

**MIDLANDS STATE UNIVERSITY
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY**



**EXPERIENCES OF PATIENT VIOLENCE ON STAFF IN ACUTE IN PATIENT
PSYCHIATRIC UNITS A CASE STUDY OF GWERU PROVINCIAL HOSPITAL**

**BY
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**FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY**

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**EXPERIENCES OF PATIENT VIOLENCE ON STAFF IN ACUTE IN PATIENT
PSYCHIATRIC UNITS A CASE STUDY OF GWERU PROVINCIAL HOSPITAL**

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DEDICATION

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

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ABSTRACT

Nurses working in acute inpatient psychiatry experience high rates of violence perpetrated by patients. Their perspectives, attitudes and feelings towards the phenomena are essential to understand the phenomena of patient violence the purpose of this study was to explore and describe in detail the experiences of patient violence directed towards staff in acute inpatient psychiatric unit at Gweru Provincial Hospital. This study particularly explore the registered mental nurses` attitudes and feeling towards patient violence. In this interpretive, descriptive study, a purposeful sample of 12 nurses were interviewed to understand how they feel and perceive their experience of violence within the workplace. A qualitative explorative and descriptive study design was used in this study by sampling only nurses who had experienced violence. Semi structured individual interviews were conducted. Data was presented using thematic content analysis. Experiencing patient violence had many perceived negative impacts on nurses though some had feelings that it was part of their job. A conceptual framework of resiliency was used in the study which correlates with the nurses` ability to endure, survive and thrive after adverse assaultive events. The study found that the participants had mixed feelings and perspectives towards the phenomena. Some experienced and mature nurses had positive attitudes towards patient violence and perceived it as part of their job, while the young and inexperienced nurses had negative attitudes towards patient violence and perceived it as an abuse or workplace harassment. Power, control and stigma also influenced nurses` perceptions and responses to patient violence. In their practices nurses used a wide variety of interventions to stay safe as well as preventing and managing patient violence. Registered mental nurses recommended increased education, resiliency and support as well as improved working environment. Future research should explore the impact of patient violence on patients and patientcare.

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List of Abbreviations

RMNs-Registered mental nurses

MHCU-Mental health care users

ICN-International Council of Nurses

PTSD-Post-traumatic stress disorder

HRQoL -Health related quality of life

GPH-Gweru Provincial Hospital

CHAPTER 1

Orientation to the Study

1.1 Introduction

Violence and aggression towards nurses working in mental health inpatients units is an everyday event. According to Stone (2009) only 7% of nurses that he surveyed believed aggressive and violent incidents could be prevented. The most vulnerable nurses are those working in the acute inpatient psychiatric units. This research seeks to assess the negative and positive attitudes of mental registered nurses who are exposed to violence in the acute care in-patient psychiatric units.

1.2 Background of the study

Registered mental nurses (RMNs), compared to other healthcare providers are at higher risk of experiencing violence in the workplace (Arnetz et al., 2014). Between 25% and 80% of nurses working in acute care hospitals have reported experiencing patient violence in one form or another with existing literature hypothesizing that these events are vastly under reported (Nolan et al., 1999). In Canada, almost one third (29%) of nurses working in direct care hospitals or long term care facilities reported a physical assault by a patient in every 12 months, and 44% reported having experienced emotional abuse (Jonker et al., 2008). Specifically within the psychiatric nursing population, Hesketh and colleagues (2003) reported that 55% of Canadian psychiatric nurses were victims of verbal or emotional abuses, 19.5% experienced sexual abuse and 20.3% reported physical abuse in their last five shifts. Overall, psychiatric nurses report among the highest violence victimization rates of all types of nurses

Registered association nurses of Ontario (2009) found out that short or long term exposure to any type of violence can result in negative outcomes for nurses and organizations. However, for nurses there may be both physical and psychological consequences. The psychological outcomes may include anger, fear or anxiety, post-traumatic stress disorder (PTSD) symptoms, guilt, self-blame, shame and decreased job satisfaction and increased intent to leave the organization, lowered health related quality of life (HRQoL). In some cases physical cases include injuries, and temporary or permanent disability (Hesketh et al., 2003). Arnetz et al. (2014) discovered that at organizational level if workplace violence occurs, negative outcomes may include, high staff turnover and difficulty with nurse retention, decreased morale, hostile work

environments, and nurse absenteeism. More frequent medical errors, more workplace injury claims, and greater costs due to disability leaves and reduced quality of patient care. According to Nolan et al. (2003) the cost associated with both short and long term disability leaves and workplace injury claims have been found to be substantial for organizations and account for approximately 30% of the overall costs of ill-health and accidents. Jonker et al. (2008) stated that statistics in New Zealand reported that 33% of workplace violence incidents occur in the mental healthcare settings and social service settings compared 14% occurring in accommodation and food services and 11% occurring in educational services. In New York however, it has been reported that the health care sector has the highest incidents of workplace violence with 8% of lost time due to violence and aggression (Registered Nurses Association of Ontario, 2009). A previous examination of Ontario

Worker's Compensation Board claims of injuries due to workplace violence shows that the number of days lost averaged 2500 per year with costs estimated at \$300,000.

In a study by Stein (2003) conducted in South Africa's Johannesburg Metropolitan Region, 61.9% of all health care workers had at least one incident of violence in the year prior to this study. However, Howerthorn Child and Mentes (2010) asserted that an accurate account of violence is unavailable as violence is defined inconsistently, inadequately documented, under-reported and normalized. Workplace violence in health care facilities can be expressed as physical assault and psychological violence expressed as verbal abuse, bullying, mobbing, sexual or racial harassments or threats. (International Council of Nurses, World Health Organization and Public Service International, 2003). Verbal abuse is the most prevalent (Pitch et al., 2010). Violence negatively impacts nurses' physical and mental health, the therapeutic environment, the quality of patient care, productivity and health costs (Gates, Gillespie & Succop, 2011). More than half of nurses in Southern Africa are exposed to at least one incident of corporeal or psychological violence from patients in healthcare facilities per year (Fagin, Maraldo & Mason, 2005). The phenomenon violates their rights to dignity, freedom from harm, physical and psychological integrity. (ICN, 2006). Registered Mental nurses working in inpatient psychiatric settings and emergency departments are particularly vulnerable to patient violence. Violence impacts nurses' day to day work as it negatively affects their physical and mental health, work satisfaction, productivity and the quality of patient care. These harmful concerns have steered the urgency in providing a safer working environment for

nurses(Cowman &Bowers, 2008).In order to create safer working environment in psychiatric inpatients settings, the occurrences of violence perpetrated by patients has to be uncovered and openly discussed. Consultations with the public and the nursing community can serve as first step towards taking a zero tolerance approach to violence.(ICN,2006).Research about violence against nurses often focuses on emergency care departments and psychiatric wards specifically Gweru Provincial Hospital. This study will allow nurses to relate their stories of violence and its effects to bring it into the open in an attempt to address it.

In Zimbabwe due to the economic crisis and lack of resources which has resulted in substandardized procedures and healthcare facilities less has been researched on the incidents of patient violence in psychiatric patients` units and the prevalence and their percentage as well.

However, it was fortunate that the researcher had an opportunity to spend the whole year working as an attachee in the psychiatric unit at Gweru Provincial Hospital. Research about violence against nurses focuses on emergency care described in the acute care psychiatric unit specifically at Gweru provincial hospital. Gweru provincial hospital is the biggest and referral hospital in the Midlands province .Being the only referral hospital in the province makes it also the only one with an acute care psychiatric unit. The facility accommodates a number of up to twenty five patients at a time.

The researcher had the opportunity to work with the registered mental nurses and witness the experiences of patient violence in the psychiatric units. Violence often perpetrated by mental health care users (MHCU) is often passively accepted because their behavior is unpredictable and not always fully under their control. Violence impacts nurses` day to day work as it negatively affects their physical and mental health satisfaction, productivity and the quality of patient care.

1.3 Statement of the Problem

More than half of the registered mental nurses at Gweru provincial hospital are exposed to incidents of physical or psychological violence from patients in acute care psychiatric units. This violates their rights to dignity, freedom from harm, physical and psychological

integrity (Fagin et al., 2005). Nurses working in inpatient psychiatric settings and emergency departments are particularly vulnerable to patient violence.

1.4 Significance of the Study

The study findings might be beneficial to the following groups of people:

1.4.1 Ministry of health and child welfare

The Ministry of Health and Child Welfare, who are the employers of nurses will benefit from the study in the way that it will help them to establish a comprehensive program for prevention of all types of workplace violence. The ministry will also be able to analyse workplace security and perform risk assessments of the physical environment as well as making ongoing formal education about workplace violence compulsory.

1.4.2 The Nurses' Council in Zimbabwe

As a professional nursing organization, it will continue to advocate for a safe work environment for all nurses and educate them about risk management and prevention. The study will also help the nurse's council to increase awareness of this issue among nurses, nurse's researchers, employees and the general public. Also the nurses council will through the study acknowledge horizontal violence, including bullying, as a very real problem in the workplace of nurse

1.4.3 Nurse managers

The management will benefit from the study in such a way that they will create and maintain supportive work environments where respectful communication is the norm, organizational policies are followed and incident reporting is efficient and blame free. Individual nurses should also be allowed to intervene when they witness aggression among their colleagues, recognize factors that may predispose patients to becoming violent and report all incidence of violence

1.4.4 Health Sector responsible for security interventions

The findings will help first step to "zero tolerance" to violence in psychiatric units and in health care facilities at large. Such generation of new knowledge will lead to improved intervention strategies for assisting nursing staff in psychiatric acute care units to learn to report and debrief incidence or episodes of patient violence. Hence make known and understandable to the health sector, policy makers, hospital authorities and the

government on the existence of workplace violence in acute psychiatric in patients units. Hence some prevention measures should be taken to prevent the nurses` from patient violence.

1.5 Research Questions

1.5.1 What are the positive experiences of nurses who are exposed to violence in acute care inpatient psychiatric units?

1.5.2 What are the negative experiences of nurses who are exposed to patient violence in acute care inpatient psychiatric units?

1.5.3 What are the coping strategies for nurses who are exposed to patient violence in acute care psychiatric units?

1.5.4 What are the intervention strategies for dealing with patient violence in acute care inpatient psychiatric units.

1.6 Assumptions

1.6.1 Registered mental health nurses who work in acute psychiatric units are vulnerable to violence.

1.6.2 Patient violence in acute psychiatric nursing homes is going unreported.

1.6.3 Registered mental health nurses are experiencing physical, sexual, psychological violence and perceived the risk factors of violence to be mental health care related.

1.7 Purpose of the Study

The purpose of the study is to explore and describe in detail the experiences of violence against nurses in acute care psychiatric unit at Gweru Provincial Hospital.

1.8 Delimitations

The study focused on the experiences of patient violence on registered mental health nurses at Gweru Provincial Hospital in the acute psychiatric unit. The participants of the study were the registered mental health nurses who work in the psychiatric unit who had experienced patient violence and were willing to participate. Purposive sampling method was used which involved the selection of participants with experiences of violence in this setting. The sample size for this study was ten nurses.

1.9 Limitations

The study was conducted in one mental health unit which is in a designated hospital, so data was setting specific and could be difficult to generalize to settings which were not included in the study. Another limitation is that the study was qualitative nature with characteristic small the sample making the transferability of findings difficult. The sensitivity of the issue under investigation encouraged nurses to hide what they felt the researcher should not hear thereby limiting the researcher's understanding of patient violence on nurses in the psychiatric unit. The qualitative nature of the study made it difficult for the researcher to eliminate both and participant researcher bias.

1.10 Definition of Terms

1.10.1 **Acute care psychiatric unit** refers to units where newly diagnosed mental health care users are admitted at Gweru Provincial Hospital

1.10.2 A **mental healthcare user** is a person who receives treatment and recuperation at Gweru Provincial Hospital.

1.10.3A **registered mental health nurse (RMN)** signifies a person who is specially trained and registered as a professional mental health nurse as specified by the nurses 'council of Zimbabwe.

1.10.4 **Patient violence** is a specific form of workplace violence that affects healthcare workers that is perpetrated by patients.

1.10.5 **Psychiatric unit** is a department that specializes in mental in mental healthcare at a hospital.

1.11 Chapter summary

This chapter outlined the background of the study, statement of the problem, justification of the study, significant of the study, aim of the study, research questions, and delimitations of the study, limitations of the study and the definition of terms.

Chapter Two

Literature Review

2.1 Introduction

The purpose of this study was to develop an in depth understanding of the experiences of patient violence by nursing staff at Gweru Provincial Hospital (GPH). This chapter reviews the current literature on the prevalence of violence towards Registered Mental Nurses (RMNs), associated risks, impact on nurses, attitudes of nurses (positive and negative) towards patient violence as well as impact of patient violence on organizations.

2.2 Types of Violence

There are different ways of categorizing the phenomenon of workplace violence .Typically it is categorized by the type of violence as defined by different behaviors or categorized by perpetrator characteristics. Violence can be physical ,psychological or involve sexual abuse , harassment , bullying or aggression that may occur intentionally or unintentionally (Registered Nurses Association of Ontario, 2009).The joint programme on workplace violence in the health sector has further defined three categories of violence (International Council of Nurses, 2002).Physical violence may include actions using force against another person for example hitting stabbing , pushing or any other forms of physical assault .Sexual is defined as any verbal or physical behavior centered based on gender or sexuality. Lastly psychological violence may include verbal or physical threats or repeated intimidation or demeaning behaviors for example criticism, insults, yelling, passive aggressive behavior and lack of acknowledgement.

