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**Chapman, R., Perry, L., Styles, I. and Combs, S. (2009)  
Consequences of workplace violence directed at nurses. British  
Journal of Nursing , 18 (20). pp. 1256-1261.**

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# **Consequences of workplace violence directed at nurses.**

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## **Abstract**

The consequences of workplace violence (WPV) are far-reaching, and impact on the nurse, the perpetrator and the organization. However, the authors were unable to identify any research in the literature on nurses' perceptions of the consequences of WPV in non-teaching hospital settings. This study therefore aimed to examine nurses' perspectives of the consequences of WPV, to identify ways to reduce the impact of these incidents. A descriptive, exploratory approach was adopted to collect qualitative survey and interview data from nurses working in several areas of one West Australian non-teaching hospital in 2006. Three themes emerged from the data: nurse, perpetrator and organizational consequences. The sub-themes included nurses accepting that WPV is part of their job; physical and emotional effects; not feeling competent; avoiding patients; organizational costs of WPV;

adverse effects of restraint; and disruption to patient care. Participants experienced several negative consequences as a result of WPV. Recommendations for improving the safety of hospitals for staff and patients are made in light of the findings.

**Key words:** Consequences; Non-teaching hospital; Organization; Perpetrator; Workplace violence

Workplace violence (WPV) in healthcare settings is of national and international concern, and nurses are at the front-line of these dangerous situations (Chapman and Styles, 2006). The consequences of WPV can be far-reaching and have both direct and indirect financial costs to nurses, the organization and society at large (McKenna et al, 2003).

One of the major concerns for researchers, employers and society is the impact that WPV has on nurses (McKenna et al, 2003). Violence toward nurses can lead to physical injury, negative effects on personal lives, and debilitating emotional, social, physical and cognitive symptoms (Bowers et al, 2007). Nurses not only face the immediate threat of physical abuse but also subsequent emotional effects such as fear, anger, anxiety, frustration, helplessness, sadness, low self-esteem and depression (Grenyer et al, 2004). Staff burnout is another consequence of WPV. Winstanley and Whittington (2002) examined the relationship between staff anxiety, coping styles and burnout, and the frequency of aggressive events. The researchers found that a higher frequency of incidents was associated with more burnout, including emotional exhaustion and depersonalization.

WPV has also been found to have a detrimental effect on nurses' work performance (Farrell et al, 2006). Two thirds of the nurses in Farrell et al's (2006) study reported that WPV frequently contributed to their making errors and also affected their productivity. Similarly, in a study examining the incidence of verbal abuse experienced by 151 nurses in a 400-bed North American acute hospital, Cameron (1998) found that these incidents influenced job performance by causing errors (52%), decreasing morale (51%) and productivity (40%), and increasing workload for their peers (29%). The findings of Cameron's study add to the literature on verbal abuse; however, the study did not include physical abuse.

A further indirect cost of WPV is the negative effect that these incidents have on the quality of patient care (Merecz et al, 2006). Henderson (2003) conducted a qualitative study in Canada and the United Kingdom to examine registered nurses' experiences of WPV and how those experiences affected their ability to care for patients. The study found that the implications of WPV for patient care are profound.

Although the literature has highlighted that the effects of WPV are significant (Bowers et al, 2007), no previous research could be found that investigated the perceptions of this phenomenon by nurses working in non-teaching hospitals. Some of the factors that differentiate teaching and non-teaching designations (e.g. non-teaching hospitals usually having fewer beds and less acute patients) may lead to differences in nurses' experiences of WPV (Chapman et al, 2009). To decrease the impact of WPV in all healthcare settings it is important to understand nurses' perceptions of the consequences of these events.

## **Aim**

The aim of the study was to identify Australian nurses' perceptions of the consequences of WPV to themselves, the offender (perpetrator) and the organization. For the remainder of this article, the word 'perpetrator' will be used when discussing the person being violent and/or aggressive. The study expands on Cameron's research—which looked at verbal abuse only—by investigating all forms of WPV, to ensure a broader view of WPV is gained.

