workplace, as described in Chapter 2 (paragraph 2.3.10), these suggestions were aligned to strategies with an individual focus, rather than those with an organisational focus. For example, the students' recommendations regarding the education and development of permanent staff, as well as those regarding the empowerment of nursing students, represented a remedial approach, targeting the individual actor. Similarly, the recommendations calling for the prompt disciplining of perpetrators of violence (table 4.19), represented a corrective approach, also targeting the individual perpetrator.

It can be concluded that student nurses of the Western Cape College of Nursing recommend that:

- Permanent, trained nursing staff of all categories be educated about student status and student needs in clinical areas;
- The interpersonal skills of the same staff be developed;
- Nursing students be taught and empowered to confront workplace violence;
- Clinical educators maintain a more visible presence in the clinical areas; and
- Perpetrators of workplace violence should be subject to disciplinary measures.

5.2.9 Objective: Investigate any relationship between the demographic variables of age, gender, year of study, and the frequency, nature, perpetrator, consequences and reporting of workplace violence

According to the findings, third-year students were significantly more vulnerable to non-physical workplace violence, than second year students, whilst older students were more likely to disagree that they did not report workplace violence, because they did not know where to report it. The reasons for these findings were not apparent and present an avenue for further research.

Apart from these findings it can be concluded that, regarding student nurses of the Western Cape College of Nursing:

- Demographic factors of age, gender and year of study are generally not related to the experience of workplace violence.

5.3 RECOMMENDATIONS

It has long been recognised that the successful prevention and management of workplace violence depend on a multidisciplinary approach (National Institute for Occupational Safety and Health, 2006:14-16), encompassing, *inter alia*, prevention initiatives among the public, the nursing community, authorities and health sector personnel (International Council of Nurses, 2007:21). However, despite these initiatives, the literature abounds with evidence of increasing workplace violence in nursing.

The recommendations ensuing from this study therefore mainly focused on preparing and equipping the impressionable neophyte to confront, withstand and break the cycle of workplace violence. Breaking the cycle is particularly important in light of Randle's (2003:397) finding that the process of becoming a nurse is profoundly dependent upon how trained nursing staff treats students in clinical areas. However, the fact that Griffon (2004:262) reported cessation of lateral violence, perpetrated by nurses, after teaching newly qualified nurses confrontation techniques, indicates that the cycle of workplace violence can be interrupted by equipping the potential victim. Placing the obligation for a pro-active stand against

workplace violence on the victim is also proposed by Jackson *et al.* (2002:18), because of their concern that bullying and harassment may be so “endemic” that they are taken for granted in the nursing workplace.

As such, most of the recommendations are located within the nursing education and training provider environment. Furthermore, in line with the findings, the recommendations are heavily weighted towards the management and prevention of non-physical workplace violence, perpetrated predominantly by fellow workers, but also by patients. Based on the conclusions and the literature review, the recommendations are structured around the following:

5.3.1 Role of management

Much mention is made in the literature of the role of management and the influence of the organisational climate in the prevention of workplace violence. The International Council of Nurses (2007:16) acknowledges that security in the workplace depends upon the value placed by the organisation on an individual’s safety and dignity. Hutchinson (2009:152) is of the opinion that organisational climate is the most neglected, yet potentially the most powerful factor when confronting bullying.

Although one would expect relevant preventative and management measures, addressing workplace violence, to be in place in the clinical settings, the findings indicated that they are largely unknown to the student nurses and singularly ineffective in safeguarding them from workplace violence. It is understandable that the management of a college or educational facility has little control, or jurisdiction, regarding the organisational climate, and more particularly the internal policies addressing workplace violence, in the multi-setting clinical placements required to meet the objectives of the training program.

Consequently, as primary custodians of the students, nursing education and training provider management has an obligation to expose workplace violence targeting student nurses, clearly state its position regarding this practice, equip students to confront and cope with workplace violence, protect students from workplace violence and support students who are traumatised by workplace violence.

The researcher therefore recommends that:

- Notwithstanding the above, the managers of clinical facilities, particularly in hospital settings, should nevertheless be made aware of the findings of the current study and be encouraged to pursue uncompromising remedial and corrective measures; and
- Education and training provider management should take cognizance of the pervasiveness of the problem and assume chief responsibility to address the problem of workplace violence that targets student nurses in the clinical areas. They should start by considering and implementing the subsequent recommendations.

