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**Violence in the emergency department: an ethnographic
study**

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LISTS OF RELATED PUBLICATIONS AND PRESENTATIONS

RELATED PUBLICATIONS

Lau, B.C.J., Magarey, J., McCutcheon, H. (2005). Violence in the emergency department: a literature review. Australian Emergency Nursing Journal, 7(2), p 27-37.

Lau, B.C.J., Magarey, J. (2006). Review of research methods used to investigate violence in the emergency department. Accident and Emergency Nursing 14(2), p111-116.

RELATED PRESENTATIONS AT CONFERENCE

Conference: 1st National Emergency Nursing Conference, Glenelg, Adelaide, South Australia

Topic: 'Violence in the Emergency Department: a review of literature' (Oral presentation)

Date: 4 September 2004

Conference: International Emergency Nursing Conference, Coogee Beach, Sydney, NSW

Topic: Violence in the Emergency Department inevitable? An ethnographic study (Oral presentation)

Date: 13 October 2005

Conference: 7th International Interdisciplinary Conference: Advances in Qualitative
Methods, Surfers Paradise, Australia

Topic: Ethnography in Action: The dilemmas (Poster presentation)

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SCHOLARSHIP RECEIVED TO SUPPORT THIS RESEARCH

2003-2006 JS Barker Divisional Scholarships

STATEMENT OF ORIGINALITY

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference has been made in the text.

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Signed:

Bee Chuo Lau

Date

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ABSTRACT

Background Violence in the emergency department (ED) is a significant problem and it is increasing. Several studies have shown that violence in the ED is more likely to occur within the first hour of a patient's presentation. Therefore, it is possible that there are some indicators of violence observable during the initial nurse-patient/relative interaction at triage.

Nevertheless the problem remains inadequately investigated as many incidents are not reported and most studies that have investigated this issue are descriptive in nature. Although these studies have provided important preliminary information, they fail to reveal the complexities of the problem, in particular the cultural aspects of violence which are crucial for the ED.

Aims The main aims of this study were to explore the cultural aspects of violence in the ED and to determine the possible indicators of violence at triage.

Methodology Contemporary ethnography based on interpretive and post-positive paradigms was adopted to frame the methodology of this study.

Methods This study was carried out at a major metropolitan ED over three months. The data collection techniques included field observations, questionnaires and semi-structured interviews. The data analysis framework adopted for this study incorporated Spradley's (1980) and LeCompte and Schensul's (1999) approaches.

Findings The study indicated that the cultural meanings of violence were complex and highly subjective with variations among nurses which in turn influenced their responses to violence (e.g. reporting or not reporting an incident). The cultural meanings were sometimes contradictory and confusing as violence could be seen as both a challenge and a threat or predictable and unpredictable. The same type of behaviour from one individual could be perceived as violent but not for another.

Many nurses perceived that violence was unpredictable and inevitable but the study demonstrated that there were indicators of violence which could be used to predict and prevent the problem. Factors such as environment, conflicting messages regarding waiting time, and patients' expectations and needs played an important part in violence. Besides, there were immediate warning signs of violence such as the overt verbal (e.g. mumbling or shouting) and covert nonverbal signs (e.g. staring or agitation). This study showed that patients' behaviours for instance being unfriendly, not appreciative, inattentive and uncooperative were better predictors of violence in the ED than their traits or problems alone.

However, nurse-patient/relative behaviours and the resulting reciprocal relationship were considered central in determining if violence would occur or be avoided. Nurses' efforts to establish rapport with patients was crucial in minimising violence and needed to occur early. There was usually a 'turning point' that provided an opportunity for the nurse to avoid violence. Nurses' behaviours at the 'turning point' strongly influence the outcome. Nurses' awareness of their personal expectations, prejudices and ethnocentrism were the pivotal points in preventing escalation of violence.

Conclusion This study has provided a more comprehensive and sophisticated understanding of the cultural aspects of violence in the ED. While violence is a complex issue with many paradoxes, there are lessons to be learned. The study indicates that effective interpersonal empathetic communication has a significant role in reducing violence in the ED.

CHAPTER 1:

INTRODUCTION

Introduction

Violence toward nurses is a significant problem worldwide (Lavoie, Carter et al. 1988; Lyneham 2000; Meuleners, Lee et al. 2004; Rose 1997; Stirling, Higgins et al. 2001; Winstanley and Whittington 2004a) and it is increasing due to rising usage of recreational drugs and escalating violence in society generally (Fernandes, Raboud et al. 2002; Lyneham 2000; Sands 2007; Whelan 2008). Besides the physical and psychological impact on health professionals, violence also directly and indirectly affects the quality of patient care and satisfaction of patients. Inevitably, it also contributes to an escalation of health care costs (Arnetz and Arnetz 2001; Hinson and Shapiro 2003; Levin, Hewitt et al. 1998; Rippon 2000).

This problem has drawn considerable attention from both clinicians and researchers since the 1980s. Nevertheless it remains inadequately investigated because many incidents are not reported (Chapman and Styles 2006; Crilly, Chaboyer et al. 2004; Farrell, Bobrowski et al. 2006; Hills 2003; Hinson and Shapiro 2003; Jenkins, Rocke et al. 1998; Jones and Lyneham 2001; Keely 2002; Kennedy 2005; Lipscomb and Love 1992; O'Connell, Young et al. 2000; Rippon 2000; Rose 1997; Wells and Bowers 2002; Yassi 1994). According to the International Council of Nurses (ICN), 80% of violent incidents in health care are not reported (Anonymous 1999a). Lyneham (2000) indicated that in one Australian emergency department (ED) setting, 70% of nurses choose not to report their violent encounters. A retrospective study in a United Kingdom ED reported that 71% of verbal abuse was either not reported or was under reported by nurses (Pawlin 2008).

This chapter focuses on describing the context, research questions, purpose and significance of the thesis. The theoretical framework and assumptions underpinning the study will also be briefly highlighted.

Context of the study

Emergency nurses working at the frontline of health care encounter many different types of patients and relatives who present at the ED with diverse physical and emotional conditions. A cross-sectional descriptive study conducted by Ross-Adjie, Leslie and Gillman (2007) to collect data from Western Australian emergency departments found that violence toward nurses is the most significant workplace stressor.

Both verbal and physical violence are common and they can happen anywhere in the ED (Fernandes, Bouthillette et al. 1999; Rose 1997; Schnieden and Marren-Bell 1992). It is commonly perceived that long waiting time is one of the most significant factors contributing to violence in this setting (Jenkins, Rocke et al. 1998; Levin, Hewitt et al. 1998; Lyneham 2000; May and Grubbs 2002). However, several studies have shown that the majority of violent incidents in the ED occur at presentation or after less than one hour of patients' arrivals in the department (Brookes and Dunn 1997; Crilly, Chaboyer et al. 2004; Morgan and Steedman 1985). In view of this, further study is needed to investigate such a discrepancy. As violence in the ED occurs early (i.e. at presentation to the department), it is possible that there are some observable indicators of violence at triage.

Research questions

This study set out to answer the following questions:

- (a) How does culture or environment affect violence in the ED?
- (b) What are the indicators of violence at triage?
- (c) How do emergency nurses respond to violent incidents?
- (d) How do the patients and nurses involved in violent episodes perceive the incidents in the ED?
- (e) How does the nurse-patient intercultural communication impact on violence in the ED?

Purposes of the Study

Violence is a complex multidimensional problem with the behaviour of individuals is usually influenced by their system of beliefs and world view. In addition, it was considered that interactions between nurses and patients/relatives in the ED are strongly patterned by culture. Therefore, the purpose of this study was fundamentally concerned with examination and exploration of the cultural aspects of violence in the ED.

Significance of the study

Numerous reports have indicated that violence in the ED has an escalating physical, emotional and psychological impact on the ED staff (Levin, Hewitt et al. 1998; Rippon 2000). Staff who are under constant and prolonged exposure to inadequately handled violence may suffer long-term psychological damage, such as feelings of bewilderment (Cembrowicz and Shepherd 1992; Erickson and William-Evans 2000;

Helps 1997; Levin, Hewitt et al. 1998; Murray and Snyder 1991), anger, helplessness (Chambers 1998; Holden 1985), fear (Hislop and Melby 2003; Hoag-Apel 1998), burnout, loss of confidence (Fernandes, Bouthillette et al. 1999; Levin, Hewitt et al. 1998; Naismith 2000) and self blame (Needham, Adderhalden et al. 2005; Sommargren 1994).

In addition, a number of studies generally agree that health care workers may develop a more serious long-term psychological problem such as post-traumatic stress disorder (PTSD) symptoms from direct acts of violence (Flannery 1996; Gore-Felton, Gill et al. 1999; Lapos, Alden et al. 2003). According to Brookes (1997), staff working with a co-worker who is being abused by a patient may experience countertransference responses which are characterised by over-identification and hence avoid patients (Brookes 1997). Such over-identification and avoidance reactions may jeopardise the subsequent nurse-patient interactions. Consequently, patient violence affects not only staff members who experience the violence but also other staff who witnessed such incidents.

It is expected that patient violence can directly cause people to leave the profession and result in escalating health care costs (Fernandes, Bouthillette et al. 1999; Hinson and Shapiro 2003; Nabb 2000; Yassi 1994) associated with loss of productivity, increased workers' compensation premiums and medical expenses (Anonymous 1994b). One popular newspaper reported that 11% of nurses had left the profession and 25% were thinking of resigning due to violence (Ooi 2003). Thirty-six percent of the participants in Mayer, Smith and King's (1999) study reported knowing someone who resigned from their ED employment after victimisation.