## **Design**

The descriptive exploratory study collected qualitative data using both a written survey and interviews, to investigate nurses' perceptions of their experiences of WPV in the previous 12 months at one West Australian non-teaching hospital.

## **Participants**

All 322 nurses working in the emergency department, aged care, medical, surgical, maternity, paediatric and mental health areas of the hospital, and who had direct patient contact, were invited to participate. Ethical approval was obtained from the ethics committees of the case study hospital and a university. All nurses participating in the study gave written informed consent before completing the survey or participating in an interview. There was no perceived risk to the nurses participating in this study.

## **Instrument**

A self-administered survey was distributed to all nurses working in the previously mentioned areas in 2006 to determine their experience of WPV in the previous 12 months. An envelope containing the self-administered survey, information sheet, consent form and self-addressed return envelope was mailed to nurses. Two open-ended questions in the survey were directly related to the nurse's perceptions of the consequences of their most recent experience of WPV.

The survey was developed following a review of the literature and feedback from registered nurses. Once developed the instrument was reviewed by nurse academics to check face-validity. The final survey comprised 10 demographic questions, 18 open-ended questions (2 of which were directly related to the nurses' perceptions of the consequences of their most recent experience of WPV), and 31 closed (yes or no) questions.

## **Interviews**

Semi-structured interviews or 'conversations' were conducted with survey respondents who consented to be interviewed. The one-to-one interviews were conducted by the principal researcher who was not known to the majority of participants (three of the interviewees had previously worked with the researcher). The interviews aimed to explore nurses' experience of WPV and to gain an understanding about the meaning, interpretations and consequences of these events (Llamputtong and Ezzy, 2005). The interviews were conducted in a setting convenient to the participant and lasted for approximately 30 minutes. Theoretical saturation

was reached after 20 interviews, i.e. when the researcher failed to obtain any new information and all categories and themes appeared to be complete (Sandelowski, 1986).

The interview questions were derived from the aims of the study, were open-ended and directed towards uncovering the meaning of the nurses' experiences of WPV (Fontana and Frey, 2000). Some examples of the questions asked are:

- Can you please tell me about a time when you experienced a violent encounter during work?
- Can you describe as specifically as possible this event/s?
- Can you tell me how the event impacted (or not) on you?

The interviews began with the researcher developing trust with the participants; this process was assisted by providing a quiet environment, where interruptions did not occur, by being receptive and by listening non-judgmentally (Llampaotong and Ezzy, 2005). All of the interviews were tape-recorded and then transcribed verbatim.

### **Data analysis**

All transcribed data were analyzed following the standards of qualitative data analysis procedure, i.e. reading, reflecting, coding, categorizing validating codes and categories and searching for emerging patterns and meaning (Speziale-Streubert and Carpenter, 2003). Three of the researchers analyzed the data individually. In addition, samples of the transcripts were given to an expert in qualitative data analysis. There was overall agreement and consistency between the researchers and the expert's analysis. Transcripts were read line-by-line and

significant words and phrases identified. Following this procedure the major thrust or intent of the transcripts were conceptualized (Field and Morse, 1994). The findings were then presented back to the participants to check the validity of the researchers' interpretation (Lincoln and Guba, 1985). An audit trail was maintained to document all aspects of the study, data analysis and description of the findings (Llamputtong and Ezzy, 2005).

## **Findings**

Of the 322 questionnaires sent to nurses, 113 (34%) were returned. Of the 113 respondents to the survey, 35 (31%) nurses consented to be interviewed. The participants in this study were mainly female, in their early 40's, had worked in the profession between 6 months and 40 years, and were largely employed on a part-time basis (Table 1).

The participants highlighted consequences of WPV on the organization, the perpetrator and themselves (Figure 1). All of the themes and sub-themes are presented in more detail in the following section, with illustrative data from both the survey and interviews.

### **Nurse consequences**

The participants identified three consequences of WPV for the nurse, namely, coming to regard WPV as an expected part of the job, physical and emotional effects, and not feeling competent.

### ***Part of the job***

Significantly, many of the respondents in this study believed that WPV was an aspect of their job. The participants appeared to be tolerant of their experiences of WPV and not only accepted but also expected these events in the course of their day. One nurse stated:

‘I accepted the incident as part of the job’ (Survey 105).