5.3.2 Creation of awareness

In an increasingly violent society, there is a danger that student nurses may equate the concept of workplace violence with physical violence and not, for example, recognise verbal aggression, bullying, the withholding of information or learning opportunities, as workplace violence, or alternatively, regard it as the norm. Awareness, therefore, needs to be created around factors such as the magnitude of the problem, the various guises and the common perpetrators of workplace violence. The researcher therefore recommends that:

- Education and training provider management should provide student nurses, clinical educators, lecturers and management of clinical facilities with an unequivocal position statement, reflecting a zero tolerance policy, on abuse and violence against student nurses; and
- Specific and sufficient provision be made in each year of the training program for the creation of awareness around the occurrence and dynamics of particularly, non-physical workplace violence in clinical settings.

5.3.3 Empowerment of students

As mentioned in chapter 4 (paragraph 4.5.8), the empowerment of potential and actual victims of workplace violence is consistently addressed in the literature. Beech and Leather (2003:603) investigated the impact of a three day multi-dimensional

learning unit on student nurses' abilities to prevent and manage aggression. Nau *et al.* (2009:18) also evaluated a three day, aggression training course for student nurses. Both studies, aimed at the management of patient aggression (type 2 workplace violence), claimed promising evidence of increased confidence levels and lasting changes in knowledge regarding the management of workplace aggression. Despite the fact that the final, self reported evaluation by students, regarding their knowledge and perceived ability around workplace aggression, occurred merely three months and two weeks, respectively, after receiving the training, the positive results support the notion of dedicated, anti-aggression training. Training in violence de-escalation techniques is also proposed by Wand and Coulson (2006:166) and the International Council of Nurses (2007:20).

Compared to the relatively uncomplicated approach to the management of patient initiated aggression, confronting lateral violence (type 3 workplace violence) can be far more stressful, difficult and complicated, due to the fear of victimization identified in this and other studies, and the position of relative powerlessness, particularly relevant to student nurses, referred to by Thomas and Burk (2009:230).

Griffin (2004:262) reported successful cessation of lateral violence by nurse perpetrators, after teaching newly licensed nurses confrontation techniques. Hutchinson (2009:150-151) emphasises the importance of commencing a moral discourse about bullying behaviour already at pre-registration level, and describes the use of 'restorative interventions' to expose and discuss the problem and gain commitment to changed behaviour. The International Council of Nurses (2007:20) highlights the improvement of staff competence as a strategy to combat workplace violence and emphasises the importance of communication skills, particularly assertiveness and debriefing skills.

The empowerment of student nurses further implies that they will know how and where to report workplace violence. The findings from this study indicated that, despite the high prevalence of workplace violence, the majority of the respondents had never reported it and had admitted ignorance of a reporting process. Undoubtedly, this was complicated by the multi-setting, clinical placement policy, required to reach the training program objectives.

The researcher therefore recommends that:

- The question of workplace violence, particularly lateral violence, be comprehensively addressed at a suitable time and place in the curriculum, with the object of raising awareness, increasing knowledge and starting a moral discourse on the topic;
- Interpersonal skills workshops, with particular emphasis on assertiveness and confrontation skills, including violence de-escalation skills, be held in each year of study; and
- A generic reporting and follow up mechanism, applicable, accessible and acceptable to student nurses in all clinical areas, be negotiated and developed at a forum where representatives of training providers, students and clinical facilities meet. The agreed mechanism should be communicated in writing to all role players, particularly to every individual student.

5.3.4 Student support

The findings indicated that students had felt unsupported and vulnerable in the clinical areas. Almost half of the respondents had been of the opinion that nothing would be done about workplace violence and more than half had admitted fear of victimisation. Various comments revealed that some clinical educators, lecturers and management had turned a blind eye to the problem. McKenna *et al.* (2003:96) emphasise that feeling safe is a prerequisite for reporting workplace violence and stress the importance of supportive action for victims of lateral violence.

The researcher therefore recommends that:

- Clinical educators and lecturers are sensitised to the prevalence and negative consequences of workplace violence and the urgent need for advocacy, support and encouragement in this regard; and
- Counseling services be made specifically available for students that are traumatised by workplace violence.

5.4 RECOMMENDATIONS FOR FURTHER STUDY

As a direct sequel to the current study, further research in the same setting, to evaluate the effect of the abovementioned recommendations, after they have been implemented for an appropriate period of time, would clearly be informative.

However, the findings also suggest various further avenues of research, for example:

- Workplace violence targeting student nurses from the perspective of trained nursing staff;
- The characteristics of a workplace that condemns workplace violence against students;
- The characteristics of a workplace that condones workplace violence against students; and
- Reasons for workplace violence being a rare occurrence among student nurses in community settings.