Violence does not exclusively impact on health professionals but it may indirectly cause the deterioration of quality of care for the patient involved in the violent incident and other patients (Arnetz and Arnetz 2001; Fernandes, Bouthillette et al. 1999). It appears that this issue has not been investigated in the ED setting. For example, in a three-year study conducted by Arnetz and Arnetz (2001) in a mental hospital, it was reported that violence experienced by health care staff was associated with lower patient ratings of the quality of care. The study indicated that violence did impact not only on the well being of the health workers both personally and professionally, but also on the quality of care provided. Whittington and Wykes (1994b) also found that inadequate and problematic staff interaction occurred following an assault by a patient. Despite this, information regarding the impact of patient violence on the care and outcomes have not been studied thoroughly from patients' perspectives (Fazzone, Barloon et al. 2000; Hills 2003).

Besides, following an extensive review, it was evident that previous studies had failed to provide a thorough understanding of violence in the ED. This was because the descriptive nature of many studies which investigated the nature, prevalence and characteristics of violence failed to reveal the important relationships among various factors that precipitate violence, i.e. staff, patient and situational/environmental factors (Chapman and Styles 2006; Hinson and Shapiro 2003).

The literature search also revealed that surveys or questionnaires were commonly used to study violence in the ED. It appeared that there had been no study where ethnography had been used to investigate this problem. This may indicate that the

culturally pertinent issues and practices underlying violence in this setting have not been explored. Understanding cultural aspects of violence is crucial in order to provide meanings, contexts and management of violence which is of particular importance to the ED.

Theoretical framework

The theoretical framework fundamentally shapes the focuses, methods and techniques required for research (Laimputtong and Ezzy 2005). Contemporary ethnography based on interpretive and post-positive paradigms was adopted to provide the theoretical and conceptual framework for the organisation of fieldwork, analysis and conduct of this research. Based on the tenets of ethnography, this study involved three months of field observations, questionnaires and interviews.

The choice of ethnography for this study was done for a number of reasons. Firstly, as the focus on culture was the fundamental issue in this study - ethnography - ‘the work of describing culture’ (Spradley 1980, p.3) was the most appropriate approach. Secondly, ethnography enables a phenomenon such as violence in the ED to be studied in the contexts in which it occurs, therefore leading to a more realistic understanding of the problem. Thirdly, complex human responses (i.e. the nurse-patient/relative interactions at triage) can be fully appreciated through an ethnographic study because it provides a deep and rich understanding of people, which is impossible to do in other research traditions (Aamodt 1982; Baillie 1995; Laimputtong and Ezzy 2005). The other reason for employing ethnography was that ethnography is unique and flexible, and the cyclical and concurrent nature of data

collection and analysis process enable the contradictions in previous findings to be investigated (i.e. the relationship between duration of waiting and violence).

Assumptions of the study

The central assumption of this study was that the participants (i.e. patients/relatives and nurses) had a collective view of the world and the researcher shared the world as intimately as possible. This involved taking part in as many of their activities as possible through around-the-clock observations. The second assumption was direct participation in the participants' symbolic world. 'This often entails learning their language, their rules of etiquette, their eating habits, and their work patterns' (Denzin 1989, p.161). This assumption was not difficult to make as the researcher was an experienced emergency nurse who had learned the language and work routine in the ED.

Definition of terms

Violence

A clear and concrete definition of violence is the first step in targeting this problem. The definition of what constitutes a violent act varies from person to person, and among various groups and cultural settings. The lack of a comprehensive and consistent definition of violence has to some extent hampered efforts to address the problem (Lee and Renzetti 1993; Rippon 2000; Ryan and Maguire 2006). Volavka (1995) indicated that there is no perfect definition of violence because it has many causes, manifestations and impacts.

For the purpose of this study the definition of violence by the National Occupational Health and Safety Commission of Australia (NOHSC) has been adopted: ‘the attempted or actual exercise by a patient/relative of any force, so as to cause injury to a nurse including any threatening statement or behaviour which gives a nurse reasonable cause to believe that he or she is at physical or emotional risk’ (Anonymous 1999b). This definition incorporated the most important types of violence encountered in the ED (i.e. physical, verbal, and threats/intimidation) and they were specifically defined as follows:

Verbal violence

Verbal violence included any raising of tone and volume of verbal remark, verbal hostility (e.g. swearing, shouting), or being personally insulting (Whittington 1996).

Physical violence

Physical violence included any aggressive physical gesture, regardless of whether the target was a person or an object or whether an injury was sustained or not from punching, biting, spitting, hitting or scratching (Whittington 1996).

Threat/intimidation

Threat/intimidation included statements that indicated intention to harm (e.g. ‘*I’m going to get you*’) or menacing/threatening gesture (e.g. staring) (Winstanley and Whittington 2004a).

Culture

In this study, culture was defined as a set of beliefs, knowledge, and ideas people use to shape their life experiences or actions (de Laine 1997; LeCompte and Schensul 1999; LoBiondo-Wood and Haber 2002). However, this does not mean that everyone in a cultural group believes the same things or behaves in the same way because their attitudes, beliefs and behaviours vary depending on their ethnicity, gender, social class, educational levels and age. Furthermore, context is also important for understanding culture and therefore people are studied in their natural settings through intensive personal contact over a period of time (LoBiondo-Wood and Haber 2002).

Patient

The term ‘patient’ may imply ‘...a more traditional paternalistic relationship- one that emphasises the authority of the professional and the relative passivity of the patient’ (McGuire-Snieckus, McCabe and Priebe 2003, p.307) as compared to ‘client’ or ‘service-user’ which indicate a more ‘equal’ relationship. However, this was the word commonly used by the participants in this ethnographic study. Under the circumstances, it is important to acknowledge such negative connotation as the labelling of the phenomenon as ‘patient violence’ may imply that the ‘patient’ is solely responsible for a violent incident.

Outline of the thesis

Chapter One provides the background, research questions, purpose and justification for this study and provides an overview of the thesis.

Chapter Two presents the literature review, which begins with the discussion about the theories of violence. This will provide a broad perspective on the understanding of why violent incidents occur. The chapter will then focus on the prevalence, characteristics, risk factors, culture, management and prevention, and prediction that are of particular importance to the ED. In addition, perceptions of violence from nurses' and patients' perspectives will be highlighted. Such an in-depth review of literature identifies the problems and gaps in the existing knowledge, which further supports the purpose of this study.

Chapter Three describes the methodology of the study. The chapter begins with an understanding of the term 'ethnography'. The similarities and differences between traditional classical ethnography and contemporary ethnography will be highlighted. The philosophical principles underpinning this study and strategies that were used to promote the rigour of research methodology will also be illustrated.

Chapter Four concentrates on the study design. It includes the setting, data collection methods, and tools used in this thesis. Following these, ethical considerations of the study will be scrutinised. The main data collection techniques such as field observations, questionnaires, and semi-structured interviews will be elaborated. This chapter also provides a detailed description of the study's data analysis framework, which incorporated Spradley's (1980), and LeCompte and Schensul's (1999) approaches.

Chapter Five involves a detailed description of the study findings. A framework was developed to facilitate this description. It was organised into three main elements: 'problems and solutions', 'them and us' and 'requests and demands'.

Chapter Six discusses and integrates the findings with broader frameworks in order to identify the implications of the study. This chapter is divided into four major sections: (1) the cultural meaning of violence, (2) the context of violence, (3) violence within the broader framework of conflict management, and (4) value of communication and empathy.

Finally, Chapter Seven summarises the major findings of the study and their significance. The strengths and limitations of the study will be identified, followed by recommendations for future practice.

Summary

This chapter provided succinct background information about violence in order to set the scene for the study. The context, significance and justification for conducting the study have also been explained. The next chapter will review the current knowledge in the field, compare the findings from previous studies and identify the gaps in knowledge pertinent to the issues associated with violence.

CHAPTER 2:

LITERATURE REVIEW

Introduction

In this chapter, the theories, prevalence, characteristics, risk factors, management and prevention of violence most pertinent to the emergency department (ED) will be evaluated and elaborated. In particular cultural aspects of violence will be scrutinised. Moreover, health care professionals' perceptions of violence along with patients' perspectives will be appraised. Such an extensive review is crucial to understanding what has been done by previous scholars in the field, and to provide the context for this study. More importantly, it helps identify the gaps in existing knowledge concerning this phenomenon which can therefore be investigated in a more constructive manner.

The search for literature in electronic databases including CINAHL, MEDLINE and PsycINFO was conducted using the following key words such as 'violence', 'aggression', 'assault' and 'abuse' for the period from 1985 to 2006. However, additional relevant studies published from 2007-2009 are addressed in the discussion chapter.

Theories of violence

Theories of violence are concerned with the understanding of violent behaviour and designing interventions that address the causes. Several theories have been generated to explain violence, which is affected by multiple factors that may be biological, psychological, situational, interpersonal, and environmental in nature. The main

theories of violence presented in the literature are the biological, social learning and frustration-aggression theories (Mohr and Mohr 2001; Walter 1998).

Biological theory

According to this theory, violence can be viewed as an instinct; its natural purpose is self-preservation and it is an inherent response (Freud 1975; Lorenz 1950, 1958). Violence is viewed as a natural drive for hatred and destruction and is an unavoidable aspect of life that is embedded deeply within all humans (Mason 1998). The drive is usually suppressed. Freud (1975) also states that a state of perpetual violence can only be avoided if there is a balance between the instinct for life and the instinct for death. When the tension created by the death instinct is too high, it will result in an overtly violent attack in order to release the tension (Freud 1975).

From this perspective, violence is viewed as an instinctive and inherent response beyond active manipulation. However, it is debatable whether violence is purely instinctive in nature. Berkowitz (1962) asserts that there is virtually no empirical evidence to support such an instinctual view of violence and that few scholars have adopted such a stance.