Another nurse explained that:

‘This type of behaviour [WPV] is so common place... It’s part of the job, we

Are just expected to cope with it, deal with it’ (Survey 29).

### ***Physical and emotional effects of WPV***

Several of the respondents experienced physical consequences including back injury, pain, bruising, and fractured ribs. One nurse reported that she had experienced:

‘Full physical contact, with good amounts of pain in upper chest, some loss of

use in my left arm due to pain, physical bruising and fractured ribs’ (Survey 46).

Some of the nurses described being emotionally affected by WPV. These feelings included apprehension, anger, and fear, as described by one nurse:

‘You get that fight and flight response as well. You get that adrenaline rush,

because you’re frightened for yourself, you feel your hearts racing, you get

that physical response that makes you feel light headed and shaky as well’

(Interview 5)

Nurses also stated that on some occasions they would take their feelings of fear, anger and intimidation home with them and that their personal relationships were affected as a result:

‘There are increased tension and arguments at home due to increased anxiety levels’ (Survey 90).

Other emotions described by the participants included feeling sadness and embarrassment.

One nurse stated that:

‘It [episode of WPV] saddened me’ (Survey 75).

Another nurse described her experience of WPV:

‘It made me feel upset, I was trying to communicate with her [patient] in a gentle non-threatening manner yet what ever I did [it] made little difference’ (Survey 83).

### **Not feeling competent**

Participants questioned their competence as nurses after being involved in an incident of WPV because they felt inadequate, overwhelmed, helpless, out of control and guilty. One nurse stated that she:

‘Felt helpless towards the patient... and I left the shift feeling inadequate and totally overwhelmed both physically and emotionally’ (Survey 43).

## **Organizational consequences**

The participants discussed the impact of WPV on the organization, namely that of financial costs, of reluctance of nurses to care for patients and of lowered job satisfaction.

### ***Cost of workplace violence***

The costs of WPV related to nurses requiring sick leave, counselling and being on workers' compensation. One nurse stated that as a result of being involved in an incident of WPV she 'required 2 weeks off work' (survey 46). Another participant reported that she experienced long-term effects as a result of WPV:

'I needed to attend a 4 week return to work program and 6 months of counselling. [I'm] still very cautious of violent patients' (Survey 6).

### ***Reluctance to care for patients***

Many of the nurses in the study were reluctant to care for violent and aggressive patients and knew that, as a result, other nurses had to take on a greater workload. Patient care was also affected by these situations because being involved in incidents of WPV was both time-consuming and person-consuming, and staff felt more vulnerable at work. One nurse explained that following an incident of WPV she had experienced:

'Decreased concentration, therefore, affecting [my] ability to apply myself properly at work' (Survey 90).

### ***Lowered job satisfaction***

Participants in this study reported that staff morale was lowered as a result of WPV leading to lower job satisfaction, resignations, lack of motivation and a decrease in staff confidence in the organization. Another negative consequence identified by the participants was the effect of WPV on the hospital's reputation. A participant noted a:

‘Decreased lack of respect due to media publicity. [The hospital] has had a lot of negative publicity’ (Survey 65).

### **Perpetrator consequences**

The nurses in this study also mentioned negative effects on the perpetrator.

### ***Restraint***

The participants reported that on many occasions the perpetrator was either physically or chemically restrained:

‘They [the consequences] were bad... A young man 19 years of age with a psyche problem, very aggressive and strong, [he was placed] in resus with [a] guard, [he] awoke suddenly threatening [the] man [guard]. Guard holding hands of patient to stop him from hurting me, he was very strong one guard was not enough. Chemical and physical restraints used ... He was in the department 5 days [chemically sedated] before a bed was available at [a tertiary mental health hospital]... (Survey 113).

### *Avoiding patients*

Another consequence for the perpetrator of WPV was that the nurses became reluctant to care for violent patients. The participants reported that patients who offend may not receive the best care and they thought that the patients' relationships with staff could be affected. One participant noted that nurses were:

'Very cautious ... it [episode of WPV] had its impact and affects your relationship with [the] patient' (Survey 23).