5.5 LIMITATIONS OF THE STUDY

The limitations of this study were mainly related to aspects of the research methodology. Although the use of a self reported, anonymously completed questionnaire enhanced subject truthfulness and reduced interviewer bias, the limited opportunity to elaborate on responses probably resulted in less depth and a more superficial overview of the problem (Burns & Grove, 2007:382). Furthermore, the researcher had no control over unanswered questions. The location of the study in a single educational setting prevented generalisation to a larger population. However, other nurse training institutions in the Western Cape utilise the same clinical placement areas for their training programs.

As mentioned earlier (paragraph 3.9), time and financial constraints, together with the way in which the training program was structured regarding the timing of clinical placements, prevented the investigation of workplace violence in specific nursing disciplines, e.g. psychiatric nursing science. The prevalence of workplace violence may have been even higher, because literature suggests that nurses working in psychiatric units are particularly vulnerable (Chapman & Styles, 2006:246; Ferns, 2005:180; Wand & Coulson, 2006:163). Furthermore, the structure of the training

program meant that respondents from the different year groups were not equally exposed to hospital and community clinical settings.

5.6 SUMMARY

A quantitative, descriptive research study was conducted, investigating workplace violence, targeting student nurses in the clinical areas. The setting for this study was the Western Cape College of Nursing and the population was all the second, third and fourth-year, pre-registration students at the college. First-year pre-registration students were not considered, due to their relative lack of clinical exposure.

The overall conclusion arising from the study is that student nurses, in accordance with a worldwide trend amongst all categories of nurses, are the targets of workplace violence in the clinical areas. The most common violence being encountered by student nurses is of a non-physical nature, e.g. verbal abuse, intimidation and bullying. The most common perpetrators are fellow nurses, particularly professional and sub-professional categories of trained nursing staff, followed by patients. Student nurses are negatively affected by workplace violence and the standard of patient care is jeopardised, because of intimidation and emotional responses, such as anger. Generally, student nurses fail to report episodes of workplace violence.

The overall recommendation is that education and training provider management should assume responsibility for the comprehensive management of the problem of workplace violence targeting student nurses, and not solely rely on policy, existent to a lesser or greater degree, in the clinical facilities. Apart from equipping the student nurse with skills to confront and manage workplace violence, the recommendations also aim at interrupting the socialisation process that perpetuates workplace violence in nursing.

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ANNEXURE 1

Letter of consent from the head of the Western Cape College of Nursing

ENQUIRIES
NAVRAE
IMIBUZO MR D. GOVIN
COLLEGE PRINCIPAL

TELEPHONE
TELEFOON
IFOWUNI (021) 684 -1202/3

REFERENCE
VERWYSING
ISALATHISO **Request to do a research project at the Western Cape College of Nursing**

DATE
DATUM
UMHLA 31 March 2010

DEPARTMENT OF HEALTH
DEPARTEMENT VAN GESONDHEID
ISEBE LEZE MPILO

PROVINCIAL GOVERNMENT: WESTERN CAPE
PROVINSIALE GOEWERMENT: WES-KAAP
ULAWULO LWEPHONDO: INTSHONA KOLONI

WESTERN CAPE COLLEGE OF NURSING

WES-KAAP KOLLEGE VAN VERPLEGING

IKHOLEJI YECANDELO LABONGIKAZI BASENTSHONA-KOLONI

Dear Ms Hewett

Request to do a research project at the Western Cape College of Nursing

Your letter dated 18 November has reference and our verbal communication on several occasions.

Your request was considered and herewith permission is granted to you to continue with the project.

You are reminded of the confidentiality aspect of the project under investigation.

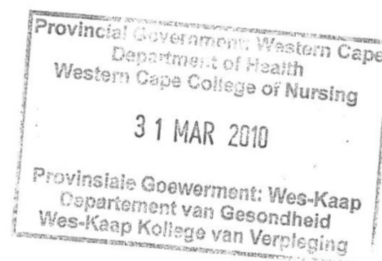
After completion of the study could you please forward a report to this institution of your findings.

We wish you well with your studies.

Sincerely.

B Rafferty

....
Mrs B Rafferty
Vice Principal
WCCN



ANNEXURE 2

Letter of approval from the Ethics Research Committee, Faculty of Health Sciences of the University of Stellenbosch

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

10 December 2009

MAILED

Ms D Hewett
Department of Nursing
2nd Floor, Teaching building
Stellenbosch University
Tygerberg campus
7505

Dear Ms Hewett

"Workplace violence targeting student nurses in the clinical areas."