On the other hand, contemporary scientists have put forward more sophisticated views of biological influences on violent behaviour. They proposed that some people are predisposed to violence as a result of their neurological, genetic and hormonal functioning (Bryant, Scott et al. 1984; Davidson, Putnam et al. 2000; Lauck 1991; Nesson 1998; Volavka 1999). For example, Miczek, Mirsky, Carey, DeBold and Raine (1994) had found that the limbic structures of the neurological system such as

the amygdala, hypothalamus, and septal area, as well as the cortex, contain networks of excitatory and inhibitory processes for different kinds of aggressive and defensive behaviour.

In addition, a number of studies have found that some violent offenders have brain dysfunction (e.g. temporal lobe epilepsy, brain tumours, Alzheimer's disease), which have resulted in unprovoked violent attacks (Bryant, Scott et al. 1984; Elst, Woermann et al. 2000; Halleck 1978; Lauck 1991; Pontius and LeMay 2003). For example, left-hemisphere brain dysfunction resulting from trauma or environmental toxins (e.g. maternal use of ethanol and illicit-drugs) can disrupt verbal comprehension and communication. In turn such a deficit can precipitate a violent encounter by individual misunderstanding of motives in an interpersonal encounter and failure to foresee the ultimate consequences of impulsive behaviour.

Behavioural genetic research has shown that genes influence individual differences in a wide range of human behaviour, including personality traits such as aggression and hostility (Plomin, DeFries et al. 1989). Additionally, the 'Y' chromosome may contribute to individual differences in male aggression (Carlier, Roubertoux et al. 1990). However, Miczek et al. (1994) argued that a genetic propensity toward violence is also likely to involve a substantial environmental variation and hence it is difficult to establish the strength of correlation between the genetic and violent behaviour.

Miczek et al. (1994) suggested that testosterone and its androgenic and estrogenic metabolites influence the probability of individual responses to aggressive

environmental events and stimuli. This mechanism appears to explain the differences in behaviour related to gender. However, Miczek et al. (1994) concluded that there is no simple relationship between hormones and violence, and it is the only one influence of many. As noted earlier, biological predisposition to violence is influenced by several factors (i.e. biological instinct, neurological dysfunction, genetic and hormonal factors). These factors in biological theory provide a basis for a medical approach in dealing with violence.

Social learning theory

Social learning theory denies that humans are instinctively aggressive. According to this theory, violence is learned and like other forms of social behaviour, it is subject to stimuli, reinforcement, and cognitive control (Bandura 1977a). For example, for an anxious person who had previously experienced a hostile encounter in an authoritative environment, the same environment may act as a stimulus provoking anger.

Bandura (1977a) also stated that modelling influences play an important role in the use of aggression and this is especially true if the behaviour is rewarded. For example, if a child's role model is a parent who uses violence to get needs met and does not suffer any serious consequences eventually the child will learn that violence is acceptable. Successful and unchallenged aggressive acts, according to Bandura (1977a), lead to further aggression. From this perspective, according to social learning theory, patients may continue to use violence because in the past it was effective in achieving their goals.

Frustration-aggression theory

The frustration-aggression model as set out by Dollard, Dobb, Miller, Mowrer and Sears (1939) posited that violence is a general response to frustration as a result of violation of important personal expectations and needs. The frustration-aggression model differs from biological theory in that aggression may be the result of instigators other than biological instincts.

According to Berkowitz (1989, 1990, 1993), frustration does not automatically invoke aggression and exposure to aggressive models (e.g. parents) does not always lead to expressed aggression. He found from his observation that people prevented from reaching a desired goal become aggressively inclined only when the interference is thought to be illegitimate or is viewed as a personal attack. Congruent with this theory is the common scenario of ED triage or waiting room area where patients become abusive to the triage nurse when they observe that someone who comes in after them is attended to first without any obvious legitimate reason. The delay in medical consultation may be seen as something unjustifiable or a bias.

Berkowitz (1989, 1990, 1993) also suggests that the magnitude of the expressed aggression is dependent on: the amplitude of the frustration, the individual's threshold for frustration, the amount of frustrating incidents, and the magnitude of the anticipated retaliation to one's expressed aggression, as well as the extent that they think that someone has intentionally and unfairly produced this interference. In addition, expectations of social disapproval and punishment can inhibit the display of an overtly violent behaviour.

Berkowitz (1989, 1990, 1993) also incorporated the principles of learning in the frustration-aggression theory. Based on his explanation, vented aggression results in a temporary feeling of relief followed by a feeling of satisfaction (i.e. 'completion tendency'). Continuous reinforcement of one's completion tendency will lead to a learned expectation to 'complete' each frustration-aggression cycle. This, however, is a vicious cycle; each completed cycle leads to a future expectation of the ability to vent one's frustrations.

All three theories attempt to achieve a plausible explanation for violence. The biological theory has a more important role in explaining the unprovoked violent incidents from individuals with organic or pathological problems (e.g. brain tumour). However, it seems that the social learning theory and frustration-aggression theory provide a considerably more compelling view and explanation of the majority of violent incidents in the ED.

Both theories seem to indicate that there is a possible trigger for aggressive behaviour and prevention is possible. They also seem to imply that violence is a vicious cycle and it is learned and reinforced through positive reward. This agrees with Stevenson's (1991) view that violence is part of a process. An increased understanding of the cycle of violence makes it possible to assess the immediate potential for violence in a given context and choose an appropriate strategy to deal with the situation before a 'full-blown' violent incident erupts.

Knowledge about various theories of violence is important to facilitate the understanding of why violent incidents occur and provide some insight into the

prevention and management of violence. However, these theories only provide a general explanation of the aetiology of violence without considering the complex interactions that occur during a violent incident in a given context. As a result, a more thorough cultural interpretation of issues that are specific to the ED setting is required.

The prevalence of violence

Estimating the prevalence of violence

Retrospective surveys have commonly been used to estimate the prevalence of violence in the ED. They involved asking the participants to report their experiences of violence in the past year. This approach depends on staff members' ability to recall past incidents and may result in bias due to the number of violent incidents being over or under-reported. Such bias is inherent in retrospective methods (Erickson and William-Evans 2000; Fernandes, Bouthillette et al. 1999; Mayer, Smith et al. 1999). However, it seems that there are no directly comparable retrospective and prospective studies available to evaluate such a claim.

Prospective surveys have also been widely used in the ED to determine the prevalence of violence (Brookes and Dunn 1997; Crilly, Chaboyer et al. 2004; Fernandes, Raboud et al. 2002; Morgan and Steedman 1985). The duration of these surveys differed among studies and ranged from 20 to 24 weeks. Prospective studies are more likely to provide a relatively accurate account of prevalence of violence than retrospective studies and it enables a comparison of prevalence of violence at various institutions. For example, a 5-month prospective study conducted by Crilly, Chaboyer and Creedy (2004) in Australia reported a prevalence rate of 0.2% or two

episodes of violence for every 1000 patients in the ED setting. The finding is consistent with another 25-week Australian study which estimated that the prevalence rate of violence in the ED was 0.28% or 2.8 cases per 1000 patients (Brookes and Dunn 1997).

Although much research has been conducted on the subject, unfortunately there is little consistency in terms of the types of violence investigated (Whittington 1997). This makes comparisons difficult, especially in regard to exact prevalence (Wells and Bowers 2002). Estimating the exact prevalence of violence is impossible due to: (1) the ambiguity of the term (i.e. violence), (2) the inconsistency of the methods used to investigate violence, (3) the wide variation in the way violence incidents are reported and recorded (Lanza 1992; Nolan, Dallender et al. 1999; Wells and Bowers 2002; Whittington 1997; Winstanley and Whittington 2002b), and (4) the under-reporting of violence (Crilly, Chaboyer et al. 2004; Hills 2003; Hinson and Shapiro 2003; O'Connell, Young et al. 2000; Rippon 2000; Rose 1997; Wells and Bowers 2002).

Even though it is difficult to estimate the exact prevalence of violence, in particular the ED, it is important to acknowledge that this is a critical problem requiring further investigation.

Comparison of prevalence across countries

The United States Emergency Nurses Association surveyed 4,500 ED nurse managers with the finding that 97% of respondents indicated that they suffered verbal abuse from patient, and 87% reported physical violence occurring more than

five times a year (Anonymous 1994a). Schnieden and Marren-Bell (1995) surveyed 300 ED nurses in London. They reported only nine percent of nurses had never encountered physical violence but less than three percent had never experienced verbal violence. Rose (1997) surveyed 27 nurses working in a large Irish ED and found that 60% had been physically abused at least once while working there. Clearly, the attempts to make direct comparisons of prevalence across countries are difficult as there are too many differing assumptions needing to be reconciled (e.g. such as the way violence is reported).

Ferns' (2005) systematic review of violence in international emergency departments suggested that there are some particular similarities and differences in terms of the nature of violence. According to this author, physical violence in North American EDs is more likely to involve weapons, compared to violence in British EDs. Nonetheless verbal violence occurs globally.

Comparison of prevalence across various settings

Psychiatric and emergency settings are widely considered to be high-risk areas for violence, with the incidence of nurses' exposure to violence ranging from 60% to 90% (Erickson and William-Evans 2000; Nolan, Dallender et al. 1999; Poster and Ryan 1989; Schnieden and Marren-Bell 1995). The comparison of prevalence of violence across settings is based on previous studies (Table 2.1). However, the results seem to provide conflicting evidence regarding this matter.

May and Grubbs' (2002) self-report survey compared the prevalence of violence in ED, intensive care unit (ICU) and general ward in a 770-bed acute care North Florida

medical centre. The ICU, ED and general ward area were represented by similar response rates (31.4%, 32.6% and 36% respectively). They reported that emergency department had the highest rate of violent incidents (i.e. verbal violence= 100%; physical violence = 82%) followed by intensive care unit (i.e. verbal violence= 85%; physical violence = 78%) and the general wards (i.e. verbal violence= 81%; physical violence = 63%) in the past year.