Workplace violence is also classified according to who constitutes the perpetrator. There have been various efforts made to define types of perpetrators. Herath, Forest ,Macrae and Parker(2011) defined three categories of perpetrators .The first type is criminal intent where the perpetrator has no relationship to the workplace .The second type is whereby a client or patient at the workplace who become violent towards a staff member or fellow client. Patient violence which is the focus of this study falls under type two category of violence .Type three a worker to worker violence is where the perpetrator is a staff member of the workplace including physicians, managers, volunteers or any other workers .The Ontario Safety Association for Community and Healthcare (OSACH) has expanded this three -category definition to include a forth type of perpetrator. This additional category is referred to as personal relationship violence. Where the perpetrator is a person with a relationship to a staff member who then becomes violent towards the staff at the work place (College of Nurses of Ontario, 2009) Due to the number of ways to classify violence, conceptual clarity is lacking and thus remains variably defined and poorly understood.

Nurses are exposed to multiple forms of violence in their day to day practice. There are at higher risk of violence in the workplace compared to all other health care providers and in a special way, at higher risk of experiencing violence perpetuated by patients or their families. (International Council of Nurses 2002; Gerberich et al., Hesketh et al., 2003). This may be due to the nature of their work and having frequent ,direct contact with people in distress (de Martino, 2002).Current research also suggest that nurses working in

psychiatry have increased risk of experiencing violence (Duncan et al., 2001; Hasketh et al., 2003) For example Hasketh et al. (2003) found that the threat of assault was double for nurses working in psychiatry than medical surgical nursing ,as well psychiatric nurses were 1:4 times more likely to be physically assaulted and 1:8 times more likely to be emotionally abused compared to nurses working in all other types of units. The other reason for this may be that violence in the community is a universal criterion for involuntary admission of an individual suffering from serious mental illness requiring hospitalization .(Monahan et al., 2001)and thus the workplace itself poses a high risk for the continuation of violence in hospital (Lanza, Zeiss & Rierdan, 2006; Owen, Tarantello, Tones & Tennant, 1998).

2.3.1 Contributing factors to experiences of patient violence in psychiatric units

Bimenyimana (2008) postulated that there are several factors that contribute or give rise to violence from patients in an acute care in-patient psychiatric units and grouped the factors into categories namely:

Type of patients admitted and hospital environment.

Staff shortages

Lack of support by management and multi-disciplinary team (MDT) and lack of comprehensive orientation.

2.3.2 Type of patients

Mental health users are admitted into the hospital on the basis of their violent behavior. In most cases ,the family request assistance from the police who use force to bring the patients to hospital as if they were criminals resulting in them, perceiving the hospital as if it was a jail .Once the patients are in the hospital they direct their violence towards nurses who are thought to be the cause of their admissions .The other contributing factor to patient violence is the involuntary admission which makes the patients very angry with their parents who will have called the police bring them to hospital .When they get to the hospital they then transfer anger and hostility towards Registered Mental Nurses(RMNs).

2.3.4 Staff shortages

The shortage of staff makes psychiatric nurses overwork .This results in exhaustion and job dissatisfaction .RMNs become discouraged and even absent themselves from work as

a sign of protest against the situation in which they find themselves .The situation further decreases the already overstretched number of staff resulting in more stress and burnout to those on duty.

2.3.5 Lack of support by management and the multi-disciplinary Team (MDT)

RMNs expressed their feelings of isolation and dissatisfaction concerning support they expect from the management and the MDT .The lack of support is experienced in many ways .They indicated that despite the shortage, it looked like the MDT team expected the psychiatric nurses to do their work also, but when psychiatric nurses need a hand there is none to help them. As for the management the nurses pointed out that in many cases the management was not there to help but to emphasize on the mistakes made by RMNs.

2.3.6 Lack of structure and effective orientation

Bimenyimana (2008) posits that there is more to the orientation of newly employed registered mental nurses than telling them what they should and should not do .What seems to be the problem is that there is no follow up after the initial orientation and in spite of the differences between the words ,the same orientation is applied to the nurses. The lack of paper and structured orientation leads to frustration and renders newly employed psychiatric nurses more exposed to violence and patient aggression.

2.4.1 Prevalence of incidence of patient violence

Reported rates of patient violence may vary across international and national reports .As previously stated, the prevalence of violent events against nurses in acute care hospitals by patients is reported to fall anywhere between 25 and 80 percent (Campbell et al., 2011; Hasketh et al., 2003; Tarantello, Jones & Tennant, 1998). This section will review several studies to provide a more in-depth discussion regarding prevalence and incidence of patient violence.

Campbell et al. (2011), Duncan et al. (2001), Gerberich et al. (2004), Shields and Wilkins (2006) also studied patient violence. It has been hypothesized that these events are immensely under reported (Gates, Gillespie & Succop, 1998). This section will review several studies to provide a more in depth discussion regarding prevalence and incidence of patient violence.

Campbell et al. (2011) studied workplace violence in four health care institutions in one US, Metropolitan area they surveyed. The survey RNs, and nursing assistance (n =2,166) to determine the prevalence of workplace violence and demographic , work related .and adult and childhood abuse histories as risk factors for violence .Overall 30 percent of their respondents reported some form of violence during the previous 12 months period which was higher amongst RNs than nursing assistants with the greatest prevalence in emergency and psychiatric departments .Ninety percent (90 percent of all workplaces , physical violence was perpetrated by patients .The study clearly identified definitions of the different types of violence as well as provided electronic and paper means of completing their survey tool. Limitations of this studies included biases inherent in self-report methods and recall.

Geberich and Colleagues (2004) conducted a nested case control study to explore the prevalence and risk factors of work related assaults on nurses. In their sample of 6 300 registered and practical nurses in Minnesota ,they reported that nurses who worked in nursing homes or long term care facilities , emergency and psychiatric departments to be at an increased risk of violence .Strengths of their study include the randomization of study participants as well as the control for response bias by the weighting observed probabilities of response .However the risk of recall bias remains and the transferability of findings have limited generalizability as the data were collected only from Minnesota ,United States. Most of the evidence supports that nurses working on psychiatric units have an increased risk for violence .More specifically ,incidence rates of patient violence towards nurses working in inpatient psychiatry is reported anywhere between 34 to 81 percent (Foster ,Bowers &Nijman, 2007; Moylan & Cullinan, 2011; Nolan, Dallender ,Soars’ , Thomsen & Arnets,1999;Shields & Wilkins,2006).

Foster, Bowers and Nijman (2006) also studied patient violence on acute psychiatric inpatient wards in the United Kingdom using cross –sectional design .The purpose of their study was to investigate the nature and prevalence of inpatient aggressive behavior directed at staff , co patients and the patients themselves via self-harm behavior .Aggression was defined as “ any verbal ,or physical behavior that was threatening to the self , others or property or physical behavior that actually harmed self ,others of property” (Foster,Bowers & Nijman, 2007 p. 142). RNs and nursing assistants on five acute inpatient wards reported aggressive incidents using the staff observation Aggression scale revised during a 10 months period .Staff were involved in 57.1 percent aggressive

incidents ,with the most frequent means reported as verbal violence.60 percent of incidents or feeling threatened (59 percent) .The researchers based on their data , nurses ,working in psychiatry have a one in 10 percent chance per year of receiving any kind of injury as a result of patient violence .Because of the location (United Kingdom)of this study the results may be less transferable and there remains a potential for unreliability of the data due to the limitations of cross sectional survey designs .

Maylan and Gullian (2011) purported that 80% of RNs working in psychiatry had been physically assaulted during the course of their careers .Their study used a mixed methods study design to provide update, in-depth information about the nature , frequency and severity of assaults and injuries among psychiatric nurses . The research also explored assault and injury in relation to the nurses' decision to restrain their patients' .Their sample included 110 RNs working in five institutions (two designated psychiatric hospitals three general hospitals with acute psychiatry units) in the New York City metropolitan area. The mixed method nature of the study provides some rigor and depth to the study however a potential for recall, self –report bias and non-response bias still remains.

Nollan, Dallender,Soares, Thomson and Arnetz (1999) carried out a cross sectional study in the United Kingdom aimed to identify the extent and nature of violence against mental health nurses and psychiatrist , and to identify what support ,If any, they received following their experiences of violence. Their sample included psychiatrist and to identify what support, if any they received following their experiences of violence. Their sample included psychiatrists (n=74) and RNs (n=301) from five West Midland trust with an overall response rate of 47%.Violence was defined in their study as any act of displaying aggressive behavior ,including spitting ,scratching ,deploying physical force, using an object as a weapon, either with an intention of physically assaulting (Nolan ,Dallender , Soares ,Thomson & Arnetz, 1999) They reported the incidence of violence among hospital based nurses .(50 %) and psychiatrist. Their sample consisted of 96 % of nurses and 95% of psychiatrists who reported violence to be perpetrated by patients .However, the low response rate of this study may lend itself to volunteer bias and non-response bias .As evidenced by these cumulative findings, the variation in prevalence rates may be due to the source of data, for example there may be a reduced prevalence rate if the data were collected from official reports rather than self-report(Lanza, Zeiss & Riedan, 2006). The length of time measured, as well as the lack of conceptual clarity on the definition of

violence for each study .Despite these limitations research clearly indicates that psychiatric nurses are at a high risk for violence.

Throughout their review, they concluded that the “magnitude of workplace violence of all types is as great in the experience of psychiatric nurses as to be virtually normative internationally” (Lanza, Zeiss& Rierdan, 2006, p. 75). This suggests that violence in nursing culture is taken as merely part of the job and may help explaining why so few incidents are reported as nurses seem to have been desensitized to violence over time .Lanza et al. (2006) also described other potential explanations for why violence is under reported and found that nurses typically only report the most severe forms of physical violence and that nurses are uncertain as to what the definition of violence encompasses.Anderson (2002) asserted that workplace violence is a “reality” (p. 351) as nurses will experience at least one event of patient violence in their careers with many experiencing numerous events of different types of abuse such as both verbal and physical abuse .This demonstrates a clear need to take action against patient violence and change the growing idea within the culture of nursing that exposure to violence is a normative component of the workplace environment.

In Southern Africa there are few recent studies on the health care professionals experiences of hostile patients .In a study by Stin (2003) conducted in the greater Johannesburg Metropolitan Region,61,9% of all health care workers experienced at least one incident of violence in the year prior to the study. An accurate account of violence against nurses is not available as violence is defined inconsistently, in adequately, documented under reported and normalized (Cowman et al.,2008; Howerthone, Child &Mentes, 2010; ICN ,2006; Kennedy & Julie, 2013; Stein, 2003). More than half of nurses in South Africa are exposed to at least to one incident of physical or psychological violence from patients in health care facilities per year (Fagin ,Mraldo & Mason, 2005).This violates their rights to dignity, freedom from harm and physical and psychological integrity(ICN ,2006).Nurses working in inpatient psychiatric settings and emergency departments are particularly vulnerable to patient violence(Howerthone Child & Mentes, 2010) Violence perpetrated by mental health care users is often passively accepted (ICN, 2006) because their behavior is more unpredictable and not always fully under their control (MacKinnon and Cross , 2008).Violence impacts nurses day to day work as it negatively affects their physical and mental health, work satisfaction, productivity and the quality of patient care (Gates ,Gillespie &Succop, 2011).Work place

violence in health care facilities can be expressed as physical assault and psychological violence expressed as verbal abuse , bullying ,mobbing, sexual and racial harassment and threats (International Labor Office , International Council of Nurses, World Health Organization &Public Service International, 2002).

In Zimbabwe,despite the deterioration of health care facilities, due to the economic hardships and lack of adequate resources, only one studyhasbeen conducted on the prevalenceof patient violence in psychiatric inpatients units.The studywas conducted at a Hospital in BulawayobyRichmanKokera in 2013. It focused onfactors affecting the emergency management and treatment of aggressive and violent behavior at Ingutsheni Hospital in Bulawayo. Health personnel wereasked to identify factorsthat they considered important in making crucial decisions about emergency interventions to reduce patient aggression and violence. The study revealed that staff and drug shortages were the major constraints in the management and treatment of aggressive and violent institutionalized psychiatric patients. Other equally important factors were perceived dangerousness of the patient, patientdiagnosis, history of violence, phase of patient illness as well as location in which patient aggression and violence took place and experience of the mental health worker. It is evident that researchers in Zimbabwe have so far paid little attention to patient violence in psychiatric wards at mental hospitals, consequently, through this study, the present researcher sought to fill the gap of knowledge.

2.5.1 The negative experiences of nurses who are exposed to violence in psychiatric units.

Several studies focused on emotional and physical reactions of staff to an aggressive incident .Thee feelings of respondents relating to verbal and physical aggression were frustration, anger, feeling hurt, fear, resentment, helplessness, anxiety and irritation (Zernike &Sharpe, 1998). Short term reactions of the victims included anger, anxiety, helplessness, apathy, depression, self-blame, dependency and fear of other patients. The long term effects indicated by respondents were a change in social relationships with coworkers, difficulty in returning to work, headaches and body tension. (Lanza, 1983, Poster & Ryan, 1994).Workmates (colleagues) were found to be the most vital source of support for the victims after exposure to violence (Nolan et. al, 1999; O'Connell et al,2000).