Another nurse stated that she:

'Refuse[s] to give care to potentially violent patients' (Survey 19).

### *Disruption to patient care*

In addition to the effect on the care delivered to an perpetrator, participants also reported that as a result of an aggressive incident, care delivered to the other patients on the ward was also reduced. One nurse explained that:

'I was frustrated that other patients had to suffer and get compromised care due to time taken up by an aggressive patient' (Survey 35).

Another participant recounted a time when she:

'Had spent 3 hours of my shift trying to sort it [incident of WPV] out, which meant... other residents missed out on care' (Survey 84).

## **Discussion**

This study provides only a 'snap shot' of nurses' perceptions of the consequences of WPV at one non-teaching hospital, and thus the generalizability of findings to other situations may be limited. In addition, the survey return rate of 34% is low and may have compromised the reliability of the data (Chapman et al, 2009). However, according to Burns and Grove (1987) the response rate to mailed questionnaires is usually 25–30%, so the rate in this case is slightly better than is usually expected (Chapman et al, 2009). The findings of this study resonate strongly with those reported in other studies, suggesting that the consequences of WPV can be expected to be similar in other healthcare settings (Grenyer et al, 2004). These findings have implications for organizations, government and society at large.

### **Consequences for nurses**

The majority of nurses participating in this study were employed part-time. This finding is reflective of the total population of nurses at the case study hospital. Studies have highlighted that limited opportunities for on-going education are available for those nurses employed part-time (Edwards and Robinson, 2004). The part-time nurses in Jamieson et al's (2008: p890) study considered themselves 'disempowered to change organizational practices that limited their ability to access information, contribute to decision making and access structured learning...'. This finding is of concern as the nurses in the current study experienced significant consequences of WPV. Organizations need to ensure that part-time staff have access to relevant and up-to-date WPV education and training. In addition, workplaces are required to enable these nurses to participate and contribute in the

decision making processes directly related to the development of WPV policies and guidelines.

The literature shows that, similar to the participants in this study, nurses in many contexts and countries consider that being a recipient of WPV is inherent in the job and accepted as part of the nature of nursing (Grenyer et al, 2004). For example, 77% of the Minnesota nurses in Nachreiner et al's (2007) study expected assault as a consequence of their job. Lanza (1992) argues that by normalizing WPV and believing that it is 'just part of the job', nurses are desensitized to working in dangerous and volatile environments, and subsequently they are protected from overwhelming feelings of anxiety and hopelessness.

The participants in the current study reported experiencing both physical and emotional consequences as a result of WPV. These findings confirm those found in the literature (Dean, 2004). Although few episodes of WPV result in physical injury (Arnetz and Arnetz, 2001), the literature — similar to this study — also highlights nurses reporting injuries ranging from bruising and fractures, to long-term chronic pain (McKinnon and Cross, 2008). The consequences of WPV were not isolated to the work environment in this study. The participants reported that on some occasions they would take their feelings of fear, anger and intimidation home with them, and that their personal relationships were affected as a result. A search of the literature failed to locate any other studies that identified perceptions from nurses that their interpersonal relationships were negatively affected as a consequence of WPV.

## **Consequences for perpetrators**

This article presents new knowledge of nurses' perceptions of the consequences of WPV, namely those directly related to the impact of restraint on all people involved in an episode of WPV. To the authors' knowledge this is the first study to focus on nurses' perceptions of the consequences for the perpetrator of WPV. When researching literature that highlighted the impact on perpetrators, the most common consequence for the perpetrators of WPV was found to be a verbal reprimand from a senior nurse (Mayhew and Chappell, 2003). However, the participants in this study identified much more severe consequences for the perpetrators, namely being physically or chemically restrained.

Restraint is used to confine a patient's bodily movements, and may be physical or chemical in nature. It is common practice in controlling a perpetrator to prevent further injury and administer drugs (Ryan and Bowers, 2006). However, the literature has highlighted several adverse psychological and physical effects on both the perpetrator and staff as a result of initiating and maintaining physical and chemical restraint (Bigwood and Crowe, 2008). These include anger, anxiety, fear, helplessness, humiliation, pain and even death (Ryan and Bowers, 2006).