In contrast, Whittington, Shuttleworth, and Hill (1996) conducted a postal survey and interviews (N=53) to collect data in an attempt to estimate the prevalence of violence to staff in a general setting. They studied all the departments in a general hospital in the north-west of England and 343 staff responded. They concluded that 90% of the violence directed at staff occurred beyond the ED and that a large number of the general setting staff had suffered patient violence. They attributed the low rate of violent incidents in the ED to the ED staff reporting of such behaviour. They surmised that the incidents experienced by ED staff might be less likely to be classified as violent and, as a result, fewer experiences were reported. The disparity in the studies' results may stem from the different methodologies used. It should be noted that there was a major discrepancy in the response rates between departments (i.e. only nine ED staff responded to the survey compared to 78 and 64 responses from 'surgical' and 'medical' wards respectively).

Winstanley and Whittington's (2004a) retrospective study at a general hospital situated in the north-east of England may provide a more accurate picture of the prevalence of violence across departments. Three hundred and seventy-five staff responded to this survey with relatively similar response rates across departments,

ranging between 36% (medical wards) and 24% (surgical wards). They reported that medical staff (42%) were significantly ($p < 0.001$) more likely to be assaulted than surgical (36%) and ED (31%) staff in the preceding year. ED staff reported the highest incident of threatening behaviour (75%) and verbal violence (75%). Nonetheless, medical and surgical staff only experienced 39% and 26% of verbal violence respectively.

Study/Year	Methods	Prevalence	
		Physical violence	Verbal violence
May & Grubbs (2002)	Self-report survey of violence in the past year	ED=100% (n=28)	ED=82% (n=28)
		ICU=78% (n=27)	ICU=85% (n=27)
		General ward=63% (n=31)	General ward=81% (n=31)
Whittington, Shuttleworth & Hill (1996)	Postal survey of violence in the past year and interview	ED=67% (n=9)	ED=100% (n=9)
		Medical=39% (n=64)	Medical=64% (n=64)
		Surgical=18% (n=78)	Surgical=35% (n=78)
Winstanley & Whittington (2004a)	Postal survey of violence in the past year	ED=30.8% (n= unknown)	ED=75% (n= unknown)
		Medical=42.4% (n= 36)	Medical=38.8% (n= 36)
		Surgical=36% (n= 24)	Surgical=25.5% (n= 24)

Table 2.1: Comparison of prevalence of violence across settings

Characteristics of violence

Common types of violence

Having reviewed the prevalence of violence, it is crucial to acknowledge its characteristics in order to acquire a better understanding of this problem. Verbal and physical violence are both common in emergency departments (Fernandes, Bouthillette et al. 1999; Jenkins, Rocke et al. 1998; Lee 2001; Rose 1997; Schnieden

and Marren-Bell 1992, 1995). However, verbal is the most frequently reported in the ED (Brookes and Dunn 1997; Crilly, Chaboyer et al. 2004; Lyneham 2000; Ryan and Maguire 2006). Verbal violence in two studies (Keep 1997; Crilly, Chaboyer et al. 2004) was most often reported at triage area. Swearing and yelling are the most common forms of this violence in the ED. For example, in a five month prospective study carried out by Crilly, Chaboyer, and Creedy (2004) in the ED in south-east Queensland, Australia, verbal violence alone constituted more than half of the incidents.

Relationships between types of violence

When physical violence occurs, it is often accompanied by verbal violence. For instance, Crilly, Chaboyer, and Creedy's (2004) study reported that only one incident (i.e. four percent; one out of twenty-three cases) of physical violence occurred without concurrent verbal violence. Another study conducted by Brookes and Dunns (1997) of two EDs in Melbourne, Australia, also demonstrated such co-existence. However, their study noted that 39% (i.e. 19 out of 49 cases) of the physical violence was not accompanied by verbal violence. There was no data provided in regard to the percentage where verbal escalated to physical violence. Such findings may indicate that verbal violence is a warning sign for impending physical violence, although this is not always the case. Therefore, it may be important to handle verbal violence cautiously in order to prevent a 'full-blown' violent incident.

Time of incidents

Several studies have indicated that afternoon and evening shift are the time that most violent incidents occur in the ED. For example, Brookes and Dunn (1997) reported that violent incidents were highest (43%) between 1600 and 2400 hours. Crilly, Chaboyer, and Creedy (2004) also observed that violent incidents peaked (37%) between 1500 and 2300 hours. This strongly contrasts to the general ward and psychiatric settings where violent incidents are less likely to take place at night (Winstanley and Whittington 2002b).

Few studies have reported on the length of time between presentation of patient and the onset of violent behaviour in the ED (Brookes and Dunn 1997; Crilly, Chaboyer et al. 2004; Morgan and Steedman 1985). Brookes and Dunn (1997) found that 74% of violent incidents occurred within one hour of patients' arrivals. These results are consistent with a study by Crilly, Chaboyer, and Creedy (2004) who found that 67% of patients who exhibited violent behaviour had been in the department for less than one hour. Contrasting this, Winstanley and Whittington's (2002b) study in a ward setting had shown that 60% of incidents occurred within three days of admission. The above findings seem to suggest that violence in the ED is likely to occur in the first hour of patient presentation. Therefore, it is plausible that future research may be able to identify some observable antecedents of violence that can be identified early in the presentation (i.e. the first point of nurse-patient/relative contact at triage).

Patients/relatives' characteristics

Studies have shown that while the patient is the most common aggressor, relatives and visitors can also be involved in violent incidents (Crilly, Chaboyer et al. 2004;

Dalphond, Gessner et al. 2000; Graydon, Kasta et al. 1994; Jenkins, Roche et al. 1998; Ryan and Maguire 2006). Researchers have also reported that the majority of the ED patients involved in violent incidents are young males (Brookes and Dunn 1997; Kurlowicz 1990; Morgan and Steedman 1985; Stirling, Higgins et al. 2001). Morgan and Steedman (1985) reported that 40% of violent patients were aged between 16 and 25 years. Similarly, Brookes and Dunn (1997) also reported that 50% of violent incidents involved male patients under the age of 29. Conversely, in the general ward and psychiatric setting, violence is more likely to involve a patient aged more than 70 years (Winstanley and Whittington 2002b, 2004a).

Staff characteristics

According to an Australian Institute of Criminology report (Perrone 1999), registered nurses have the second highest rate of workplace violence, only second to police. Of the healthcare professions, nurses are at the greatest risk of patient violence (Fottrell 1980; Wells and Bowers 2002; Whittington, Shuttleworth et al. 1996; Winstanley and Whittington 2004a) with doctors experiencing fewer attacks or episodes. Daffern and Howells (2002) hypothesised that the reasons why nurses are at greater risk compared to their medical counterparts are related to the increased contact with patients, particularly problematic communication where nursing staff more frequently impose limits and enforce decisions. However, it seems that some of these studies did not consider the total number of staff from each category. The higher risk of patient violence for nurses may be simply due to their numbers.

Some studies revealed that staff with certain characteristics such as young age, inexperience, lean build and female are more prone to violent attacks (Arnetz, Arnetz

et al. 1996; Convey 1986; Crilly, Chaboyer et al. 2004; Dalphond, Gessner et al. 2000; Gudjonsson, Rabe-Hesketh et al. 2000; May and Grubbs 2002; Mayer, Smith et al. 1999; Poster 1996; Vanderslott 1998) whilst others take a different view on this issue (Gorden, Gorden et al. 1996; Shepherd and Lavender 1999; Winstanley and Whittington 2002b) and suggest that there is no correlation between staff characteristics and patient violence.

Studies of ED nurses indicates that nurses who experience violence tend to be in their mid-30s and are relatively experienced (Crilly, Chaboyer et al. 2004; Dalphond, Gessner et al. 2000; May and Grubbs 2002; Mayer, Smith et al. 1999). A controlled study by Whittington and Wykes (1994a) in two psychiatric hospitals found that there was a significant difference in relation to grade ($p < 0.05$) and age ($p < 0.001$). Compared with the control group, nurses in charge and in position of authority were nearly twice more likely to be assaulted and they had a lower mean age (i.e. 28.09 years). This may be explained by the fact that these nurses are more likely to handle violent incidents and enforce decisions than the less experienced or junior grade nurses. Although the findings in terms of age seem contradictory, it is actually hard to determine with any certainty as people may start their nursing career at a mature age; in 2004 the average age at graduation for registered nurses in the United States was 29.6 years (Anonymous 2004).

Apart from staff demographic characteristics, Ray and Subich (1998) have found that staff personality and behaviour also play a significant part in patient violence. Their study indicated that staff with a high level of trait anxiety, who were less authoritarian and who blamed patients for assaults were more likely to be assaulted.

This is not in accordance with Poster's (1996) finding that authoritarian staff were at greater risk of a violent attack by a patient. In view of the limited studies and conflicting results, it is difficult to obtain a clear picture about staff personality and behaviour, and further research is required.

Lee's (2001) study provides a more comprehensive view about this issue. She surveyed 130 staff and her study demonstrated that staff with a greater perceived ability to handle a violent situation, faced a lower rate of violent episodes. Greater self-efficacy in managing violent behaviour was observed in senior staff, and in staff who had experienced higher level of verbal violence (Lee 2001). It is possible that the senior staff had more experience in dealing with violence and, therefore, felt that they were more competent (Lee 2001). The higher level of verbal violence experienced by staff who had high self-efficacy could be attributed to increased willingness of these staff to approach verbally abusive patients, and subsequently head off this behaviour by using physical or chemical restraint (Lee 2001).