Psychiatric nurses faced with violence from patients experience mostly negative feeling of fear anger, frustration, despair, hopelessness and helplessness. They then use in effective coping mechanisms such as substance abuse, absenteeism, retaliation a development of an “I don’t care attitude” and apathy towards the work and towards what is happening around them (Bimenyimana, 2008).

2.5.2 Feelings and emotions that accompany the experiences of violence and aggression

2.5.2.1 Fear

Carlson ,Dahlberg, Lutzen and Nystrom(2004) asserted that unmanageable fear makes the caregivers feel small and helpless unable to think clearly ,while a feeling of powerlessness overwhelms them .The registered mental nurses defined fear in different ways .The major point is that for some registered mental nurses (RMNs)fear tends to dictate their reactions and each time they think about going to work be another risk of being harmed .The work becomes a burden and the working environment becomes more stressful.

2.5.2.2 Anger and frustration

Psychiatric nurses experience anger and frustration basically because they found themselves caught in between their vacation for a caring career and what they view as the ingratitude of some of the patients who use their mental condition as shield and excuse to hurt nurse, even when the mental health care users are aware of what they are doing .When the nurses become angry depending on the nurse the patient either withdraw and harbor resentment or they strike back in retaliation. However, Friez (2005) argue that when someone is victimized, another type of response is to become angry and to fight back .Sometimes the nurses would just give the patient a bit of his own medicine.

2.5.2.3 Helplessness and hopelessness

Needman , Abderhalden , Halfens,Dasesen ,Haug and Fischers (2005) discovered that adverse consequences such as avoiding the perpetrator or the perception of an impaired relationship with patient involved can lead to psychiatric nurses doubting their professional abilities or even provoke feelings of being a failure .RMNs do not express hope that things would change for the better .In this battle that the RMNs are faced with in caring for violent patients, it cannot be adequately emphasized how they feel .That

would be an understatement to express the feeling of hopelessness and helplessness that one reads on their faces as they talk about their experiences. Their only hope is the patient gets better after being given medication and they send them back home but they go back and do same thing that they did before.

2.5.2.4 Resentment and despair

Resentment takes place when dealing with the situation becomes difficult and the end to the problem is not at sight (Bimenyimana, 2008) .Some RMNs (resort) decided to keep everything inside themselves and resenting the person who caused the pain, while waiting for an opportunity to strike back. In most cases this happens when a conflict arises between a RMNs and a member of the multi-disciplinary team.

However, Sian (1985) pointed out that it is when people fail at risk both psychologically and physically that the displacement of their emotional insecurity on to others become particularly rewarding. Resenting may for a while make the registered mental nurses forget the real source of the problem. Also the RMNs in their state of despair feel that they have done all they can and then the result is not what they expect, they feel like giving up.

2.6.1 RMNs ineffective coping mechanisms as a result of continued experiences of violence and aggression from patients

2.6.1.2 Substance abuse

Frieze (2005) confirms that one of the ways to avoid thinking about a highly stressful event is not get drunk, and he goes on to say that a larger majority of people of all ages turn to others to highly emotional experiences .Some psychiatric nurses have resorted to idea that in order to cope with the amount of violence from (patients) mental health users they drink alcohol on a daily basis, regardless of the fact that they are on or off duty.

2.6.1.3 Absenteeism

Absenteeism, according to Frieze (2005) initially affects the registered mental nurses who ae in regular contact with the patients ,in though some psychiatric nurses absent themselves as a sign of protest and to show dissatisfaction at what is happening .Some RMNs feel that instead of getting moral support from their managers and other members of the team , they get blamed for each incident that happens .These situations end up

causing emotional stress to nursing staff leading to alcohol abuses and high rates of absenteeism.

2.6.1.4 Job Dissatisfaction

Registered Mental Nurses (RGNs) are demotivated by in action of management the lack of communication and coordination of activities among MDT and the lack of family involvement in the treatment and rehabilitation processes of the patients .As a result psychiatric nurses feel that they are doing the same thing over and over admitting the same patients with no end to this vicious circle .Some nurses even feel that they have lost direction that they no longer know why they are still working as registered psychiatric nurses .Some of RMNs even doubt their caring capacity .Some nurses feel demotivated up to an extent of only working because they have no choice.

2.6.1.5 Burnout

Felton (1998) defined burnout as the exhaustion of physical or emotional strength as a result of prolonged stress of frustration .Some psychiatric nurses have reached a stage of wondering why they should committing themselves entirely to the work that is not rewarding .Psychiatric nurses feel that they are being neglected and their situation is not adequately being looked into by the hospital authorities hence ending up also taking the “I don’t care attitude” RMNs sometimes question why they ended up working in a psychiatric unit(Bimenyimana, 2008).However they consequences of burnout are not only detrimental to psychiatric nurses but also to the institution as a whole.

2.7 Positive experiences of Nurses who are exposed to Violent in Acute Psychiatric Units

Two thirds of the psychiatric nurses believed that mentally ill patients were not responsible for all their behavior .The majority of respondents agreed with the statement that staff could expect to be physically assaulted. Most psychiatric nurses said that they believed that physical assault is the result of staff performance deficiency, clinic incompetence or personality traits of nurses (Poster &Ryan, 1989).Whittington (2002) found out that staff with more than 15 years of experience were more tolerant towards aggression than those with fewer years of experience.

A tolerant attitude proved to correlate significantly with all these subscales of the Maslach Burnout Inventory Human Services Survey. In fact tolerance was found to

correlate negatively with exhaustion and “depersonalization”, and positively with personal accomplishment. In the studies on psychiatric wards about 80% they felt safe from physical assaults most or all of the time. It was hypothesized that nurses who continuously focus on the negative aspects of patients developed a more cynical view of human nature. Participants in the study perceived the culture of nurses as one where patient violence should be accepted as part of the job and many felt this belief was unavoidable. This was especially true of verbal violence and RMNs in the study identified the routine nature of violence as not only part of the job but no longer worthy of reporting.

Duxbury and Whittington (2004) propounded that interactions between nurses and patients are a major factor in prevention and management of aggression. Education and training designed to teach nurses the necessary interpersonal communication skills, coupled with the nurses attitudes of empathy can greatly influence the incidence and outcome of aggression. Gergolas et al. (2002) described the therapeutic relationship as an interpersonal process that occurs between the nurse and the client, it is a purposeful, goal directed relationship that is directed at advancing the best interest and outcome of the client. From a clinical perspective mental health nurses seek to obtain a positive working relationship to minimize conflict and improve health outcomes for their patients (Gergolas et al., 2002).

Abderhalden et al. (2006) asserted that nurses’ attitudes towards aggressive patients and level of experience in dealing with them can either amplify a breakdown or conversely improve patient nurse interactions and relationships. Experience and skill in dealing with aggressive or potentially aggressive patients and their attitudes to them furnish mental health nurses with the confidence and professionalism to maintain safety and provide care in challenging situations Whittington (2002). He also observed that nurses who have gained professional wisdom through experience are more competent and comfortable in dealing with aggression. Their attitude determine the type of intervention and clinical planning used to manage the situation and will impact positively or negatively upon the patient’s health (Abderhalden, 2006).

Positive attitudes and skills equipping nurses to provide a high level of care include empathy, tolerance and open mindedness which can be well received by patients improving the therapeutic relationship (Abderhalden et al., 2006). A high level of

interpersonal communication skills is the cornerstone of a therapeutic relationship. Even with an aggressive patient, nurses use skills such as active listening, summarizing, paraphrasing, negotiating, questioning for clarification and body language to come to a mutually beneficial outcome (Ferall et al., 2010).

2.8 Patient and Staff Responsibility for Aggressive Behavior

Two thirds of psychiatric nurses believe that mentally ill patients were not responsible for all their behavior. The majority of respondents agreed with the statement that staff could expect to be physically assaulted. Most registered mental nurses believed that physical assault is not the result of staff performance deficiency, clinical incompetence or personality traits of the nurses (Poster & Ryan, 1989).

Psychiatric nurses faced with violence from patients experience mostly negative feelings of fear, anger, frustration, despair, hopelessness and helplessness. They then use ineffective coping mechanisms such as substance abuse, absenteeism, retaliation and development of an "I don't care attitude" and apathy towards the work and towards what is happening around them.

2.9 Theoretical Framework of Resiliency

The study took a theoretical framework of resiliency propounded by Gillespie et al (2007). An in depth understanding of the strategies that nurses use to maintain and enhance emotional wellbeing in response to work place violence may assist in positive adaptation. Nurses need to capitalize on their strengths and resources when faced with the significant unending challenge of work place violence. The theoretical framework that was used in this study was based in resiliency. Resiliency is characterized by good outcomes in spite of serious threat to adaptation or development (Masten, 2001). The resiliency framework identifies risk as a base predictor of high probability of undesirable outcomes. The terms risk and vulnerability can be used interchangeably (Johnson & Weichlt, 2004). The major difference between risk and vulnerability is that risk refers to groups of people and vulnerability refers to characteristics of these individuals (Johnson & Weichlt, 2004). The framework corresponds with the tenants of violence in the work place against nurses.

There are several pathways to resiliency. Resiliency has been described as an interplay between biological, psychological dispositional attributes, social supports and other socially based concepts (Herrman et al., 2011). The domains of resiliency remains salient

and linkages between the conceptual models of resiliency and violence in the work place towards nurses will be applied in this section.

One of the first factors that contributes to resiliency is personal attributes. Internal locators of control, mastery, self-efficacy, self-esteem, positive cognitive appraisals of events and optimism can contribute to resiliency (Herrman et al., 2011). Evidence suggest that positive coping and the presumption of locus of control has been found to increase wellbeing when managing stress (Arslan, Dilmac & Harmart, 2009). Self-efficacy is a defining characteristics and maybe developed overtime when an individual is faced with uncertain outcomes and failure is still able to persevere (Gillespie, Chaboyer & Wallies, 2007). The attribute of hope encompasses the belief that an individual has some degree of control over the goals that has been set and these goals are achievable. Achievable goal setting provides the opportunity for success in attainment an increased hope.

Positive coping is also a characteristic of resiliency. Increased exposure to stressful events assist in the development of problem focused strategies that ameliorate consequences and assist in adaptation (Gillespie et.al., 2007). Given the theoretical underpinnings of resilience the applications of resilience has already been applied to workplace violence in health care. The implementation of administrative guidelines, the management of aggression and the institution of mandatory reporting with hope of follow up are already considered the bench mark within a culture of safety. Resilience research indicated that some individuals emerge from adversity with stronger capacities when challenged (Gillespie et al., 2007).

The social environment also has a significant impact on the resilient individual. Social support that includes family and peers with secure attachment and positive reformation from peers is associated with fewer behavioral issues and overall psychological wellbeing (Herrman et al, 2011). Communities represent attachment, social networks, and support to its members. Evidence suggest that resilience can be improved through the provision of protective factors that have positive high expectations, and provides appositive environment that is strong, supportive, and offers peer relationships (McAllister and Mckinon, 2009). Organization can promote and contribute to resiliency studies have suggested that individuals who report greater satisfaction with support, also report greater use of adaptive ways of coping with stressful situations (Delonysis and

Haltzman,2005).The notion of organizational staff support, in the provision of culture of safety has also been identified as a determined in current work place violence improvements guidelines.

Personal characteristics of individuals are highly correlated with resiliency. The three personal attributes that can be identified that contribute to resilience are control, commitment and challenge individuals who perceive that outcomes are within their control believe they are more responsible for their own destiny and perceive adversity as a challenge (Aslan et al 2009) .Evidence will further stipulate that when individuals see themselves as able to influence their everyday life as a challenge rather than as a threat they report less depressive symptoms of anger, anxiety and cognitive disturbances (Harrison,Loiselle, Duquete & Semeaic, 2002).This belief in one' capabilities to mobilize cognitive resources assists the individual in course of action to successfully execute a specific task within a given context (Aveyet al., 2010).

Inherent in the resiliency's frame work the concept of self-efficacy. There is strong statistical association between self-efficacy and resiliency (Gillspie et. al, 2007). Individuals who believe they are effective and do not imagine their own failure and have increased self-efficacy are empowered. (Simon, Larabee, Birkhimar, Matt& Gladden, 2004).Research has indicated that nurses who regained control of their situations by employing strategies such as attending counselling , reporting events , initiating restraints and avoiding similar situations after an assault rebuilt confidence (Chapmen et al., 2010).If an individual perceives mastery and control in challenging situations,they will encounter less distress if they were potentially encounter a similar event. This resiliency characteristic is a key element in the exploration of return to work after an assaultive incident.

The theoretical framework of resiliency also identifies positive coping as indices .Active coping is characterized by problem focused coping and seeking social support (Ming-Huij, 2008). Problem focused coping correlated with less psychological symptoms when forced with a stressful encounter (Folkman et al., 1986).This form of adaptive coping begins with the cognitive appraisal of an event followed by interpersonal efforts to alter the situation and rationale deliberate effort to problem solve using available resources (Folkman et al., 1986).An individual's positive psychological state development characterized by self-efficacy positive thoughts about the future, persevering towards

goals and sustaining through adversity are consistent with overall wellbeing (Avery et al.,2010; Luthens,Youssef & Avolio, 2007).

The conceptual framework of resiliency is based on human capabilities and adaptive symptoms that promote overall wellbeing.Resilience focuses on a strength based strategies and the building onto existing capabilities including individual's inner strength competence, optimism and effective coping patterns (Wagnild, 2009).The resiliency framework correlates appropriately to the phenomenon of returning to work place after experiencing violent.