Providing safe patient care is fundamental to the nursing profession, therefore, it is not surprising that the participants in this study felt that restraint had negative consequences for the perpetrator. This could be a result of the conflict that manually restraining a patient brings to the nurse's belief in a therapeutic nurse-patient relationship. Nurses employ touch during their interactions with patients and these actions are used to demonstrate caring (Routasalo,

1999). The act of caring is fundamental to nursing, thus the requirement for nurses to practice physical restraint can cause ethical and personal conflict (Bigwood and Crowe, 2008).

Although the participants in this study reported that restraint was a necessary intervention when patients became violent or aggressive, they also recognized that this intervention was extreme and one which negatively impacted on all parties.

### **Consequences for organization**

Similar to other research findings, the participants in this study considered that incidents of WPV directed at the nurses had both a direct and indirect cost for the organization. These costs included absenteeism, reluctance to care for patients, increased workload for other staff, lowered staff morale, resignations, lack of motivation, a decrease in staff confidence in the organization, depersonalization of patients and lower job satisfaction. All of these consequences have been highlighted in the literature as leading to a decrease in quality patient care (Merecz et al, 2006). Henderson's (2003) qualitative study in Canada and the United Kingdom examining registered nurses' experiences of WPV in the workplace found that the implications of WPV on patient care are profound.

Considering the rising costs related to clinical negligence (Tingle, 2002), the current findings are significant. Nurses have a legal duty of care to their patients and one could argue that by avoiding or refusing to treat aggressive patients, nurses are breaching their duty of care.

Therefore, organizations should be made aware that this is one way nurses deal with WPV and administrators are required to establish policies and procedures to legally protect not only staff but also the institution in these situations.

## **Recommendations**

This study has clearly demonstrated that the consequences of WPV are significant to all involved. The research literature on manual (holding) restraint is limited and focuses on either the use of mechanical restraints (Brice et al, 2003) or control and restraint in the mental health settings (Duxbury, 2002). Little is known about the use of manual restraint in the general hospital setting. Therefore, considering that the literature has highlighted physical, psychological, ethical, philosophical and legal consequences of the restraint treatment option for not only the perpetrator but also to their family and the staff involved in the process, future research efforts should focus on manual restraint use in non-teaching hospitals. This research should concentrate on the nurse's decision making to manually restrain, the effectiveness of the task, and the physical and the psychological effects of the process on both the patient and staff. As a result, this new knowledge could be used to form policy and direct future legislation that may in turn provide nurses with a more ethical framework in which to provide safe patient-centred care.

In addition, the literature demonstrates that nurses feel unsupported by their organizations following WPV (Dean, 2004). Therefore, a major challenge for organizations is to develop policies and procedures that effectively protect staff from the consequences of WPV (Jackson et al, 2002). The literature has highlighted that nurses who attend critical incident debriefing following an episode of WPV feel more supported by the organization and report less interpersonal conflict (Laposa et al, 2003).

To effectively reduce the impact of WPV, organizations should be required to provide staff with instrumental and informational supports, both of which have been shown to moderate the psychological and somatic effects of WPV (Schat and Kelloway, 2003). Instrumental support involves direct help or assistance to staff who have experienced an incident of WPV (Schat and Kelloway, 2003). This support can be received from co-workers, management and supervisors. Informational support refers to the support an organization provides staff through information and training to enable them to better deal and cope with incidents of WPV (Schat and Kelloway, 2003). In addition, to reduce the number and impact of these events, future research should focus on effective intervention strategies. It may be possible to identify methods which nurses can use to prevent situations escalating into full-blown attacks or, when that is not achievable, to decrease the severity of the consequences of WPV on the nurse, perpetrator and the organization.

Prior to the study the organization had few policies, guidelines or resources to protect nurses from WPV. However, since the study was completed the hospital has introduced 24-hour security personnel, personal duress alarms in the mental health unit and WPV training for staff.