Risk factors related to violence

The understanding of risk factors related to violence is crucial for developing accurate and effective violence management and prevention strategies. It is imperative to acknowledge that some risk factors are specific to a particular setting. In view of this, a thorough investigation of risk factors specific to the ED setting is required. The risk factors commonly reported in the literature can be classified as intrinsic and extrinsic to the patient.

Intrinsic risk factors

The intrinsic risk factors are internal to or inherent in the patient. These include: (1) patient's demographic characteristics (e.g. young males), (2) disorientation and confusion due to drugs/alcohol used, psychiatric problems or neurological abnormalities (e.g. Alzheimer's disease and brain dysfunction), (3) pain, (4) frustration and anxiety, and (5) a previous history of violent attack (Brayley, Lange et al. 1994; Fitzsimmons 1991; Haller and Deluty 1988; Morgan and Steedman 1985; Nabb 2000; O'Connell, Young et al. 2000; Whittington and Wkyes 1996). A lack of understanding of the triage categories may also be considered an intrinsic risk factor for violence in the ED (Lyneham 2000).

Other possible intrinsic risk factors include patients' preconceived expectations and perceptions of the care they should receive. For example, it has been proposed that misconceptions held by the public about nursing and the nurses' extended roles have resulted in impossibly high expectations of nurses, which cannot possibly be met in the current economically stretched health care environment (Levin, Hewitt et al. 1998; Nabb 2000). These unmet needs and expectations may result in violent outbursts.

It is undeniable that the risk factors mentioned above have contributed to a considerable amount of violence toward nurses working in the general health care setting and the ED. However, Duxbury (2002) asserts that the predictive value of such risk factors has been called into question and the need for more investigations in this area is evident.

Anecdotal evidence in the ED suggests that the majority of violent incidents, especially the verbal ones, are not related to such distinct risk factors. Violent attacks quite commonly occur in 'normal' patients without disorientation, confusion, intoxication or severe mental problems. This could be linked to the way staff approach and interact with patients. To put it simply, 'drunk' patients may be perceived by staff as being threatening, and are therefore 'handled with care' whilst the potential for so-called normal patients to be violent is underestimated by staff. This supposition seems to be validated by the results of a study by Brookes and Dunn (1997) where patients with past or present history of drugs/alcohol abuse, prior history of violence or previous involuntary psychiatric admission were only implicated in 18% (14 out of 79 cases) of the violent incidents. However, such a finding does not provide information regarding the likelihood of these patients (i.e. patients with alcohol or psychiatric problem, or prior history of violence) to become violent because the ratio of these patients to 'normal' patients was not reported.

Extrinsic risk factors

While intrinsic risk factors are related to patients, extrinsic risk factors are external to patients and these include environmental, situational, and interactional factors. Environmental factors such as layout and function are possible risk factors associated with violence (Daffern, Mayer et al. 2004; Lanza 1988; Levin, Hewitt et al. 1998; Noble 1997). For example, a bank-like counter that the triage nurses stand behind may act as a physical barrier that evokes anger because it denotes lack of access to triage staff and disempowerment of patients. In addition, a lack of privacy during the patient-nurse conversation at triage due to the need to reveal personal issues in a public area may contribute to violence.

Situational factors such as long waiting-time, inability to obtain desired services, over-crowding, and lack of access to the information have been found to play a major part in escalating violence and this is of particular importance for the ED (Derlet and Richards 2000; Garnham 2001; Hinson and Shapiro 2003; Jones and Lyneham 2001; Lyneham 2000; Morrison 1999; Stirling, Higgins et al. 2001). Many studies have also implied that staffing levels such as inadequate nurse to patient ratio, staff shortage and cuts in the number of trained staff are contributors to the incidence of violence (Lanza and Kayne 1995; Lyneham, Cloughessy et al. 2008; Nabb 2000; Yassi 1994; Zernike and Sharpe 1998).

The finding about long waiting time for services is, however, not supported in studies by Crilly, Chaboyer and Creedy (2004), and Brookes and Dunn (1997) because the majority of the patients in their study became violent during the first hour of their presentation to the department. Such a revelation is important for health professionals as it may highlight that violence is not directly related to the quantity of waiting but the quality of waiting. The quality of waiting appears to be appreciated by patients following positive nurse-patient interactions.

Interactional risk factors include demanding, thwarting, provocative or intrusive behaviours from both patient and staff (Convey 1986; Emrich 1989; Finnema, Dassen et al. 1994). A coercive interactional style where staff provoke patients by acting in an over-controlling manner is a significant interactional factor as well (Morrison 1998). According to Levin, Hewitt and Misner's (1998) focus group (N= 22 ED nurses), approaching a patient in a respectful and confident way is important

in preventing violence. Such a finding seems to indicate that interactional factors (i.e. staff behaviour) have a significant role in violence.

Duxbury's (1999) study compared nurses (N=32) in mental health and general setting indicated that nurses mostly attributed violence outbursts from patients to intrinsic factors (e.g. individual patients' problems). Extrinsic factors - particularly the situational and interactional factors - were rarely referred to, reflecting a very one-sided view of the aggression response.

Lanza and Kayne (1995) stated that interactional factors are more valid predictors of violence than intrinsic factors alone. Unfortunately, at this time, there is a paucity of information on their influence across health care settings and it appears that the influence of interactional factors on violence has not been thoroughly analysed in the ED setting. Lanza and Kayne (1995) maintained that the obstacles in studying such interactional factors between patients and nurses are numerous and tedious. In particular, the variety of situations or factors in a nurse-patient encounter is complex.

Ranking of risk factors

Jenkins, Rocke, McNicholl and Hughes (1998) conducted a postal survey of 219 consultants working in 233 EDs. This study found that alcohol (98%), waiting times (86%), drugs (85%), patient expectation (82%) and staff attitude (55%) were regarded as significant precipitating factors for abusive behaviour.

A study conducted by May and Grubbs (2002) with subjects involving 86 nurses from three speciality groups (i.e. ICU, ED and general ward) indicated that: (1)

cognitive dysfunction (79.1%) such as head injury, dementia and developmental delay, (2) substance abuse (60.5%), and (3) anger related to long waiting times (55.8%) and hospital visiting policy (38.4%) were common factors contributing to violence in the ED. The difference between the two studies can be accounted for by participants' diverse backgrounds. Both studies had reports focusing on intrinsic patient and situational factors but only Jenkins et al.'s (Jenkins, Rocke et al. 1998) study pinpointed interactional factors as being important. It is possible that the consultants had less direct patient contact compared to the nurses and therefore they were more objective and critical in acknowledging the causal factors of violence.

Contributing culture

An understanding of risk factors for violence would be incomplete if the cultural context where the interaction between patients and nurses takes place is not explored. The culture of a workplace may also contribute to violence, but contemporary researchers rarely put any weight on such an inadequately defined issue. The following sections will concentrate on the three most pertinent cultural aspects that are important to understanding violence in a setting: organisational culture; culture of blaming; and culture of not reporting.

Organisational culture

As mentioned earlier, staff personality and behaviour have an important role in patient violence. Morrison (1990a) proposed that an organisation's culture influences the people working in it, which in turn influences their behaviour toward others. This has been validated by the studies in subsequent years.

Wright, Linde, Rau, Gayman and Viggiano (2003) conducted a written survey of 109 emergency nurses and concluded that their positive perceptions of organisational fairness and equity (e.g. compared with staff at other hospitals, I am paid fairly), and workgroup cooperation (e.g. when I face a difficult task, the people at the ED help me out) seem to cause them to have stronger empathy for people with psychiatric illnesses. On the other hand, role ambiguity was associated with lower levels of understanding and less frequent interaction with mental health patients. Such a finding is crucial as nurses in the ED regularly feel frustrated in providing care to patients with mental health issues (Mavundla 2000). Therefore, Wright et al.'s (2003) research demonstrated an indirect relationship between organisational culture and violence.

A study carried out by Morrison (1998) of 162 nursing staff from three hospital psychiatric settings found that the staff who worked in a less authoritative environment were more comfortable in their physical surroundings and less restrictive in their interactions with patients. Moreover, they perceived there was less violence than other staff who worked in a more authoritative environment. It is probable that in the more authoritative environment, staff may perceive a sense of duty to conform to the standards specified by the hospital when in reality it is not possible to achieve. They may feel inadequate and stressed, and consequently, these feelings may influence their interactions with patients/relatives in a negative way. These findings may have important implications for the ED as nurses are required to constantly juggle the demands of multiple tasks and work beyond their capacities.

Culture of blaming

In terms of causes of violence, anecdotal evidence suggests that a culture of blaming is common. Nurses often attribute its causes to intrinsic patient factors (e.g. drugs/alcohol use or psychiatric problems) as previously mentioned. The culture of blaming takes on two other forms: victim blaming (i.e. nurse-victim) and self-blame. For example, Baxter, Hafner and Holme (1992) surveyed 425 psychiatric nurses and reported that 70% of nurses believed that some staff invited violence. In Holden's (1985) study, 85% (n=264) of general nurses, including those working in the ED, indicated that the feeling of inadequacy with respect to managing violence undoubtedly contributed to a generalised feeling of self-doubt, in which nurses blamed themselves (i.e. self-blame) for the episodes.

Similarly, Lanza and Carifio (1991) assert that such a culture of blaming may increase the chance of violent episodes. This is because placing blame solely on individuals may mean there is a risk of ignoring other important factors precipitating violent episodes (e.g. interactional and environmental factors). However, Lanza and Carifio (1991) stated that a culture of blaming is seen as acceptable because by doing so staff can maintain the false belief that their work place is not inherently violent and, if violence does occur, it is the fault of the person assaulted. Even though some nurses may find it painful to blame themselves for the violence, they may prefer not to view the world as a place where undesirable events happen randomly for no reason (Wortman 1976). In other words, blame placement is determined by a need to feel a sense of control over the environment. From this point of view, although it is not always the case, it seems that a culture of blaming may not be exclusively problematic.