Although the resiliency framework provides a broad base of adaptive measures such as control commitment support, self-efficacy and positive coping little is known about how resiliency constructs are implored and applied by psychiatric nurses when resuming work or returning to work place after an assault .However ,the returning to work alone after an adverse event represent resiliency in some manner.

2.10 Copying Strategies for Nurses who are exposed to Patient Violence in Acute Care Inpatient Psychiatric Units

2.10.2 Staying safe

Registered Mental Nurses (RGNs) strategies to ensure their own personal safety .General strategies to protect one's personal safety of paramount importance with nurse working in the acute inpatient psychiatric units .These protective ways are used routinely while they are at work, regardless of the risk of violence and often these strategies are all within the realm of nurses control and abilities.

2.10.3 Awareness of surroundings and colleague's whereabouts

RMNs aim to know where exits are located in their immediate vicinities, made appoint that they know who else was around and where their colleagues were in order to ensure their safety .They also paid attention to milieu of the unit all the time as well as identifying all the objects that could potentially be used as weapons by patients and taking steps to eliminate risk. They also made sure they removed sharp objects or specific furniture from the unit .RMNs believe in what they call having eyes on the back of one's head pertaining to where people would be positioned .Psychiatric nurses emphasis on the telling one's colleagues where one would be going and with whom at every particular

moment. This helps them to be able to trace one's movements in case of violence, the colleagues would keep an eye out in case of trouble.

2.10.4 Use of personal alarm devices

Some nurses were alarms or other devices such as whistles as a way of calling for help and preventing escalating violence. However, this heavily depended upon the culture of the unit relating to the use of devices. Some nurses believe that the alarms are useful since they would quickly attract attention of other coworkers in case of trouble, whilst other nurses thought they were an annoyance due to their size.

2.10.5 Safety of self

RGNs made sure that they had a clear and undisturbed vision, tied their hair back if it was long and did not wear any bracelets on their necks. They also ensured that they do not wear earrings that could be grabbed.

2.11 Interventions Strategies for Nurses in Dealing with Patients' Violence in Psychiatric Units

RMNs described prevention of exposure to violence from two different perspectives which are primary prevention strategies and secondary prevention. Primary prevention strategies are proactive and are aimed at stopping violence before it starts, and try to reduce the factors that put people at risk of experiencing violence. Secondary prevention aims at the immediate responses to violence and then tertiary prevention entails long-term approaches that occur in the post violence period which also include reducing the emotional trauma to the victim.

2.11.1 Patient centered strategies to prevent violence

In terms of communication and engagement with patient RMNs described the importance of empathy and respect with their patients in order to avoid violence. Also they emphasized on the importance of engaging with patients to discuss their needs and concerns before the situation escalates, for both physical and verbal violence, leaving the area was also a means to give the patient space to cool off or for the nurse to escape danger.

2.11.2 Nurse centered strategies

Nurses were required to take a non-violent crisis education course annually which involved crisis and de-escalation theory as well as hands on component .RMNs recommended the use of medications as a method of prevention and containment. They justified the use of medications to calm patients to prevent violence to the patient or other patients, thus was in the student's best interest. Medications such as chlopromazine and carbamazepine were used to keep patients calm and lessen any risk of violence as well as help in their treatment .Medications were also used as chemical restrains when a patients behavior was escalating and RMNs needed to intervene before more serious events happened .However chemical restraint was preserved as the least coercive measure and preferred to any other strategies such as seclusion and any other strategies.

2.12 Application of the theoretical framework of resiliency to the study.

A resiliency framework for research, policy and practice was developed through concept analysis by Gillespie et al (2007).Violence in acute inpatient units directed at nurses is a significant issue. The literature findings have demonstrated that after incidents of patient violence registered mental nurses may not only experience physical trauma but long-lasting psychological trauma that can impact them both personally and professionally. However, the conceptual framework of resiliency correlates appropriately to the phenomenon of the registered mental nurses returning to workplace after experiencing patient violence. Resiliency focuses on the strength based strategies and building onto existing capabilities including individuals' inner strength competence, optimism, and effective coping patterns. Resiliency is characterized by good outcomes in spite of a serious threat to adaptation or development. The application of resiliency as a conceptual framework demonstrates considerable promise in the registered mental nurses' workplace setting after adversity. Resilience is the process of human development that is activated by adversity and the introduction of interventions that reduce difficult circumstances. Everyone has the potential for resiliency.The mental health nurses successful strength focused outcomes after a negative event gives them inner strength, self-efficacy and effective coping patterns.

2.13 Knowledge gap

The literature review has reviewed the phenomenon of patient violence mostly from the perspective of registered general nurses who do not have a post basic training in psychiatry,and usually their reports were focusing mainly on the negative impact of

patient violence in psychiatric units. What lacks in the literature review are the positive experiences of nurses who are also exposed to patient violence in psychiatric inpatient units. The registered mental nurses receive as a post basic qualification which makes them able to thrive and survive in times of adversity. Majority of the RMNs have a passion for psychiatry and that alone motivates them to keep keep on coming to work. The literature could not uncover the issues of staff experience as a determinant to the phenomenon of patient violence in acute inpatient psychiatric units. Experienced and mature registered mental nurses have developed resilience and competence in caring for mental healthcare users.

2.14 Chapter Summary

This chapter has presented the review of related literature on experiences of patient violence in acute inpatients psychiatric units. The literature was discussed under the following sub titles: Types of violence, contributing factors to experinces of patient violence in psychiatric units , prevalence of inciedence of patient violence, negative experiences of nurses who are exposed to patient violence in acute psychiatric units, positive experiences of nurses who are exposed to patient violence in acute inpatient psychiatric units, theoretical framewokr of resiliency, coping strategies for psychiatric nurses in acute inpatient psychiatric units, intervention strategies for nurses in dealing with patient violence in acute psychiatric units, application of the theoretical framework of resiliency to the study and knowledge gap. The next chapter will discuss the methodology.

Chapter Three

Research Methodology

3.1 Introduction

This chapter will present the methodology adapted in this study. Harris (2003) postulated that research methodologies are the examination of ideologies and methods used by a discipline. This include the choice of research design , sampling and sampling procedures, instrumentation, data collection produce, data analysis and ethical considerations as well as the conclusions. The research paradigm which was used is qualitative research design.

3.2 Research Approach

As indicated by Creswell (2000) research approach is the general approach or philosophy that is taken in dealing with a particular research matter with a particular focus on hearing the perspectives of those individuals affected by a particular phenomenon(Creswell, 2007). As this study aims to explore patient violent based on the nurses experiences with this phenomenon, qualitative approach was considered the most appropriate research paradigm. Nurses who were working directly with psychiatric patients were given the opportunity to share their working experiences as they, themselves, perceived of these experiences.

3.3 Research Design

According to Jacelon and Odell (2005) research design is an action plan for getting from here to there, where “here” maybe defined as the initial set of questions to be answered and there is some set conclusions. For the purpose the present research, an interpretive phenomenological and descriptive design was selected because it is suitable for advancing subjective knowledge as well as subjective individual experiences that have not been previously or adequately reported (Thorne, 2008).Interpretive description arose as a methodology that is congruent with the pacific requirements for knowledge within nursing health care. It is qualitative research approach whose purpose stems from two

sources which are: (i) an actual practice goal (ii) an understanding of what is or not known from the empirical evidence from all sources (Thorne, 2008). Interpretive description is an inductive method of research that involves the formation of a description but then takes it beyond the self-evident to further discover “associations, relationships and partners with the occurrence that has been described” (Thorne, 2008, p. 50). The goal of interpretive descriptions is to create an understanding that is of practical importance to the applied disciplines such as nursing. The principles of interpretive description will be employed to guide all of the current study decisions with regard to sampling, data collection and data analysis.

3.4 Target Population

According to Crown et al. (2003), the term target population is used to denote all those who fall into the category of concern. At least theoretically the, population is finite and can be counted. The fundamental unit of the population are elements, and elements are often people. In this study, the target population are the Registered Mental Nurses (RMNs) who work in the acute care in-patient psychiatric unit at Gweru Provincial Hospital (GPH). The total population was ten RMNs, four student nurses and three general hands.

3.4 Population Sample

Chapman et al. (2010) assert that the term population sample is used to indicate a small group. In qualitative research only a sample (that is a subset) of population is selected for any given study. In this study a sample of ten registered nurses and two auxiliary nurses or general hands were used. From this group of ten registered nurses, one worked as a sister-in-charge of the psychiatric unit. Out of these nurses five of them were women while seven of them were male nurses.

3.5 Sampling Technique

The sampling technique that was used in this research is purposive sampling which is the selection of individuals based on their ability to provide a rich and detailed description of the research occurrence to be studied (Creswell, 2007). The major motive for the researcher to select purposive sampling was to gather quality and detailed information and descriptions from the participants who had really experienced patient violence in a psychiatric setting. The setting was the acute care in-patient psychiatric unit at Gweru

Provincial Hospital (GPH) .The setting was the acute care in-patient psychiatric unit at GPH and the inclusion criteria were all nurses working in the acute care in patient psychotic unit who had experiences of patient violence regardless of how long they had worked in the environment. All categories of nurses who were permanently employed at GPH and general hands who were working in the psychiatric unit and were willing to participate were considered for inclusion in the study.

3.6 Research Instrument

The researcher used semi-structured interviews that were supported by an interview guide to collect data from the participants.Semi- structured interviews are commonly used in qualitative research by all researchers to explore more deeply into the social and personal occurrences under study and to create meaning with participants exploring either individual views of their experiences (Diciccio –Bloom & Crabtree, 2006).The semi-structured interview technique ensured that the researcher would obtain all the information required,but at the same time, allowed the participants freedom of responses and descriptions to illustrate issues affecting them. Semi structured interviewing begins with several predetermined questions and probes with follow up questions to elicit more information. The researcher conducted all interviews with all participants in person.The focus of semi-structured interview was to gain an understanding of how nurses define patient violence and to capture their lived experiences (stories) of violence in the work place.

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

3.7 Pre-Testing the Research Instrument

The interview guide was subjected to pretesting with the nurses who had previously worked in the psychiatric unit at GPH but have now been assigned to other units of the hospital. The sister-in-charge of the psychiatric unit referred the researcher to these 3

nurses. Interviewing the three nurses helped in fine-tuning the interview questions as well as sharpen the researcher's interview skills for this research. In a big way the process of pretesting helped in improving the validity and reliability of the interview guide. The supervisor assisted the researcher to correct and clarify interview questions and to make sure the questions in the instrument covers all aspects that needed to be probed in order to give content and construct validity to the instrument.

3.8 Data Collection Procedures

The researcher obtained ethical approval from Midlands State University department of Psychology which helped the researcher to be granted permission by the Medical Superintendent for GPH to interview the targeted population which are the RMNs in the acute psychiatric in patient unit. The researcher approached the RMNs in the psychiatric unit at GPH to obtain their informed consent. Face-to face interviews was used to collect data for the study. Prior to data collection, the researcher discussed the data collection strategy, venue and duration with the sister-in-charge of the psychiatric unit at GPH. The language used during data collection was Shona. The participants were assured that their names were not to be mentioned for the sake of confidentiality and data was only used for academic purposes only. Research data was collected from the 14th of August to 18th of August 2017.

3.9 Data Analysis

Content analysis was used in the study and according to Creswell (2007) content analysis is a rich methodology that utilizes a set of producers to make valid inferences from the text. The process of data analysis begins with categorization and organization of data in search of partner's critical themes and meanings that emerge from the data. A process called open coding was used where by the researcher identified and tentatively named and conceptual categories into which the observed occurrence were grouped. The goal was to create a descriptive multi-dimensional categories that provide preliminary framework for analysis. Content analysis was mainly based on the four research questions. Each interview was read and patterns among data were identified under each of the four themes forming units of analysis. Each unit of analysis was named and formed the categories and sub categories. Data was, therefore, presented in themes where major theme were identified and explained followed by sub-themes that were also identified and explained.

Themes and sub-themes were supported by verbatim statements that were given by the participants.

3.10 Ethical Considerations

Creswell (2007) portrays ethics as norms that are an arrangement of how the researcher chooses what is bad and what is good for the respondents' sake. Subsequently one can say that a study can be conducted either ethically or unethically which means in a proper or in proper way. The researcher upheld the following ethical standards while conducting the study:

3.10.1 Permission

The researcher was granted permission to do the research by Medical Superintendent of GPH and the Sister-in-Charge of the psychiatric unit.

3.10.2 Informed consent

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

3.10.3 Confidentiality

The data gathered was dealt with strict confidentiality and the researcher assured participants that it would not be disclosed to unauthorized third parties without their permission. It is ethically proper to hold certain information as confidential as a way of protecting both the information collected and the individuals who provided it.

3.10.4 Privacy

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

3.10.5 Anonymity

The names and genuine identities of the participants were also hidden. The participants were given pseudo names such as Thembi, Monalisa, Liberty and Tendai for the four

participants respectively. The hospital staff's personal details were not hidden because these were well-known specialists in the field who helped patients at the hospital.

3.11 Chapter Summary

This chapter focused on the research approach, design, target population as well as the sampling used to gather the participants. The aim of the chapter was to discuss the data gathering methods that were utilized and justify these methodological approaches. Finally thematic and content analysis were used as methods of analyzing data. The next chapter presents the findings of the study.