## **Conclusion**

Dealing with the occurrence and consequences of WPV is a major challenge for nurses, management and society at large. This study has explored nurses' perspective of WPV at one non-teaching hospital in Western Australia, and hence the generalizability of findings to other situations is limited. However, the findings support and, importantly, add to the body of

research in this area, in particular, the consequences for the perpetrator of WPV. This study has demonstrated that nurses experience physical, psychological and emotional harm as a consequence of WPV. It is possible that the physical injuries of WPV heal quickly. However, the emotional and physical consequences may take much longer to repair and can interfere with their everyday lives (Rippon, 2000). The nurses in this study considered that WPV was an expected aspect of the job although they identified that the consequences of these events for themselves, perpetrator and organization were extreme and far-reaching.

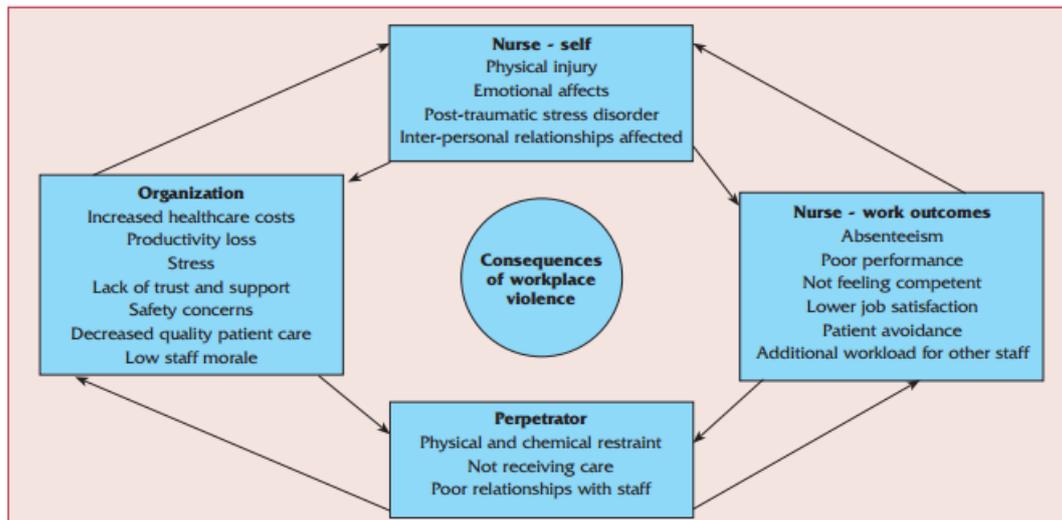
We accept that the risk for staff of being involved in an incident of WPV remains high. Health agencies cannot control who is admitted to their hospitals, and patients who are distressed, in pain, frightened, have a mental illness or who are under the influence of drugs or alcohol — and who therefore may be prone to aggressive behaviour — will continue to present for treatment. However, we would argue that organizations are required to ensure that all efforts have been made to reduce these risks. One way to achieve this is to provide staff working in all areas of the hospital with relevant and up-to-date WPV education and training. In addition, organizations should be obliged to offer staff and perpetrators emotional and physical support following these events to diminish the negative consequences of WPV. Further research exploring both prevention and management of WPV in the hospital environment is needed.

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**Figure 1.** The consequences of workplace violence as identified by participants in the study.



**Table 1.** Characteristics of nurse participants

<b>Nurse demographics</b>		<b>Percentage of total sample (%)</b>
Gender	Female	92
	Male	8
Level	Registered nurse	52.2
	Clinical nurse	19.5
	Clinical nurse specialist	3.5
	Nurse unit manager	5.3
	Staff development nurse	2.7
	Enrolled nurse	7.1
	Unknown	9.7
Work areas	Emergency department	23
	Mental health	11.5
	Maternity	13.3
	Medical	10.6
	Surgical	19.5
	Aged care	11.5
	Paediatrics	4.4
	Unknown	6.2
Educational level	Hospital-based diploma	41.6
	Bachelor degree	33.7
	Post-graduate degree	10.7
	Unknown	14