Culture of not reporting

As mentioned before the phenomenon of not reporting violent incidents is common in health care settings. Lyneham (2000) indicated that in one Australian ED setting, 70% of nurses chose not to report incidents of violence to the authorities. Various reasons have been given for this behaviour, which include: (1) the time and effort required to fill out incident reports, (2) lack of expected positive outcomes from reporting, (3) the view that violent behaviour is to be expected, (4) avoidance and denial of violence (Arnetz 1998), (5) toleration of minor incidents (Hills 2003), (6) a perception of performance failure (Poster 1996; Yassi 1994), (7) fear of retaliation and investigation (Zernike and Sharpe 1998), (8) individual embarrassment, and (9) the perceived conflict between the tenets of the caring role and the violence reporting behaviour (O'Connell, Young et al. 2000).

Researchers have also investigated the relationship between staff characteristics and their reporting behaviours. Erickson and Williams-Evans' (2000) study found that nurses who experienced a higher rate of patient assaults were less likely to report these than nurses who were assaulted less frequently. Such a finding implies that nurses are more likely to become desensitised with repeated exposure to violence. Patient violence is thus ultimately considered as inherent in the job and unavoidable (Erickson and William-Evans 2000).

However, Rose's (1997) study discovered that the likelihood of reporting increased with their length of service in the ED, in which case, 70% of those with ten years or more experience reported verbal abuse. It is reasonable to believe that senior staff

have more exposure to violence and if the explanation provided earlier is true, then, they should be more reluctant to report their encounters with violence. In view of this, further research is needed to clarify such confusion.

It is apparent that cultures such as an over-controlling organization, blaming and not-reporting do have a significant role in violent incidents and this indicated that there was a need to conduct an ethnographic study to examine and explore the cultural aspects of violence in order to gain a deeper understanding of the issues underpinning this phenomenon.

The management and prevention of violence

Micro management and prevention of violence

Generally, there are two major types of strategies used to manage violence in the hospitals: firstly, one that focuses on micro level (i.e. patients and staff levels); and secondly, another that concentrates on macro level (i.e. hospital-wide level). Management which targets patients includes preventive measures (e.g. observing the patient closely, taking detailed history, teaching patient appropriate ways to cope with stress, and effective verbal and non-verbal skills) and traditional methods (i.e. chemical and physical restraint, and seclusion) (Eriksson and Westrin 1995; Finnema, Dassen et al. 1994; Lowe, Wellman et al. 2003; Needham, Abderhalden et al. 2004; Wright, Gray et al. 2002).

However, some argue that these traditional methods are coercive (Eriksson and Westrin 1995) and may traumatise patients and others (Cannon, Sprivulis et al. 2001;

Cohen 1994). Traditional methods continue to be used and appear to be underpinned by biomedical models of care and the biological theory of violence. McDonnell and Jones (1999) also proposed that these short-term interventions may cause increased levels of staff stress and anxiety, and result in social distancing and reduced patient-staff contact, which in turn may indirectly cause more patient aggression. The increased levels of staff stress and anxiety may be related to the feeling of guilt toward patients in employing such extreme measures.

Micro management and prevention aimed at staff involves training in general skills (e.g. non-verbal and verbal skills) and stress management (e.g. relaxation, aerobic exercise, adaptive coping skills) for reducing the negative emotional impact related to working in high-demand environment (Flannery 1996; Lavoie, Carter et al. 1988). It also involves more specific skills training (e.g. employee-victim debriefing and formal counselling) to address the psychological sequelae of patient violence, and training in identification and recognition of pre-violent signs and symptoms as well as handling of violent patients (Flannery 2001; Murray and Snyder 1991; Saines 1997).

Evaluation of micro violence management and prevention strategies

Few studies have evaluated the effectiveness of micro violence management and prevention strategies, and the limited findings are contradictory. Although the duration of training programs varies from days to years, some studies indicate that the training programs that target violence management and prevention have a positive outcome (Paterson, Turnbull et al. 1992). For example, Paterson, Turnbull

and Aitken (1992) evaluated the impact of a 10-day in-service training program using a combination of questionnaire and video rated role-play. Their study reported that positive and significant changes on the knowledge and behaviour of participants were common. Likewise, a controlled study of health care workers conducted by Arnetz and Arnetz (2000) reported that a one-year structured feedback programme seemed to improve staff with knowledge, violence reporting behaviours and awareness of risks for violence in the intervention group.

In contrast, the results of several studies indicated adverse effects of education and training programs (Baxter, Hafner et al. 1992; Needham, Abderhalden et al. 2004; Nhiwatiwa 2003). For instance, a controlled study by Nhiwatiwa (2003) of 45 nurses working in the medium security settings found that nurses in the educational group who read the booklet on effects of trauma and coping, showed evidence of greater distress level at 3-month follow-up. According to Nhiwatiwa (2003), reading the material may have increased nurses' awareness of their symptoms.

Baxter, Hafner and Holme (1992) in their postal survey of 425 psychiatric nurses suggested that there were no significant differences between nurses who had attended an aggression management workshop and those who had not. Needham, Adderhalden, Halfens, Dassen, Houg and Fischer (2004) also found that there was no statistically significant reduction in violent incidents from a five days risk prediction and staff training program.

It is important to bear in mind that the above studies differed markedly in the methods used and target outcomes (staff knowledge, reporting of violence or

coping). Thus, a claim of effectiveness of violence educational programs may only be made from the comparison of two or more comparable studies.

Macro management and prevention of violence

The management and prevention of violence at macro level includes hospital-wide administrative (e.g. functional reporting system, effective security training, 24-hour on-site security) and environmental measures (e.g. security doors, security cameras, controlled access, metal detectors, protective acrylic windows and panic alarms) (Brayley, Lange et al. 1994; Grainger 1993; Hislop and Melby 2003; Kuhn 1999; Wright, Gray et al. 2002).

Evaluation of macro violence management and prevention strategies

Studies evaluating the macro management and prevention strategies have demonstrated variable outcomes. On one hand, Spar, Drummond and Hamilton (1988) reported that the introduction of an electronic flagging system for violence-prone patients, managed to significantly reduce the disruptive behaviour among this high-risk patient group. Such identification systems enable the earlier recognition of potential problematic interactions and therefore preventive measures can be implemented.

On the other hand, Rankins and Hendey's (1999) retrospective review of security records from 1992 to 1996 found that the implementation of a security system over a period of 54 months increased the likelihood of weapons confiscation at patient presentation, but did not decrease the number of violent incidents to a statistically

significant level. This study, however, did not compare the severity of staff injuries resulting from patient violence before and after the security system's implementation. The confiscation of weapons appears to reduce the severity of injuries sustained.

The effectiveness of macro violence management and prevention strategies may be better understood by comparing studies using similar methodologies. In view of the lack of comparable research on this theme, the effectiveness of macro violence management and prevention cannot be ascertained and therefore further investigations are required.

Prediction of violence

Nature of violence prediction

The ability to manage and prevent violence also depends on the credibility of violence prediction because if reliable cues predicting violence by patients can be identified, it may be possible to train the staff to recognise these cues and thereby preclude a violent outburst. Violence prediction in the ED setting has not been systematically investigated. However, various studies have highlighted that a previous history of violent attack is the most reliable predictor of a future attack (Hill and Petit 2000; Keely 2002; Lidz, Mulvey et al. 1993; Nolan, Dallender et al. 1999; Steinert 2002a; Tanke and Yesavage 1985; Zeiss, Tanke et al. 1996).

Accuracy of violence prediction

According to Steinert (2002a), the early studies of clinical prediction of violence were substantially flawed because they did not obtain predictions directly from clinicians. Predictors were indirectly derived via measures of violent behaviour using police arrests, committal hearings reports, or clinical records.

Some aspects of accuracy of violence prediction have been investigated in psychiatric settings. For example, Haim, Rabinowitz, Lereya and Fennoy (2002) compared the accuracy of violence prediction among professionals. They concluded that no significant differences emerged in the accuracy of predictions between the 14 psychiatrists and 9 psychiatric nurses.

Mossman (1994) compared the short- and long-term accuracy of violence prediction by clinicians for mental health patients. The study reported that short-term (1-7days) predictions were more accurate than long-term (> 7days) predictions. In view of the nature of nurse-patient interaction in the ED setting (i.e. patients only stay in the ED for a short period of time), such a finding may suggest that accurate prediction of violence in the setting is possible.

A prospective study conducted by Zernike and Sharpe (1998) in a general setting may indicate the possibility of violence prediction during the initial nurse-patient interaction. In their study, 68 incidents of aggression were reported over a five-month period. Among the 68 patients who became violent, twenty-six (38%) were identified by nursing staff as having the potential for violent behaviour on admission. Of these 26 patients, nine were identified in their medical charts as having prior

episodes of violence on previous admissions and ten patients had previous medical histories of psychiatric illness, dementia, alcohol abuse and overdose, which alerted nurses to the possibility of violent tendencies. The remaining seven patients were identified by staff as having the potential for aggressive behaviour based only on the nurses' professional judgement. No documentation as to the basis of their opinions accompanied the seven survey forms. It is possible that staff picked up some cues of violence during their initial interaction with patients on admission.