Chapter Four

Data Presentation, Analysis and Interpretation

4.1 Introduction

This chapter focuses on findings from individual interviews which were explored and synthesized using the principles of interpretive description and conventional content analytic strategies to create thematic patterns. This chapter begins by exploring the characteristics of the purposeful sample of the RMNs who participated in the study, followed by an in-depth description and interpretation of the nurses' experiences with patient violence. Data presentation starts with presentation of a table of demographic information followed by the three major themes revolving around RMNs' experiences of patient violence, effects of violence on RMNs and violence as part of the nursing job. Direct quotations by various RMNs are used throughout the chapter.

4.2 Response Rate

A total number of 12 participants at Gweru Provincial Hospital acute inpatient psychiatric unit participated in the research. The table below shows the number of participants who participated in the interview. Using unique recruitment strategies a total number of 12 RMNs consented to participating in an interview while 5 others who were invited declined participation due to the other commitments. The researcher conducted in-depth interviews and to ensure confidentiality, the true identities of participants were not revealed instead, they were named Participant 01, 02, up to 12.

4.3 Characteristics of participants

4.3.1 Table Number 1 showing the summary of participants' demographic information.

Participant	Registered Mental Nurses RMN	Nurse Aid N.A	Age	Sex	Duration in Unit	Level of Education
1		01	58	M	3 years	O` level
2	01		47	F	16 years	O` level
3	02		32	M	6 years	A` level
4	03		26	M	3 years	O` level
5		02	38	F	6 months	O` level
6	04		34	M	4 years	O` level
7	05		34	M	3 years	A` level
8	06		34	F	9 years	O` level
9	07		35	F	9 months	A` level
10		03	51	F	7 years	O` level
11	08		37	M	18 months	A` level
12	09		34	M	10 years	O` level

The above table indicates that the participants in the purposive sample are nine registered mental nurses and three nurse aids with their age ranging from 26 years to 58 years. The table also indicates that the psychiatric unit staff are mainly male because of the nature of the duties in the ward. It is also indicated that most of the workers in the psychiatric unit have the same level of education, which is mainly ordinary level. Most of the participants are also young and inexperienced. The participants mostly hold diplomas in psychiatry alongside with the registered general nurse certificate.

4.3 Nurses` experiences of violence

Forms of violence experienced by nurses

Registered mental nurses and nurse aids described numerous incidents of violence and the violence range from physical, emotional, verbal, psychological and sexual violence. More specifically the type of physical violence expressed included beating, grabbing, clinching, being attacked using weapons, being kicked, being strangled and being cornered. One of

the participants who was beaten up while in the acute care psychiatric ward said the following;

4.3.1 Physical violence

Asked to disclose her experience of physical violence of psychiatric patients, one of the participants had this to say:

The patient came in the duty room where we were having our lunch and while standing at the entrance looking into my plate full of food he said give me food please I am hungry before I could say any words, he jumped onto my plate and quickly grabbed it as I tried to find my way out he started pushing me into the corner and hitting me right in the face with his fists, I could not run away because there was no enough space.

It is evident from this nurse's typical statement captured during the interviews that psychiatric patients are violent to those who care for them. The violence becomes worse when the patients are hungry and in short of food – a situation that sometimes obtains in general hospitals where there are stringent government budgets.

Participant no. 02 confirmed psychiatric patients' violence on nurses when she reported that:

I had severe attacks from the soldier who had been admitted for the first time in the psychiatric ward and was in the acute phase of psychosis, I wanted to sedate him since he was restless and seemed not aware of what he was doing completely, he saw me preparing the syringe and needles that I wanted to use to inject him and he moved towards me with a mop that he had picked up from the ward corner, he bit me up with the mop and as I held the mop trying to stop him he started hitting me using his fists and shouting at the top of his voice that he wanted to kill me. He finally broke my right hand since all the staff had run away and I was left alone.

This shows that registered mental nurses face challenges in trying to execute their duties of treating and calming patients especially with male patients who will be in the initial phase of psychosis since they will be in a state of not knowing what they do. Such scenarios put nurses in a state of psychological panic and, in worse situations, in a state of hopelessness, particularly for female nurses.

Participant no. 09 also gave her experiences of physical violence when she said:

I was kicked by a patient whom I wanted to treat with the routine chlorpromazine intramuscular injection. The patient was an adolescent who had been admitted with the drug induced psychosis. There were only two of us on duty that day and the boy noticed that there was a staff shortage and took advantage of the situation. I was 7 months pregnant and the boy kicked me in the right back and I fell down unconscious. I only noticed that I had collapsed since I regained my consciousness whilst I was admitted in the private ward. Unfortunately I gave birth to a premature child due to the attacks.

Another participant also echoed his sentiments about the unavoidable violence that exist in the unit when she said:

About two weeks ago I was hit by a gold panner with a stone right on my cheek because I had told him that he was not fit for the discharge since had not regained his insight. On hearing these remarks he just went out as if we had agreed upon the further hospitalization and picked up a big stone from the garden which he used to hit me on the cheek. I had to go home since I was bleeding and it actually triggered by anger.

This means that female nurses who work in the acute inpatient psychiatric units are subject to more stressful and traumatizing attacks from the patients than their male counterparts since the male patients seem to take advantage of the weaker sex. Some experiences can be very traumatizing, imagine having somebody going to the extent of having a premature birth because of violence.

Nurses' revelations of physical violence perpetrated on them by psychiatric patients were similar to those reported by nurses in a study conducted by Gacki-Smith et al. (2009) on nurses' experiences of violence in the United States of America psychiatric hospitals that revealed hitting, slapping, punching, ditching and being pushed or jostled as common forms of physical violence experienced involved hitting, slapping, punching, ditching and being pushed or jostled.

4.3.2 Sexual Violence

The sexual violence experienced by registered mental nurses comprised sexual aggravation with verbal content and sexual provocation with physical contact. Participant no. 02 who is a nurse aid explained, *"I didn't know that these patients sometimes get attracted to us staff during their period of admission. There was this patient who had a diagnosis of drug induced psychosis and was sexually enticed to me. I was not aware of it*

until I had asked the two of them to accompany me to the laundry for collecting linen. The other patient went inside to be given linen and the two of us remained outside the laundry. He came near me with an erect penis and said to me, 'I love you'. I got so startled and confused, I lost whatever trust and faith I once had for the mental healthcare users, they are capable of doing anything given the chance”.

Participant no. 06 added that the mental healthcare users were very unpredictable patients who needed to be watched so closely all the time since most of them especially the male patients can turn to be sexually violent at any given time regardless of their diagnosis. The participant experienced sexual harassment with bodily contact and reported, “A mental healthcare user in this ward wanted to rape me when I was on duty. We were just two nurses and it was in the evening when he approached me and said he had a wife but at that particular time he wanted a nurse, before I could reply him, he quickly pushed me into the corner and I screamed for help and he pushed me down to the floor saying, ‘I want to rape you’. I was screaming and rolling on the floor when my fellow nurse and the security came to my rescue”.

This shows that some mental healthcare users are really dangerous and highly unpredictable especially to female nurses. Female nurses on night duty are more exposed to this threat of being raped.

More so, a study carried out by Shiao et al (2009) revealed that nurses in psychiatric hospitals experienced high rates of sexual assault which included verbal harassment with sexual contact. Also research conducted by Kwok et al (2006) incidents of workplace violence against nurses in Japan revealed that 18% of the participants were sexually aggravated in the workplace.

4.3.3 Psychological Violence/ Verbal Violence

The findings in this study show that psychological violence usually in the form of swearing, verbal threats, intimidation, gestures, sexually inappropriate comments and insults were common when working in the acute care inpatient psychiatric wards. Experiences of verbal violence were a bit more difficult for nurses to explain. One participant, participant no 03 emphasized that verbal violence happens all the time.

Participant no. 07 explained her incident of verbal violence saying, “*These patients are very rough and can sometimes be ungrateful, one day I was insulted by a certain boy who*

had been diagnosed with bipolar affective disorder, I was making beds in the morning and he was refusing to come out of his bed. I kindly asked him to get up for a few minutes so that I could change linen and then he would come back on his bed. He looked at me and said, 'I can't be told what to do by you nurse aid, an uneducated somebody like you, I don't take orders from you sorry poor nurse aid or rather general hand'. I felt very disappointed and helpless at the same time but I could not do anything since we take that as illness".

Participant no. 01 also reported of being verbally attacked by the patients whilst on duty revealed that during their execution of duty and care to patients the patients feel they are being deprived of their right to freedom during admission. The participant said she was verbally insulted by the mental healthcare user, *"There was a certain patient who insulted me and later wanted to strike me with a very heavy wooden stick after, I had refused to let him go for the leave. The patient shouted at me saying, 'I am not your child, leave me alone, I want to go home now or else you shall open the gate after I have bitten you, I don't respect you at all, voetsk'. I felt very angry with him, that I just decided to call the other staff to seclude him".*

In addition Pitch et al (2010) emphasizes that verbal violence is the most common form of violence experienced by nurses who work mainly in the acute psychiatric units, but the impact is similar to physical assault. However, there were more detailed verbal violence incidents described and these ranged from swearing, threats, intimidations and gestures and confrontation or demeaning incidents.

Participant no. 06 reported her experience with verbal violence when she was on night duty. She explained, *"I was verbally insulted by a patient who was diagnosed of senile dementia when she said, 'you are the one who has been beating me when I was asleep last night, I was so surprised to hear her remarks during the early hours of the morning, she continued to shout at me saying, 'you think I don't know you, I saw you in my dream wearing your white dress beating me up whilst I was asleep. 'Idiot, stupid I will revenge on you', I was very angry and disappointed with her to the extent that I just told myself that she is ill anyway".*

4.4 Contributing factors to patient violence

In describing their experiences of patient violence registered mental nurses noted the factors that they observed to be contributing to factors for violent behavior by mental

healthcare users. In this study registered mental nurses pointed out on several intra-personal factors and interpersonal factors that contribute to patient violence in acute inpatient psychiatric units. Under intra-personal factors there patient related factors such as; type of psychiatric diagnosis, history of patient previous violent behavior and substance use during admission and level of mental illness. On interpersonal factors there are; nursing related factors such as communication between patients and nurse, the quality of nursing care given to patients and nurse of patient assessment.

Finally ward related factors of the inpatient psychiatric unit were also said to play a pivotal role in patient violence and these were; inadequate staffing levels, poor lighting and physical space and availability of activities for patient and availability of food and drugs.

4.4.1 Patient related factors

Talking in terms of patient related factors, usually a mental healthcare user's diagnosis was said to be a determinant factor to the violence that registered mental nurses experienced. According to the participants, patients who were diagnosed with acute phase of psychosis, substance abuse and personality disorders contributed to violence in acute inpatient psychiatric unit. Registered mental nurses insisted that patients abused drugs during admission and before admission into hospital. Participant no. 05 echoed his sentiments on the above statement, *"The patient went out into the backyard and started smoking marijuana with his friend. After a short period of time he came back asking for permission to go home and join his family, I could even give an answer, he slapped me right in the face and held me by my collar uttering insulting words, he pushed me into the corner and beat me severely before my colleagues could help me, I got very angry and frustrated that I almost wanted to beat him also but eventually I managed to calm down and restrain him to bed"*.

The other reasons for violence included the mental illness itself. The participants mentioned that when patients come in with diagnosis of acute psychosis the patient is in a state of loss of insight. Participant no. 10 pointed out, *"If a patient is in an acute phase of psychosis, he or she doesn't know his or her condition and that the patient is likely to harm anyone at any time"*.

On history of patient previous violent behavior the participants explained that some patients have a habit of violence, while some will be having very bad history of violence

previously before admission. Participant no. 11 explained, *“I think it was because some patients have a habit of violence, the patient came in and said, ‘I have always beaten my mother and I want to show you that you are not special’. He started beating me up using his fist and I blocked him as a man and then sedated him with diazepam”*.

Regarding patients` personalities the participants discovered that general wickedness was also seen to be a contributing factor to violence as participant no. 05 pointed out that, *“Inasmuch as a history of violence and drug abuse may trigger patient violence in a small number of participants, there are dangerous people with long criminal histories of violence and some previous murder cases so it is not surprising that they may regress and be violent in hospital or violent in their daily lives”*. Some participants explained that if a patient was brought to a hospital because of violence in the community, it was also seen that it contributes to violence in hospital. Participant no. 08 narrated that participants with a long history of substance use indicated their inability to cope with stress and thus contributing to violence in hospital.

Pitch et al (2010) in support of nurses` views that habitual violent behavior was related to violence in ward assert that the greatest risk factor in health facilities is a recent and past history of violence.

4.4.2 Interpersonal related factors

Specifically poor communication staff and patients may end up in unnecessary incidents of patient violence. Participant no. 11 emphasized that, *“The type of communication and relationship that a nurse creates with a patient from the first day you meet him/her matters most. As a trained psychiatric nurse you should create a rapport with the patient so that you will gain trust and maximum cooperation during the patient`s period of admission”*. Participant no. 06 added that, *“The patients need to be listened to, also they need to be updated on issues concerning their treatment and recovery”*. Most of the participants mentioned that the mental healthcare users do not want to be taken for granted but instead they want to enjoy their freedom and rights. For example one participant mentioned that during their admission they enjoy being given updates concerning their recovery such as, *“If you remain in this state up to Friday this week, you will go home”*. This kind of communication is said to shed a greenlight into their lives and can motivate them to recovery quickly.