ETHICS REFERENCE NO: N09/11/338

RE : APPROVED

It is a pleasure to inform you that a review panel of the Health Research Ethics Committee has approved the above-mentioned project on 9 December 2009, including the ethical aspects involved, for a period of one year from this date.

This project is therefore now registered and you can proceed with the work. Please quote the above-mentioned project number in ALL future correspondence. You may start with the project, but this approval will however be submitted at the next meeting of the Health Research Ethics Committee for ratification. Notwithstanding this approval, the Committee can request that work on this project be halted temporarily in anticipation of more information that they might deem necessary to make their final decision.

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.

Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Approval Date:9 December 2009 Expiry Date: 9 December 2010

Fakulteit Gesondheidswetenskappe · Faculty of Health Sciences

Verbind tot Optimale Gesondheid · Committed to Optimal Health
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Yours faithfully

MRS MERTRUDE DAVIDS
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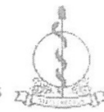

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ANNEXURE 3

Research questionnaire

Student Questionnaire

Title of the research project

Workplace violence, targeting student nurses in the clinical areas.

Definition of workplace violence

Workplace violence is aggressive behavior towards another person or object of that person, finding expression in physical assault, sexual harassment and non-physical violence such as verbal abuse, incivility, bullying and intimidation.

Instructions

Please complete the questionnaire. Select your response by placing a tick (√) at the appropriate spot next to each question. Where applicable, add a relevant example.

There is one open-ended question at the end of the questionnaire where you are asked to formulate your own response to the question.

The principles of confidentiality and anonymity will be maintained.

SECTION A: DEMOGRAPHIC DATA

1. Gender

Male	
Female	

2. Age: Please fill in:

3. Year of study

2nd year	
3rd year	
4th year	

SECTION B: DATA RELATED TO WORKPLACE VIOLENCE

Please read each question / statement carefully.

Make a tick (√) in the appropriate box next to the question.

Tick (√) only one (1) box for each question/statement.

		1	2	3	4
In the past year in the *clinical areas*, I have been intimidated, bullied or verbally abused in the following ways:		Never	Occasionally (1 - 2 times)	Sometimes (3–5 times)	Often (> 5 times)
4	Non-verbally, e.g. raised eyebrows, rolling eyes				
5	sworn, shouted or yelled at				
6	harshly judged/criticized				
7	ignored or neglected				
8	ridiculed or humiliated				
9	been unfairly treated regarding on/off duty schedules				
10	given unfair work allocation				
11	not received acknowledgement for good work				
12	denied learning opportunities				
13	had a racist remark directed at me				
14	not been treated as part of the multidisciplinary team				
15	other: please write down and make a tick in the appropriate box				

		1	2	3	4
In the <u>past year</u>, *in the clinical areas,* I have been physically abused in the following ways:		Never	Occasionally (1 - 2 times)	Sometimes (3–5 times)	Often (> 5 times)
16	pushed or shoved				
17	kicked				
18	slapped or punched				
19	hit with something				
20	had a gun or knife pulled on me				
21	been threatened with physical violence				
22	had something of mine deliberately damaged				
23	other: please write down and make a tick in the appropriate box				
	In the <u>past year</u>, *in the clinical areas,* I have been sexually abused in the following ways:	Never	Occasionally (1 - 2 times)	Sometimes (3–5 times)	Often (> 5 times)
24	been inappropriately touched				
25	been threatened with sexual assault				
26	had sexist remarks directed at me				
27	had suggestive sexual gestures directed at me				
28	had a request for intimate physical contact				
29	other: please write down and make a tick in the appropriate box				

SECTION C: NON-PHYSICAL VIOLENCE ONLY (INTIMIDATION, BULLYING OR VERBAL ABUSE)

Tick (√) only one (1) box for each question/statement.

		1	2	3	4
In the past year I experienced intimidation, bullying or verbal abuse, in the following *clinical areas*:		Never	Occasionally (1 - 2 times)	Sometimes (3–5 times)	Often (> 5 times)
30	hospitals				
31	community settings, e.g. day hospitals, clinics				
In the past year I experienced intimidation, bullying or verbal abuse, in the *clinical areas* from the following sources:		Never	Occasionally (1 - 2 times)	Sometimes (3–5 times)	Often (> 5 times)
32	patients				
33	doctors				
34	patients' relatives or friends				
35	matrons/nurse managers				
36	registered nurses				
37	staff nurses				
38	assistant nurses				
39	other student nurses				
40	clinical educators (mentors)				
41	lecturers				
42	administrative staff				
43	housekeeping staff				
44	other: please write down and make a tick in the appropriate box				