Neither of the above studies provided a specific or concrete explanation of how or on what grounds the predictions were formulated. A three-years retrospective study conducted by Tanke and Yesavage (1985) appears to provide a more specific or concrete validation of violence prediction. They investigated the accuracy of high-visibility and low-visibility violence prediction. Visibility was defined in term of verbal behaviour such as the patient engaged in verbal threats. They found that clinicians were fairly accurate in predicting the high-visibility or 'noisy' patients. On the other hand, the use of actuarial methods (i.e. objective methods through using instruments such as the Brief Psychiatric Rating Scale) may be particularly useful to predicting violence among low-visibility or 'quiet' patients.

In terms of ED setting, there is typically less substantial initial interaction between nurse and patient. This prevents nurses being fully aware of a patient's diagnosis and behaviours, and consequently, the prediction of violence in low-visibility or 'quiet' patients may not be easy.

Zeiss et al. (1996) proposed that knowledge about violence and its predictors in one setting cannot be generalised to other settings. Since most studies of violence prediction derive from mental health perspectives, it is reasonable to deduce that the predictors of violence in the ED may vary and therefore some knowledge about predictors from mental health settings should be applied with caution.

Perceptions of violence

Exploration of perceptions of violence may provide important information for designing acceptable management and preventive measures. According to Bahareethan and Shah (2000), an understanding and improvement in the perceptions of staff may help to reduce the occurrence of violence. Perceptions of violence from both health professionals and patients are important. However, most studies had been confined to the investigation of health care professionals alone, with the opinions and experiences of patients involved in violent incidents ignored. Such an approach is limited in providing an understanding of the complexity of cultural issues surrounding violence in the ED.

The following sections describe and evaluate the perceptions of violence from nurses' (i.e. psychiatric and ED nurses) and patients' point of view.

Nurses' perceptions of violence

Emergency nurses' perceptions of violence have been explored in several studies (Erickson and William-Evans 2000; Hislop and Melby 2003; Lyneham 1999; O'Connell, Young et al. 2000; Rose 1997). In a prospective survey conducted by

Erickson and William-Evans (2000), the majority of emergency nurses perceived that violence was ‘part of the job’ and many were reluctant to report the incidents. Hislop and Melby’s (2003) in-depth phenomenological study of 26 ED nurses reported that the majority of nurses had negative feelings and perceptions of violence. The major themes that emerged from this study were a sense of frustration and powerlessness, and isolation. After experiencing patient violence, all the informants felt a sense of frustration because they felt that the care they provided was not being appreciated.

This is similar to a retrospective descriptive study carried out by O’Connell, Young, Brooks, Hutchings, and Lofthouse (2000) in an Australian metropolitan teaching hospital. Their study reported that among the 400 randomly selected nurses, feelings of anger and frustration were most frequently reported after they experienced patient violence.

The feeling of loneliness and helplessness in facing a difficult and dangerous situation, and dissatisfaction with the support from administrative and managerial staff, had ultimately led to a sense of isolation. Disappointment with the lack of support and feedback from the administrators and legal system was also widely recognised in other studies (Hislop and Melby 2003; Rose 1997). It appears that emergency nurses’ perceptions of violence are primarily negative in nature.

Conversely, psychiatric nurses’ perceptions of violence have been studied extensively. The study of perceptions of violence from psychiatric nurses’ perspectives suggests a wide divergence of views compared to perceptions of ED

staff. Mental health nurses seem to consistently take control of the violent situations whilst general nurses tend to rely more upon other health workers to intervene.

In a study conducted by Finnema, Dassen, and Halfens (1994) in the Netherlands, 24 psychiatric nurses (ten male and fourteen female nurses) were interviewed. They reported that nurses perceived and described violence in different ways. The descriptions nurses used were not always negative. Most of the nurses acknowledged negative as well as positive aspects of violent behaviour by patients (e.g. violence is a way to express feeling, sending out a signal, the start of a more positive nurse-patient relationship, a way to get things done which would otherwise not have been done). Similarly, Abderhalden, Needham, Friendli, Poelmans and Dassen (2002) investigated 729 nurses in a psychiatric setting in Switzerland using the Perception of Aggression Scale (POAS) and reported that nurses did not perceived violence as only negative.

A survey conducted by Whittington and Higgins (2002) in mental health facilities in China and the UK using the POAS provided a different perspective in regard to this issue. The study indicated that positive views of violence were present amongst mental health nurses who were tolerant toward patient violence. The study also revealed that a sense of personal satisfaction and feeling in control at work was significantly associated with a tendency to perceive violence more positively. In other words, the acceptance and tolerance of patient violence was higher for nurses with these qualities.

Whittington's (2002) cross-sectional survey added to the above finding by indicating that tolerance for aggression was higher amongst more experienced mental health staff ($p < 0.01$) and higher tolerance was associated with less emotional exhaustion, less depersonalisation and high sense of personal accomplishment ($p < 0.01$). Perhaps the ability of staff to maintain a sense of patients' personhood and to empathize with their reasons for acting violently enables a more positive view of behaviour to be adopted. It may also be the result of a strong sense of self-efficacy drawn from numerous successful experiences in managing violent incidents (Whittington 2002). This sense of control enables them to view patient violence from a broader, more positive perspective than less experienced staff. However, this study could be criticised in that there were only low rates of participation from junior grade staff.

Patients' perceptions of violence

The patients' perspective is important in the accurate identification of the problem, subsequent development of preventive measures and promotion of effective approaches in both training initiatives and practice. Patients' perceptions of violence have been explored in a few studies (Evanczuk 1998; Lanza and Kayne 1995; Duxbury 2002) but not in the ED setting (Lee and Renzetti 1993; Rippon 2000). It is possible that this results from the difficulties in researching this issue in the setting. For example, following an incident, patients may experience a sense of guilt or fear of being branded as violent and this may then prevent them from giving their views. Ethical concerns that restrict access to vulnerable patient populations also compound difficulties in ascertaining the patients' perspective.

From a broader social policy perspective, such a gap in the literature regarding the ED patients' perspective may mean that there are important needs (e.g. availability of services such as shelters for homeless people, drug/alcohol related rehabilitation program) that have not been considered.

Evanczuk's (1988) phenomenological study described psychiatric inpatients' experience of being violent. The study involved three open-ended interviews for each of the six participants. Two main perceptions were found: firstly, for some it was seen as a part of their illness; and secondly, for others it was viewed as a normal reaction to a provocation (e.g. feeling of being unjustly singled out and treated unfairly). The former implied that even though patients were the cause of violent episodes, they felt they could not be held responsible because the cause was out of their control. The latter indicated clearly that the other party (i.e. nurses) were at fault. From their view point, patients viewed that they should not be blamed for behaving aggressively.

Comparison of nurses' and patients' perceptions of violence

Duxbury and Whittington's (2005) study indicated that there are differences between the views of staff and patients about causes of aggression and its management.

Lanza and Kayne (1995) conducted a study using closed-ended questions compared the perceptions of thirteen pairs of assaultive patients and staff victims regarding violent incidents (i.e. physical assault) in a psychiatric ward. They were asked to compare ten objective items (i.e. location, date, time of assault, number of people involved in the assault, and amount of contact the staff member had with the

patients) and eight subjective items (i.e. the staff members' role in relation to patient, their feelings toward each other, the precipitants to the assault, and preceding threats). For the objective items, there were six agreements and four disagreements between patients and staff. However, patients and staff provided different answers for all eight subjective items. Clearly, there was more similarity between patients' and staff's perceptions on objective or factual than subjective information about the assaults.

Duxbury (2002) and Ilkie-Lavalle and Grenyer (2003) found a clear distinction between the way staff and patients view both the problem and response. Patients viewed staff approaches as 'controlling' and believed that environmental factors and poor communication underpinned violent behaviour. Conversely, nursing staff did not believe that the way they interacted with patients was problematic or a cause of patient violence. In other words, extrinsic factors such as the environment, situational and interactional factors evidently underpinned the patients' perspective, while intrinsic factors such as patients' emotional, cognitive, and physiological conditions appeared to reflect more closely the staff perspective.

Duxbury's (1999) study confirmed that nurses mostly attributed violent outbursts from patients to intrinsic factors (e.g. a patient's illness, treatment induced confusion and pain), and situational and interactional factors were rarely referred to, reflecting a narrow view of the aggression response. Staff and patients' views about the violent encounters are at times contradictory and disparities such as this need to be investigated.

Summary

The literature review indicated that several gaps have been identified. Firstly, most studies that have been carried out to investigate violence in the ED are descriptive in nature. In other words, these studies have failed to reveal the important relationships among various factors that precipitate violence (i.e. nurses, patients and situation/environment) and the cultural aspects which are crucial to the understanding of violence in this setting. For such an interactive, multidimensional and culturally significant problem, it seems that an explanation and understanding could be better achieved through an ethnographic study.

Secondly, several studies have shown that violence in the ED is more likely to happen within the first hour of patients' presentations. Such a finding may indicate that there is a potential for exploring the indicators of violence at triage. Last but not least, in view of the lack of knowledge about this issue and the discrepancies in the views between patients and health professionals, an understanding of this problem from ED patients' perspective is necessary.

This chapter has described and discussed the various issues pertaining to violence in the ED. The next chapter will describe the methodology adopted for conducting this study.

CHAPTER 3: METHODOLOGY

'Methodology ought always to follow from the research question itself' (Bernard 1994, p.264)

Introduction

This study was mainly concerned with the creation of a descriptive and interpretive account of cultural aspects of violence in the emergency department (ED). Contemporary ethnography based on interpretive and post-positive paradigms was adopted to accomplish this task. This methodology was deemed appropriate because it facilitated a holistic view of the complex issues underpinning the cultural aspects of violence in the ED. The different types and philosophical assumptions underpinning ethnographic study are discussed in this chapter.

This chapter is divided into three major parts. Part one highlights the major characteristics of classical traditional and contemporary ethnography. Part two presents the essence of paradigms on which this ethnography was grounded, and describes and discusses the implications for paradigmatic triangulation. Part three examines issues of rigour in relation to this methodological approach.