Participant no. 12 pointed out that poor communication between a nurse and a patient highly contributes to patient violence in acute psychiatric unit because it demoralizes the patient. The participant said, *“It was on a Friday when I called an epileptic girl who had been admitted for two weeks and told her that she was not going home because she had not shown any signs of recovery instead, she was violent and restless, she was infuriated by my remarks and she jumped on me and started frightening me slapping me and finally tried to strangle me with her fingers”*. In this study also communication amongst nursing staff was seen as nursing related factor contributing to patient violence especially poor communication on issues of passing risks or safety issues to other colleagues.

The quality of nursing care given to patients was also perceived to contribute to patient violence. Participants in this study pointed out on the issue of favoritism as a trigger to patient violence in acute psychiatric unit. Participant no. 09 echoed his sentiments on the above statements. *“Psychiatric patients should be treated fairly and equally in terms of medication and food allocation, there was one incident when an elderly man was admitted and supposed to have been treated by Fluphenazin deconate but unfortunately the drug was out of stock, the following morning the drug was available and before he was injected he saw me injecting a boy who had come for review, it actually triggered him into being violent to an extent of kicking the drug trolley that I was pushing and shouted at the top of his voice that I was being evil and selective of the patients”*. The participants mainly emphasized that the patients needed equal treatment and fair treatment.

4.4.3 Ward-related factors

Unit related factors comprised of physical space, staffing levels, more side rooms, availability of food and drugs and availability of activities for patients. Throughout the RMNs descriptions of their encounters with patient violence, the number of staff on the unit played a role in causing patient violence in the unit. Participant no. 01 who is a registered mental nurse and has experience of more than ten years on the ward said, *“Safe staffing serves lives”*. *In this unit we have a critical shortage of staff and the nurse patient ratio is quite unbearable since the ward admits that up to twenty-five patients at a time and usually on duty we have two registered mental nurses and one nurse aid or general hand, this kind of shortage has always exposed us as nurses to patient violence.*

Participant no. 11 also pointed out on the importance of having adequate staff on duty when he said, *“Staff patient ratio influences patients to become violent, normally patients take advantage of the weak points especially during the night when there is only one registered mental nurse and a general hand taking care of twenty to twenty-five patients”*.

Also, throughout the RMNs narratives the issue of physical space on the unit also played part in contributing to patient violence. Participant no. 10 said, *“Crowding and unavailability of physical space contributes immensely to patient violence, in our case in this unit we have only two side rooms and we admit up to a capacity of twenty patients at a time, this only means that when we have more than two patients at a time who display episodes of violence we will not be able to seclude them and we are in trouble”*.

Nursing staff at this organization raised the issue of shortage of drugs and pharmaceuticals also played part in accelerating patient violence. Participant no. 06 said, *“Drugs and pharmaceuticals are quite essential in calming and containing the psychiatric patients’ drugs like chlorpromazine, flufenazine deconate, haloperidol and carbamazepine were out of stock. We had a high rate of relapses and admissions since the patients were unable to get their routine supply, this led to commotion and more incidents of patient violence”*. Also another participant mentioned that, *“Mental healthcare users on admission need adequate supply of food because their medication is meant to be taken after food, if they do not have adequate food agitation may start to show resulting into eruption of violence”*.

During the course of interviews, the registered mental nurses described the change of environment as a major cause of patient violence in acute inpatient psychiatric units. Participant no. 05 said, *“The geographical appearance of psychiatric unit appears as a cell and is therefore not user friendly to the patients, patients feel that they are too confined and are being deprived of their right and freedom of movement”*. Also on the way through the nurses emphasized idleness and inactivity from lack of patient-oriented activities was another unit related cause of patient violence. Participant no. 07, for example said, *“These patients also need entertainment and recreation in order to deal with redundancy and idleness which may trigger episodes of violence. When we are out at the grounds playing soccer and other games, the patients feel very happy and confident that they can do what other people do in the community”*. However, the RMNs mentioned that the availability of facilities depends on organizational budgets.

Theme 2

4.5 The effects of violence on registered mental nurses

Throughout the study, physical and emotional effects were the most reported impacts of patient violence, patient aggression, whether it is verbal or physical was reported to have detrimental effects on both registered mental nurses as well patients themselves. The most common theme in the data was emotional distress comprising feelings such as anger, anxiety, helplessness, bitterness, shock and numbness as well as a fear of future violence. There were a series of emotions expressed after incidents of physical patient violence ranging from physical pain, frustration, anger, emotional distress and bitterness.

An RMN described feeling scared and anxious. Participant no. 07 said, *“It was my first time to be beaten up by a patient while on high duty, I felt fearful at first and then after realizing that I was bruised all over my face I felt very angry and wanted to quit night duty at all”*. In addition participant no 12 also said, *“I felt very sorry about what had happened to me at first but later felt confused and frustrated as to whether I should keep on coming to work or resign, what if it happens again, what will my family benefit from this?”*. Some participants in the study were frequently complaining about anxiety and fear of future episodes of violence. Participant no. 03 said, *“After having sustained a fracture on my right arm, I felt very frustrated, anxious and depressed since I am the breadwinner in my family, I thought what if I cannot be fit to go back to work again, who will feed my family?”*.

Furthermore, participant no. 10 said that, she felt very confused and disappointed when she gave birth to a premature baby after an incident of patient violence in the unit. She said, *“At first I felt very sad and I was anxious about what had happened to me, but later when I was at home, I was depressed and was thinking what if I had died, who would have been looking after my children including the premature baby, at once I thought I should resign”*.

However, some RMNs took the incidents of violence to be unavoidable and said, *“I feel that our patients are unwell most of the times that they cannot control what they do”*. Another example that they gave was that of a participant who was in his acute phase of psychosis who eloped from the ward after injuring three nurses. Participant no. 01 said, *“I was more scared for his wellbeing when he ran away, I thought someone is going to hurt*

him or he is going to hurt someone, but it is not his fault and I felt very protective of him”.

All the way through the study it was immediately after the incident that RMNs were usually the most able to reflect on their feelings and try to account for their emotions. It was during this point that the nurses showed that they feel distressful. The participants were not only afraid for their safety but also they feared what could have happened if the situation ended the other way. Participant no. 08 said, *“After every incident of patient violence, I always ask myself several questions like, what if I had lost my ability to do my job because I have been seriously injured?, what will my family do?, who will take care of my two children?, and what happens if I get permanently injured?. Actually that instill fear into me”.*

A study conducted by Lau, Magarey and McCutcheon (2004) asserted that violence against nurses could result in discomfort, rage, terror, loss of confidence and depression. Within their study on occupational violence and assault in mental health nursing, MacKinnon and Cross (2008) discovered that nurses who had been subjected to violence in acute psychiatric units could suffer long-term negative emotional effects that included depression, distress, and loss of self-esteem, self-dissatisfaction and anxiety. Also Kindy et al (2005) confirmed that nurses who experience violence in acute inpatient psychiatric units fear future injuries and moreover, others have a zeal to quit the job after weighing the costs and benefits of continuing with the job.

Theme 3

4.6 “Violence as part of the job”

Throughout the interviews, the researcher observed that participants in the study view the culture of nursing as one where patient violence should be accepted as part of the job and moreover, many felt that the belief was inevitable. This was particularly true of psychological violence and many RMNs in this study pointed out that routine nature of patient violence as no only part of the job but something no longer worthy of reporting. Some of the participants were experienced and confirmed that they had been trained during their post graduate studies in psychiatry on how to contain and survive patient violence in psychiatry.

Participant no. 06 said, *“I take precautions before violence can erupt, I assess the patients in order to correctly judge their mental states, I was trained and thoroughly prepared to meet patient violence and I know how to curb it, with psychiatric patients you need to talk to the patient in a low voice and calmly”*.

Although a few elderly and experienced registered mental nurses felt that patient violence was the culture within nursing, this had a negative impact on the majority of younger and inexperienced registered mental nurses who said, *“We never thought we would sign agreement contract of employment forms to be battered and abused as part of our job, we feel betrayed because we never knew that it happens so frequent and it is assumed to be okay for nurse to be harassed at work”*.

Contrary to the majority of nurses, participant no. 09 said, *“I was pushed and had to fall down while trying to help a fellow nurse who was attacked up to the extent of sustaining a fracture, I did not take any case upon the mental healthcare users because I understand that these people are mentally ill and they do not mean to do what they do, actually I feel empathetic on them”*.

Also participant no. 01 added that, *“I think the gloomy reality is that anyone who goes into nursing should be ready to encounter patient violence. I suggest that violence is inevitable to our culture and there are certain types of careers that one is more at risk for it, but I consider nursing to be definitely one. I suggest that people should expect it surely”*.

4.6.1 Role Conflict: The duty to care and the duty to self.

During the course of interviews, registered mental nurses were usually conflicted between their duties of acting as the healthcare giver whose role is to deliver care in the best interest of their patients as opposed to the way that would protect their own health and safety. The registered mental nurses in the study often struggled to balance the mandate to execute their duty in providing therapeutic care with the idea that it is not part of their job to be assaulted, hence engaging in self-preservation activities which trigger stress. Participant no. 05 confirmed that, *“It is really difficult to strike a balance between the duty to care and the duty to self, during almost every incident of patient violence, quality nursing care will be complimented because one will retaliate and try to discipline the patient”*.

Participant no. 10 also complained that nurses had to fight their natural autonomic responses such as flight and fight in order to be able to offer a therapeutic role as healthcare providers. However, some participants offered their sentiments that in violence situations prompted by terror and low confidence in their ability to curb patient violence, participants usually use to preserve their own health at the expense of patient care. Nevertheless, when situations comprised mental healthcare users who would be out of control due to illness, often registered mental nurses opted to put patients` needs first at the expense of theirs.

Theme 4

4.7 Nurses` influence and authority

The notion of power and control was common throughout the narratives of the registered mental nurses. In recent systems, the participants view themselves as being ultimately responsible for controlling patients and the environment. Some participants mentioned that engaging in authority and influence struggles and loss of power and control for mental healthcare users were usually antecedent factors to patient violence. However, realizing this the nurses strategized to prevent violence by giving control back to the patients

Participant no. 12 suggested that *“It is best to create a rapport with these patients right from their first day of admission so that we can incorporate them in their treatment and recovery plan”*. On the other hand participant no. 04 and 07 insisted that there was need to have authority and influence over the environment as they felt would improve safety such as having more seclusions, with mental screen doors and more physical space between nurses and patients. Most of the participants confirmed that they often felt a loss of control resulting in the vulnerability and feebleness when they are found being unable to curb patient violence which as a result affected many participants to therapeutically care for and empower their patients. Participant no. 03 explained, *“These patients are different in the sense that some have a total loss of control while some have control and insight of what they do, violence is responded in a harshly manner if it arises from a patient who have full insight rather than one who has lost total control”*.

4.7.1 Registered mental nurses feelings Stigma

Stigma was witnessed throughout the registered mental nurses' narratives of patient violence. Stigma was discovered when RMNs held the perception that when working in the acute care psychiatric units, violence is inevitable and most of the nurses struggled with the concept. Participants confirmed that violence could not be discounted with the population, but at the same time they also felt that their patients should not always be stereotyped as violent or should not always be assumed as more violent. Participant no. 02 said, "I thought after three years of working in the psychiatric unit that I may be deemed mentally unstable since people hold such perceptions against mental nurses". Also one participant had the perception organization as also promoting a culture of stigma acceptance due to the fact that in the mental health act reporting system there is no option to report verbal or psychological violence.

Participant no. 12 explained, *"If you work in the psychiatric unit the attitude as opposed to what if that behavior would have happened in a medical ward? The nurses would probably have been allowed to write a report because of verbal violence is not tolerated there, but in the acute psychiatric unit, it is like we are not going to count verbal threats as warranting risk reports"*.

However, stigma also influenced how the registered mental nurses experienced violence. The majority held the perception that patient violence triggered by someone with a diagnosis of a personality disorder and drug addicts was seen to be more intentional and they perceived the patient as having more ability to control their behavior. Participant no. 03 and 04 said, "They are exhibiting the behavior only to make you suffer but they know better what they do". Participant no. 08 added that patients with personality disorders drug abuse diagnosis were perceived as manageable behaviors and not as serious mental illness. Registered mental nurses tended to be distressed, angry and affected by patient violence perpetuated by a mental health users with personality disorders or drug abusers. Nonetheless, participant no. 01 pointed out on the importance of having emotional intelligence and the ability to control countertransference. Also participant no. 11 said, "When coming to work in the morning one should know that you are going for battles and should be prepared for attacks rather than these other nurses who do not do work in the psychiatric units who only wait to execute their duties only". All the way through the participants were emphasizing that patient violence in the acute inpatient psychiatric unit was inevitable the organization itself also promotes that culture.

4.8 Registered mental nurses` views of their needs concerning patient violence

Perceived needs by RMNs in this study are grouped into (i) needs for prevention and (ii) needs for follow-up and support as well as tertiary prevention.

4.8.1 Individuals needs for prevention

Throughout the study the nurses suggested that further education related to preventing violence was the crucial identified need. Participants confirmed wanting further education around a wide range of topics comprising mental health diagnosis, symptomatology and treatments, identifying antecedents, learning more ways of preventing patient violence leaning self within relationships, emotional intelligence along with how to self-regulate and this affects the therapeutic relationships, awareness of control and influence imbalance between nurses and patients. The true definition of violence and that nurses should shed off the stigma violence should be expected just because one works in the acute care psychiatric unit.