		1	2	3	4
Intimidation, bullying or verbal abuse in the *clinical areas* has influenced my work performance in the following ways:		Never	Occasionally	Often	Always
45	made me consider leaving nursing				
46	caused me to call in absent				
47	made me scared to check orders for patient care				
48	negatively affected my standard of patient care				
49	other: please write down and make a tick in the appropriate box				
Intimidation, bullying or verbal abuse in the *clinical areas* has resulted in me experiencing the following personal consequences		Never	Occasionally	Often	Always
50	anger				
51	depression				
52	humiliation/embarrassment				
53	anxiety/fear				
54	confusion				
55	feelings of inadequacy				
56	negative effect on personal relationships				
57	other: please write down and make a tick in the appropriate box				

SECTION D: REPORTING OF WORKPLACE VIOLENCE

58. Have you ever reported an episode of *any* kind of workplace violence to the authorities?

Yes	
No	

If Yes, proceed to question 65.

If No, continue with question 59 by ticking the appropriate box

Tick (√) only one (1) box for each question/statement.

		1	2
I have never reported an episode of physical or non-physical workplace violence to the authorities because:		Agree	Disagree
59	it is part of the job		
60	nothing will get done about it		
61	I am afraid I will be victimized		
62	it is not important enough to me		
63	I do not know where/how to report it		
64	other reasons for not reporting workplace violence: please write down :		

65. Are you aware of any policy in the clinical areas addressing workplace violence?

Yes	
No	

SECTION E: MANAGEMENT OF WORKPLACE VIOLENCE

66. Do you have any suggestions regarding the management of workplace violence targeting student nurses in the clinical areas?

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

D Hewett: 2010

ANNEXURE 4

Participant information leaflet and consent form

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

Title of the research project: Workplace violence targeting student nurses in the clinical areas

Investigator: D Hewett

Contact number: 0842303294

You are being invited to take part in a research project. Please ask the researcher any questions about any part of this project that you do not fully understand. Your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Ethics Research Committee, Faculty of Health Sciences of the University of Stellenbosch** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

1 What is this research study all about?

This study will be conducted at the Western Cape College of Nursing. Approximately 30% of 2nd, 3rd and 4th yr students, randomly selected, will be asked to take part in the study.
Literature has shown that nurses are often the target of workplace violence, which can have serious physical and emotional consequences. The aim of the study is to investigate the existence and extent of workplace violence (physical and non-physical) targeting student nurses in the clinical areas. It is important to find out if this is a problem and to develop measures to counteract it.
Once you have declared yourself willing to take part in the research study you will be asked to complete a questionnaire that will take approximately 10 – 15 minutes of your time. Absolute confidentiality and anonymity will be maintained and no-one will be able to match completed questionnaires to specific individuals.

2 Why have you been invited to participate?

You are a representative of the group of students to be studied.

3 What will your responsibilities be?

You will be asked to complete a questionnaire that should take about 10 minutes to complete.

4 Will you benefit from taking part in this research?

The benefit of this research lies in the fact that insight will be obtained about the problem of workplace violence as experienced by student nurses of the Western Cape College of Nursing. Specific and relevant measures to counteract the occurrence and consequences of workplace violence can then be implemented. Student nurses from other nursing education institutions will also benefit from these outcomes. A report of the findings will be made available to the Head of College and the heads of the clinical facilities. A research article

based on the study will also be submitted to an accredited nursing journal for possible publication.

5 Are there any risks involved in your taking part in this research?

There is a risk that recalling an incident of workplace violence may be upsetting to you. If answering any of the questions results in distress to yourself, please contact the researcher so that appropriate interventions can be organized. Alternatively, you can contact the student counselor, Miss L Robertson on telephone 021 684 1242.

6 Who will have access to the completed questionnaires?

Data from the questionnaires will be captured by the researcher. The only other persons who may have access to the data is the study supervisor and the statistician. All information collected is confidential and anonymity is ensured by the fact that no-one will be able to match a completed questionnaire to a specific individual. Completed questionnaires will be stored in sealed containers in a locked storage area.

7 Will you be paid to take part in this study and are there any costs involved?

No you will not be paid to take part in the study. There will be no costs involved for you, if you do take part.

8 Is there anything else that you should know or do?

You can contact the **Ethics Research Committee** at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by the researcher.

Declaration by participant

By signing below, I ………………………………..…………. agree to take part in a research study entitled **workplace violence targeting student nurses in the clinical environment.**

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurized to take part.
- I may choose to leave the study at any time and will not be penalized or prejudiced in any way.

Signed at (*place*) ....…......……………..on (*date*) …………...……….. 2010.

Signature of participant ……………………………………….….