The nurses also pointed on the need to have knowledge of the team approach and roles as well as to have better knowledge and understanding of the organizational policies related to managing patient violence. Participant no. 05 asserted, "I think there is a need for organizational policies to be amended so that they also look into the plight of psychiatric nurses concerning the issues of patient violence other than the current policies that only cushion the plight of psychiatric patients alone". Participant no. 07 mentioned that due to the pressure of their shift work and the current staff shortages that they are experiencing in the acute inpatient psychiatric unit, the registered mental nurses were unable to attend any educational programs. Participant no. 09 concurs, "I think local based training programs would be better though...due to my shifts sometimes I even fail to attend". However, support was identified to include not only encouraging the registered mental nurses to attend to educational programs but the ability to release them off from work to utilize educational opportunities.

4.8.2 Ward related needs

Participants throughout the study described a variety of unity related needs for the prevention of patient violence. In terms of the unit environment or structure, participants had several remarks to make. *Participant no. 03 and 08 said, "The unit environment is not suitable for the big number of patients that it accommodates, the unit accommodates*

up to thirty patients whilst it has only two seclusions or side rooms, what will happen if more than two patients become more aggressive at one time, then it will be a catastrophe". Also participant no. 09 added, *"This kind of a setup is whereby the staff toilet is situated inside the patients` toilet is not safe at all because patients are very unpredictable one maybe strangled to death or even raped by the mentally ill patients, I think staff toilets should be separated from mental healthcare users` toilets".*

Throughout the nurses' narratives, the notion of poor staffing levels was the perceived to be the major cause for patient violence in the acute inpatient psychiatric unit. Participant no. 01, 05, 09 and 11 had this to say, *"We have a critical shortage of staff in this unit resulting in a poor nurse patient ratio, usually we are two registered mental nurses and one general hand on duty with up to eighteen patients which is so frustrating when patient violence erupt, we definitely are not able to manage the violence because of staff shortage".* Moreover, participant no. 06 emphasized, *"With this kind of staff shortage, nursing quality care is compromised as we divert attention to managing patient violence".* Whereas, participant no. 01 added, *"More staffing is needed in order to assist with a lower staff to patient ratio as well as increasing safe ratio of experienced and novice nurses".* This would also allow nurses time to meaningfully communicate with their patients. The following sentiments were echoed by participant no 8 *"Lower staff to patient ratio is meaningful in the sense that we can actually spend time with our patients getting to know them and finding out what their triggers are and what their expectations are, that would also give us enough time to work as a team and manage the unit against violence."*

RMNs during the course of the study also recognized the need to maintain spirit, cooperation and support of each other to help curbing patient violence. In this particular unit where the study was conducted the participants explained that the current culture of support and teamwork differs and the majority pinpointed the need to persistently work on improving teamwork. Participant no 01 elaborated her view of the effects of teamwork and cohesion in the ward relating to the need for improving team cooperation. *"I was attacked by the by the patient who had a diagnosis of schizophrenia and we were three nurses on duty but only to find out that the other two nurses and a nurse aid had ran away leaving me alone with the violent patient, giving the patient more room to attack me and broke my arm, I felt very disappointed with them at first, but later realized that the team collaboration and cohesion needed to be improved on".*

Participant no 05 also mentioned the need to have a psychiatrist to evaluate the authenticity of some patients for admission to the acute inpatient psychiatric unit. The following were his sentiments concerning the above statement. *“I think sometimes it is necessary to have a psychiatrist to evaluate the appropriateness of some patients for admission in the psychiatric other than the process being done by a general practitioner who is not well trained in psychiatry, because we sometimes get deceivers who are here for a different cause other than mental illness, sometimes secondary benefit ---- is their primary gain for being here, for example we previously admitted a criminal who had absconded from prison and pretended to be mentally ill in order to be able to secure a place to hide.”* Participants also pointed on the need for more physical space for patients including the availability of therapeutic spaces such as quiet or comfort rooms offering increased programming activities.

4.8.3 Administrative Needs

All the way through the nurses’ narratives emphasized on the need for an increased presence of security personnel on the unit which was believed to enable better management of patient violence. The nurses were advocating for a security station to be placed right in the unit in order to increase the relationship between the nurses and the security services. Participant no 2 explained *“I was beaten up by a violent patient until I sustained some bruises all over my face while I was busy trying to call the security but at the same time could not find the keys to unlock the gate for the security personnel to enter the premises, I felt very frustrated and angry at the set-up of the unit and security personnel as it provided the patient with leeway to attack the staff”*.

The desire to have security services more involved in preventing violence may indicate the nurses’ limited inadequate skill and confidence level in themselves to control escalating situations. Participant no 7 explains, *“The current shortage of staff in the unit needs even the help of security personnel suctioned in the unit in order or help managing escalating situations”*. The participants also were advocating for improved organizational policies concerning management of patient violence as well as clear expectations for patient behavior. Alternatively, participant no 12 suggested that there is a need to have better trained security personnel when he said, *“Training programs and workshops for acute psychiatric nursing staff and security personnel together are necessary to enhance prevention of patient violence”*.

4.8.4. Acknowledgment and Tertiary prevention needs

Registered mental nurses in this study constantly ascertain the need to have the event acknowledge especially by their authorities and supervisors. The perception that their authorities did not diminish the occurrence of the event regardless of whether it was verbal or physical violence gave them hope and inspiration. Alongside the acknowledgement of the event, the participants emphasized on the importance of expecting the authorities and sister in charge to recognize the risk intrinsic in the situation, see trauma and to support not be taken as “part of their jobs”. Participant no 8 said, *“It is so demoralizing for anyone to go to work and get injured or hurt as part of your job irrespective of the patient’s diagnosis.”*

This follow-up and support by managers and authorities was felt to be critical by almost all the participants and the lack of it influenced the occurrence of violence for the registered mental nurses in relation to how they perceived the response from the authorities. Participant no 6 highlighted, *“ The organization have to support us their staff or else staff will feel undervalued, they don’t care you are injured or you are emotionally hurt for as long as you report for duty the next day....whereas follow up and acknowledging that something bad has happened would have relieved anger and stress..”*

Participants throughout this study expressed the need to be psychologically and emotionally supported by both coworkers and authorities in a non-judgmental environment of whether they were the direct victim of violence or helper because it is very traumatizing may compliment job satisfaction. Participants no 7 insisted, *“If a nurse has been involved in patient violence he should be offered compassionate leave in order to rest and calm his emotions, for he will be so emotionally unstable”*.

During the course of the nurses’ narrative, the RMNS expressed the need to be given a risk allowance as crucial and consoling in their monthly wages. Almost three quarters of the participants said, *“ In all psychiatric hospitals and institutions registered mental nurses’ were being given risk allowance expect only for us in the acute care in patients psychiatric units but the duties are just the same it actually demoralize us”*. Moreover some participants pointed out on options for counselling as vital for RMNS.

4.9 Chapter Summary

Chapter 4 has delivered an account of the research findings including the registered mental Nurses, views perceptions and experience of patient violence. It also discovered some patient violence prevention strategies at the individual, unit and organizational levels. Also, the findings described the psychological, emotional and physical impacts of patient violence, short and long-term answers of Registered mental nurses as well as the predominant themes namely Nurses' experiences of violence. The effects of violence on rethe job and nurses influences and authority. Finally, nurses views of their needs concerning prevention of patient violence.

Chapter 5

Discussion, Conclusions and Recommendations

5.1 Introduction

The aim of this chapter is to discuss the research findings in relation to the literature review and the research questions. Major highlights of the research will be given. The conclusions will be drawn from the research questions. Limitations of the study will be outlined in the last section as well as the recommendations of the future research will be given.

The findings have shown that, to a large extent, psychiatric nurses experience physical, psychological, sexual and verbal violence. RMNs attributed patient violence in the acute care inpatient psychiatric units to patient related factors, nurse related factors and environmental factors. These findings are now discussed in relation to the research questions of the study.

5.2 What are the Positive Experiences of Nurses who are exposed to Violence in Acute Inpatient Psychiatric Units?

The findings revealed that two thirds of the registered mental nurses and the assistant staff believed that mentally ill patients were not responsible for all their behavior. The research confirmed that the majority of participants expected to be physically assaulted. Most psychiatric nurses believed that physical assault was indicative of staff deficiency, clinic incompetence or communication breakdown between nurse and patients. The present

findings concur with Whittington's (2002) findings which reflected that health staff with more than 15 years of experience in psychiatric units were more tolerant towards aggression than those with fewer years of experience. Whittington (2002) revealed that a tolerant attitude toward patient violence correlates negatively with fatigue and depersonalization, and positively with personal accomplishment. The participants in the current study, however, confirmed that nurses who continuously focus on the undesirable aspects of patients develop a pessimistic view of human nature. The researcher found that RMNs viewed the role of a psychiatric nurse as one where patient violence should be tolerated as part of the job because it was inevitable. This was reported to be especially true with verbal violence. The nurses in this study acknowledged the repetitive nature of violence as not only part of the job but as no longer worthy of reporting.

The findings revealed that education and training designed to teach mental health nurses the necessary interpersonal communication skills, together with the nurses' assertiveness and empathy could greatly impact the incidence of patients' aggression. The findings are consistent with Duxberry's (2004) findings which confirm that interactions between nurses and patients are a major factor in controlling and management of aggression. A research carried out by Gergolas et al. (2002) also emphasizes that the therapeutic relationship and interpersonal process that occurs between the nurse and the patients, is a purposeful, goal oriented relationship that is directed at advancing the best interest and outcome of the patients. The research found that it was the kind of relationship that the nurse creates right from the first day he or she meets with the patient, which matters most and it actually makes the nurse gain trust and maximum cooperation from the patients. Gergolas et al. (2002) argued that from the clinical perspective mental health nurses should seek to obtain a positive working relationship to minimize conflict and improve health outcomes for their patients. Also the research revealed that a level of interpersonal communication skills is the basis of a therapeutic relationship.

The findings revealed that psychiatric nurses needed more counselling skills in handling patients. Even, with a violent patient nurses used skills such as active listening, summarizing, paraphrasing, negotiating, questioning for clarification and body language to come to a reciprocally helpful outcome (Ferall et al., 2010). However, Abdernhalden et al. (2006) suggest that attitudes and skills train nurses to provide a high level of care including empathy, tolerance and open mindedness which can be well received by patients improves the therapeutic relationship.

5.3 What are the Negative Experiences of Nurses who are exposed to Violence in Acute Inpatient Psychiatric Units?

The negative experiences of the participants included distress, frustration, anger, anxiety, depression and fear. Similarly, Carlson et al. (2004) noted that unmanageable fear makes the psychiatric nurses feel small as well as unable to think clearly, while a feeling of powerlessness overwhelms them. In addition, the study revealed that mental health nurses defined fear in varied ways, in fact for some nurses fear tended to determine their reactions and each time they think about going to work they thought of another risk of being harmed. Due to nasty experiences in the psychiatric unit some nurses in the present study were contemplating resigning as they feared the recurrence of patient violence.

Furthermore, the study established that the registered mental nurses experience anger and frustration because the duty to care for patients conflicted with the duty to self. The participants reported that to relieve their anger they either withdrew themselves from irritating situation to cool their temper or they struck back in retaliation. In support of this finding Friez (2005) notes that when someone is victimized, a typical response is to become angry and to fight back, sometimes the nurses would just give the patient a bit of his medicine.

The current study also noted that in the face of patient violence some nurses responded with helplessness and distress. The participants did not express hope that things would change for the better. This finding is consistent with Needman's (2005) finding that when confronted with patient violence, some psychiatric nurses perceive the relationship as impaired and avoid the perpetrator. This response leads to mental health nurses doubting their professional abilities or even evoke feelings of being a failure.

The research also revealed that psychiatric nurses suffer from depression and desperation due to the emotional and physical assaults by mental healthcare users. The participants revealed that the Mental Health Act seems to only cater for the plight of patients alone when it comes to issues of patient violence while totally leaving them out. The study participants alleged that some incidents of patient violence go unreported because the current Health Policy does not consider verbal violence to be worthy reporting. Consequently, some RMNs psychiatric nurses resorted to keeping everything to themselves and resenting the person who caused pain, while waiting for an opportunity to strike back (Bimenyimana, 2008). In their state of despair, some psychiatric nurses

believed that despite not achieving their expected goals in the psychiatric unit, they had done their part and felt like giving up.

5.3 What are the Effective and Ineffective coping strategies for Nurses who are exposed to Violence in Acute Inpatient Psychiatric Units?

Findings show that most participants had developed resiliency as a major effective coping strategy in cases of continued exposure to patient violence. The research found that unlike general nurses and nurse aids, registered mental nurses were thoroughly trained and prepared to meet patient violence. The research also unveiled the importance of nurse patient communication during the first encounter as so vital in creating a good future rapport with the patient. Creating good patient rapport helps in building trust and maximum cooperation between the patient and the caregiver.

The conceptual framework which was used in this study was based on resiliency. Mansten (2001) asserted that resiliency is characterized by good outcomes in spite of serious threat to adaptation or developments. The theoretical framework concurs with the findings that revealed that nurses need to capitalize on their strengths and resources when they are faced with incidents of patient violence. However, the findings revealed that age and experience contributed very much to the development of resiliency among registered mental nurses. The experienced nurses confirmed that due to increased exposure to stressful events of patient violence, they had developed positive coping characteristics. Gillspie et al. (2007) concurred that resiliency research indicated that some individuals emerge from adversity with stronger capacities when challenged.

Research findings also indicate that some personal qualities of individuals determine one's level of resiliency. The RMNs revealed that self-efficacy, hope and control over the situation helped in achieving their set goals. The statement is supported by Aslan et al. (2009) who assert that the three personal attributes that are associated with resilience are control, commitment and challenge. Individuals who perceive outcomes as within their control believe that they work towards their own destiny and view adversity as a challenge.

The findings in this study also revealed that young inexperienced mental health nurses were the ones who experienced more frustration and stress and resorted to ineffective

ways of coping with workplace violence such as absenteeism, job dissatisfaction, substance abuse and burnout. Some participants confessed that through continued exposure to stressful situations one may decide just to be absent from work as way of showing dissatisfaction with the job. Bimenyimana (2008) supported that some registered mental nurses feel that instead of getting moral support from their managers and other members of the team they get blamed for each incident that happens and the situation ends up causing emotional stress to nursing staff leading to alcohol abuse and high rates of absenteeism. The findings also showed that mental health nurses felt that they were being neglected by the hospital authorities and their concerns were not being adequately looked into resulting in them adopting a negative attitude towards work. This finding was echoed by Felton (1999) who reported that mental health staff experience burnout which is the exhaustion of physical or emotional strength as a result of prolonged stress and frustration.

However, Fosters, Bowers and Nijman (2006) also carried out a study on patient violence in the acute care inpatient wards in the United Kingdom using a cross-sectional survey design and their study focused mainly on investigating the nature and prevalence of patients' aggressive behavior directed at staff. The current study mainly focused on the positive and negative attitudes of nurses who are exposed to patient violence in acute inpatient psychiatric unit and the findings revealed that experienced and mature nurses were better able to contain violence than the young and inexperienced nurses who do not tolerate violence at all. Unlike this study Fosters et al's study focused on five acute inpatient psychiatric ward and the registered nurses in their study also reported aggressive incidents using the staff observation aggressive scale. Contrary to their study this study focused on exploring the experiences of patient violence directed towards the registered mental nurses and assistant staff at a designated unit in a hospital. The results on the negative effects of violence are notably comparable to Campbell et al's findings in USA and Giberich's (2004) findings, again in USA.

Similar results on the negative effects of patient violence were reported by Nollan et al. (1999) in their across-sectional study in the UK aimed at identifying the extent and nature of violence against mental health nurses and to identify what support, if any they received following their experiences of violence. Contrary to this study their study sample included psychiatrists and also their study reported incidents of violence study focuses on the registered mental nurses who are not hospital residents. Whereas most studies

including the study by Nollan et al. (1999) found negative effects of violence on mental health staff, the current study established some positive effects of patient violence, for example it emerged that experienced and mature staff members had developed some resilience and had come to appreciate that patient violence is part of the job at GPH. In fact the current study found that registered mental nurses had mixed feelings about patient violence with some experienced nurses viewing it as a sign of incompetence on the nurses' side.

5.4 What are the Registered Mental Nurses' Intervention Strategies for dealing with Patient Violence in Acute Care Inpatient Psychiatric Units?

The research found that most RMNs categorized the intervention strategies into separate groups namely person-centered strategies and nurse-centered strategies. The research found that communication between nurse and patient plays a pivotal role in preventing incidents of patient violence. The findings also reveal that nurse empathy and respect with their patients was also of paramount importance. Nonetheless, these findings concur with the studies that were carried out by Bowers et al. (2011) which confirmed that nurses should listen to mental health care users' requests and be transparent about ward rules in order to prevent patient violence. The findings also uncovered the need for mental health nurses to go for non-violent training annually which encompasses crisis and violence management. Notably this idea is supported by Stein (2003) who conducted a study on enhancing nurses' and mental healthcare user's relationships and interactions. The research found that registered mental nurses also use some chemical restraints such as chlorpromazine, Carbamazepine, Haloperidol and Amitriptyline to calm their patients.

Interestingly it also emerged from the current study that the low nurse patient ratio should always be maintained in order to prevent patient violence. All the way through the participants emphasized on the need to maintain adequate staffing levels in the unit as the only way to curb patient violence. However, the findings also indicated that engaging the security personnel in the unit was of paramount importance in an effort to prevent patient violence. Moreover, (ICN, 2006; Pitch et al., 2010) confirm that appropriate security system and adequate staffing levels help in preventing patient violence.

5.5 Conclusions

Registered mental nurses who work in the acute care inpatient psychiatric units are truly vulnerable to patient violence. These nurses are exposed to different forms of violence including physical, verbal, psychological and emotional violence. However, the RMNs have mixed feeling about the phenomenon of workplace violence. Some have a feeling of job dissatisfaction due to continued exposure to violence but only keep on coming to work because the job is their means of earning a living. Some RMNs have a passion in psychiatry and have developed resiliency to the phenomenon of patient violence. In fact they have been desensitized to the occurrences of violence resulting in them having the conviction that patient violence is part of their job. The organizations are facing problems with retention of staff due to the problem of patient violence. However, in support of these vulnerable nurses, some special appreciation should be done to these mental health nurses in form of support and follow up after the incidents of violence. Their duties should be recognized as equal to their counterparts who work in real mental hospitals and should also be considered in terms of risk allowance. Improvement need to be focused on improving the unit environment and creation of policy and guidelines against patient violence. Policies should be made clearer on how to manage workplace violence registered mental nurses. More workshops and training sessions should be done in order to educate the mental health nurses on how to cope with patient violence especially targeting the young and inexperienced nurses. Newly employed nurses should be given intensive training on how to manage patient violence. Majority of the registered mental nurses mentioned that they were motivated to do psychiatry by the desire to work with the marginalized group so they should also be appreciated and supported during their period of need. However, if they feel neglected they will also neglect the patient. This study did not come up with many new ideas but it managed to uncover the aspect of mixed feelings that the psychiatric nurses have concerning the issues of patient violence.

5.6 Limitations

The study was conducted in one mental health unit which is in the particular designated hospital making the findings very limited from one hospital which lead to limited generalizability. The size of the data sample was very small in the sense that it limited transferability of the findings and the results could not be generalized. However, the qualitative nature of the study made it difficult for the researcher to eliminate participant researcher bias.

5.7 Recommendations

5.7.1 Registered mental nurses

They should improve on their communication with patients, try to create good rapport with mental healthcare users in order to have sound and empathic relationship with their patients.

RMNs should develop a tolerant attitude which counter exhaustion and burnout while encouraging personal accomplishment.

Registered mental nurses should seek to obtain a positive working relationship with patients in order to improve the health outcomes of their patients.

Ward level

Staff levels should always be adequate to be able to manage patient violence.

Lower nurse patient ratio should always be maintained in order to allow nurses more time for interactions with their patients.

Some adjustments should be made to the structure of the unit including the idea of having more side rooms and their conditions improved

Should cooperate and work as a team all the times especially during times of need.

Staff should be involved in aftermath support and episode recording.

5.7.3 Institutional level

Should develop organizational policies that support their staff during times of need.

Should realise that RMNs are affected much by patient violence and help them to do away with the belief that patient violence is part of their job.

Revise the policy on incident reporting so that it allows the nurses to report verbal violence.

Nurses' duties should be allocated in such a way that nurses maybe able to pursue their post basic training without hindrance.

5.7.4 Training recommendations

Training programs should be conducted regularly in hospitals in order to train nurses on how to manage patient violence.

Registered mental nurses should be provided with special training on ways to prevent violence and also intervention strategies used to curb patient violence.

Trainings should also be extended to psychiatric nursing staff as well as hospital security personnel.

5.7.5 Future Research

Future research should carry out similar studies but with a large sample of mental health staff

Other future studies should go beyond GPH in examining patient violence

Future studies should equally examine violence perpetrated against patients since the current study only focused on violence against mental health staff

5.8 Chapter Summary

This chapter discussed the results of the research findings. The research findings were compared with findings from previous researches on the subject matter. The discussion revealed some issues that are unique to this study such as the positive attitudes of registered mental nurses towards patient violence which is not found in the previous research studies that mainly focused on the negative attitudes alone. Conclusions of the study were also drawn in this chapter eventually recommendations were made on causes, effects and intervention strategies of patient violence in acute care inpatient psychiatric units.

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APPENDIX A- RESEARCH INSTRUMENT

INTERVIEW GUIDE QUESTIONNAIRE

PRIMARY QUESTION	EXAMPLE OF PROBES
“Can you tell me a bit about yourself what led to you work in psychiatric	i. Probe for information regarding their role, responsibilities, work experience, context of the work place (that is how many beds does the unit have , average work load/ patient assignment)

<p>“What do you consider to be patient violence?”</p>	<ul style="list-style-type: none"> i. Provide definition for patient violence that the study utilises ii. When I talk about “patient violence” I am referring to any incidents of aggression that is physical, verbal or emotional that occurs when nurses are abused, threatened or assaulted in circumstances related to their work, but often everyone has their own considerations.
<p>“Would you mind sharing with me your experiences with patient violence”</p>	<p>If there are several experiences ask participant to chose one that “sticks” in their mind the most to start, if they are more than one incident go through each separately.</p> <ul style="list-style-type: none"> i. What do you think are the causes or antecedents which lead up to the event? ii. What are the client’s diagnoses? iii. What time of day/night was it? iv. How many staff were you working with? Is this a typical staffing level? v. What happened during the event? vi. How did it end? vii. What were your feelings as this occurred and afterward? viii. How distressing did you find your experiences? <p>Probe: Compare theses to other incidences participant has described.</p>
<p>What impact did your experience have on you personally?</p>	<ul style="list-style-type: none"> i. What were the immediate impacts? ii. What were the longer term impacts? iii. What are the different impacts of verbal violence versus physical violence? iv. What impact did it have on carrying out your role as an RMN after the incident? <p>Probe: Compare these to other incidences participant</p>

	has described.
What practice strategies influence your current response (management) to patient violence ?	<ul style="list-style-type: none"> i. What personal factors influence your response to patient violence? ii. Probe for hospital policies, guidelines, unit forms, individuals training and strategies.
In your opinion, what unit and organisational strategies facilitate prevention of violence?	<ul style="list-style-type: none"> i. What do you as an individual do to stay safe and prevent violence ?What about the unit as a whole ?The organisation ii. What are the strategies that increase the risk of violence? iii. How confident do you feel in using these strategies? Probe: Compare responses and needs to various incidents described by participants.
What do nurses need from the unit and or organization for management of patient violent?	
What do nurses need from the unit following an incident of patient violence?	<ul style="list-style-type: none"> i. What support and follow up did you receive after your patient violence incident? ii. Was there anything you felt was necessary to support you that did not occur?

Authority Letter

APPENDIX C-AUDIT SHEET
MIDLANDS STATE UNIVERSITY

SUPERVISOR- STUDENT AUDIT SHEET

DATE	TOPIC DISCUSSED	COMMENT	STUDENT'S SIGNATURE	SUPERVISOR'S SIGNATURE
26/05/2017	Topic Approval	Proceed	S. MAMBENDE	
09/06/2017	Proposal	Corrections	S. MAMBENDE	
23/06/2017	Proposal Approval	Proceed	S. MAMBENDE	
02/07/2017	Chapter 1	Proceed	S. MAMBENDE	
07/07/2017	Chapter 2	Proceed	S. MAMBENDE	
12/07/2017	Chapter 3	Proceed	S. MAMBENDE	
27/07/2017	Approval of instrument	Proceed	S. MAMBENDE	
	Data collection	Proceed	S. MAMBENDE	
20/09/2017	Chapter 4	Corrections	S. MAMBENDE	
20/09/2017	Chapter 5	Proceed	S. MAMBENDE	
09/10/2017	First draft	Corrections	S. MAMBENDE	
18/10/2017	Final draft	Proceed	S. MAMBENDE	

STUDENT'S SIGNATURE

SUPERVISOR'S SIGNATURE

Turnit in originality report

APPENDIX E-MARKING GUIDE

NAME OF STUDENT: SHEILA MAMBENDERE NUMBER R141371Y

	ITEM	POSSIBLE SCORE	ACTUAL SCORE	COMMENTS
A	RESEARCH TOPIC AND ABSTRACT Clear and concise	5		
B	PRELIMINARY PAGES Title page, approval form, release form, dedications, acknowledgement, appendices, table of contents	5		
C	AUDIT SHEET/PROGRESSION	5		

	Clearly shown on the audit sheet			
D	CHAPTER 1 Background, statement of the problem, significance of the study, research questions, objectives, hypothesis, assumptions, purpose of the study, delimitations, limitations, definition of terms	10		
E	CHAPTER 2 Addresses major issues and concepts of the study, findings from previous work, relevance of literature to the study, identifies knowledge gap and subtopics	15		
F	CHAPTER 3 Appropriateness of design, target population, population sample, research tools, data collection procedures, presentation and analysis	15		
G	CHAPTER 4 Findings presented in a logical manner, tabular data properly summarised and not repeated in the text	15		
H	CHAPTER 5 Discussion (10) Must be a presentation of generalizations shown by results; how results and interpretations agree with existing and published literature, relates theory to practical implications. Conclusions (5) Ability to use findings to draw conclusions Recommendations (5)	20		
F	Overall presentation of dissertation	5		
G	References	5		
	Total	100		

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

.....

MODERATOR:.....SIGNATURE:.....

DATE:.....