Ethnography

Defining ethnography

Spradley (1980, p.3) indicated that ethnography is ‘the work of describing culture’ but who undertakes this work and how they proceed with their investigation is the subject of considerable debate (Adler and Adler 1987; Brink and Edgecombe 2003; Denzin and Lincoln 1998; Goetz and LeCompte 1984; Hammersley 1992; Muecke 1994; Pellatt 2003; Streubert and Carpenter 2003; Wolcott 1990). Like many research approaches, ethnography is not static in that over time and due to a variety of influences its character changes.

The theoretical frameworks of ethnography are informed by many orientations and traditions such as structural functionalism, symbolic interactionism, cultural and cognitive anthropology, feminism, critical theory and post-modern approaches (de Laine 1997). Clearly, defining ethnography is problematic and it is hard to specify the underlying paradigm because there are many contradictions in this methodology. The problem seems to be more apparent for novice researchers when they attempt to reconcile such contradictions. However, de Laine (1997) proposed that it is the combination of orientations and traditions that has made ethnography a well-established and common approach used in social and health science research (de Laine 1997).

Agar (1996, p.251) stated that ‘ethnography is a perspective that coexists with some contradictions - humanity and science, involvement and detachment, breadth and depth, subordination and domination, friend and stranger’. In addition, Hammersley and Atkinson (1995) highlighted that ethnography ranges from highly detailed

description to the development and testing of substantive theories. Clearly, ethnography is not a concrete entity but it is situated in a continuum of perspectives and approaches. For this reason it is unique and flexible, and therefore it is a suitable methodology for investigating a complex social phenomenon such as violence.

Classical traditional ethnography

Following an extensive literature search, it was evident that ethnography could be divided into classical traditional and contemporary ethnography. Classical traditional ethnography (CTE) is also known as traditional ethnography, anthropological oriented ethnography and conventional ethnography. CTE was originally developed by Western anthropologists to study the non-Western, non-literate cultures in remote regions of the world (Denzin and Lincoln 1998; Streubert and Carpenter 1999). It was characterised by investigation of a small, relatively homogenous population in a geographically bounded site; long-term residence of the researcher in the field; the use of participant observation, and a preoccupation with interpretive description and explanation of the culture, ways of life, and social structure of the groups under investigation (de Laine 1997; Goetz and LeCompte 1984; Streubert and Carpenter 1999). Such work is typically inductive, generative, and constructive (Goetz and LeCompte 1984). However, it has been regarded as too holistic, too culture-and-context oriented, and too time-consuming by researchers from disciplines outside anthropology (de Laine 1997; Wolcott 1990).

Thus a different approach for conducting ethnographic research has evolved. The approach is more focused and may be used by scholars from fields such as sociology, education, medicine and nursing to study health problems and social issues in

contemporary Western society. The new trend has been termed contemporary ethnography (Bernard 1994; de Laine 1997; Handwerker 2001; LeCompte and Schensul 1999).

Contemporary ethnography

Contemporary ethnography (CE) is essentially both pragmatic and adaptive. The reason CE has developed is that traditional ethnography was unable to meet the needs of researchers who investigated aspects of culture, where the questions being asked had a very different focus and scope than was previously the case. CE encompasses a number of terms including focused ethnography, problem-oriented ethnography, mini-ethnographies, rapid anthropological appraisal, quasi-ethnography, and quick ethnography (Bochner and Ellis 1996; Emerson 1987; Handwerker 2001; Lofland 1995; Porter and Ryan 1996; Wolcott 1990). These approaches differ in focus, scope and even their philosophical perspective.

Handwerker (2001) provided explanations for the evolution of CE. He explained that cultural diversity in the 21st century requires the abandonment of false assumptions that only specific groups have a given culture, and the notion that ethnography means only 'qualitative' research. Ethnographic research can be both qualitative and quantitative where triangulation of both types of data ensures validity and effective representation of the phenomena being measured (Denzin and Lincoln 1998; Savage 2000; Schensul, Schensul et al. 1999). Agar (1996, p.65) concurred that '...without science, we lost our credibility. Without humanity, we lost our ability to understand others'.

In addition, the need for speed arises in the contemporary society in dealing with complicated matters such as issues of human rights and the prevention of violence. Handwerker (2001) also indicated that the growing cost of field research means there is a demand for greater efficiency and productivity in ethnographic research. Agar (1996) and Dongen (2001) further added that competition from non-anthropological ethnographers has been a major threat to the CTE and the motivator for CE.

Bernard (1994) described contemporary ethnography as doing short-term fieldwork and getting on with the job of collecting data without spending months developing rapport, and going into a field situation with a list of specific questions to answer or perhaps a checklist to complete. This is quite a departure from CTE where much time is spent in the research setting to ensure a sufficient understanding of the culture in order for the researcher to 'participate' in a meaningful way. Bernard (1994) proposed that this short-term research is possible because the researcher already speaks the native language and has already picked up the nuances of etiquette from previous experience.

Common ground and contrasts for classical traditional and contemporary ethnography

The ontological nature of reality, the epistemological assumptions of what constitutes knowledge, the methodological practices by which knowledge is generated and the strategies through which knowledge is constructed, set the CTE and CE apart. Ontologically, traditional ethnographers adopt a 'pattern of behaviour' as the definition for culture and embrace the views that only a specific group can have a culture. The pattern, or as de Laine prefers, 'model *of* behaviour' refers to

‘observable phenomena of the social world, like social structure and social organisation, and patterns central to an understanding of an indigenous group or subculture, such as patterns of enculturation, religious practices, rituals and ceremonial behaviour, as well as economics and political relationships’ (de Laine 1997, p.104).

Conversely, contemporary ethnographers believe a pattern (or model) for behaviour to be the definition for culture. Model for behaviour is ‘...standards for deciding what is, standards for deciding what can be, standards for deciding how one feels about it, standards for deciding what to do about it, and standards for deciding how to go about doing it’ (Goodenough, cited in de Laine 1997, p.103). A ‘pattern for behaviour’ is considered to be a model for understanding behaviour (de Laine 1997). On the one hand, culture is used to define behaviour and on the other hand behaviour defines the culture.

Epistemologically, CTE and CE differ in what constitutes knowledge. Ethnographers who conduct CTE are usually naïve about a cultural group and need a long period of time to understand the cultural knowledge of the subject group. With the assistance of electronic and technological advances in contemporary society, or personal experience in the culture, contemporary ethnographers already have some level of knowledge and preconceived ideas about the group that they are going to explore, for example sociologists investigating nurses (Handwerker 2001).

Methodologically, traditional ethnographers believe in long periods of field work without obvious structure in their research, while contemporary ethnographers

engage in shorter periods of field work and have more structure in conducting their research. Thus, those who espouse the CTE approach seem to believe in the fluidity of research design, while contemporary ethnographers attempt to make explicit the ethnographic process and its contribution to the development of ethnographic methods. According to Wolcott (1990, p.52), in such a complex contemporary society, ‘...every qualitative researcher needs some structure or conceptual framework through which to view, record, and interpret social action’.

In addition, traditional ethnographers usually undertake participant observation, informal conversation with members from the culture and collection of cultural artefacts (i.e. the things cultural member shape or make from natural resources, e.g. educational material and clothing) as common data collection methods. On the other hand, contemporary ethnographers adopt a more structured method such as formal interviews and surveys to collect data in a more focused manner.

However, the focus on culture is the fundamental characteristic of all ethnographic research. Wolcott (1990, p.69) emphasises that ‘if cultural analysis is not your goal, then ethnography is a misnomer’. de Laine (1997, p.100) also stated that ‘virtually all anthropological fieldworkers seek to uncover a “latent underlying form” in society’. As the members of a society ‘live’ their culture, and are usually too integrated to analyse its structure and content, ethnographers interpret the taken-for-granted understandings or ‘tacit’ knowledge and assumptions of cultural members (Spradley 1979). In other words, ethnographers make explicit to outsiders what is implicit within a culture (Clayton and Thorne 2000). According to Bull (2002), the ‘tacit’

knowledge embedded in a culture can be inferred through the combination of observing what people do and listening to what they say.

Another similarity between CTE and CE is the researcher being a tool for data collection. Personal characteristics, experiences, cultural background, professional training and socialisation of the researcher do make a difference in fieldwork. All of these will have an influence on the assumptions made about the nature of reality and the choice of approach in an ethnographic study (Agar 1996; de Laine 1997; LeCompte and Schensul 1999). Therefore it is impossible to eliminate the influence of the observer on the data in ethnographic fieldwork (Agar 1996; Bernard 1994).

Although in both CTE and CE the researcher is a tool, for CE, the influence of an observer may differ because the pre-existing relationship with the cultural group may be much closer, for instance nurses doing ethnography in a hospital. In the case of nurses investigating nurses, some ethnographers believe that it is not appropriate for an insider to investigate their own group; they are too close (Baillie 1995; Morse 1989). Therefore it is difficult to separate the insider's perspective of the nurse and an outsider's perspective of the researcher. However, it could be argued that today (using a 'pattern for behaviour' model), as individuals we belong to and share many aspects of a number of cultures. Such proximity could be positive as there is less time needed for an insider to learn about the basic language, knowledge and meaning of a group's routine activities.

Ethnography in nursing

In nursing the CE approaches of ‘focused ethnography’ and ‘mini-ethnography’ which are narrow in focus, are more popular than CTE for the development of nursing knowledge and practice (Baillie 1995; Laugharne 1995; Leininger 1985; Muecke 1994). According to Boyle (1994), the purpose of conducting ethnography differs between anthropologists and nurse ethnographers. Nurse ethnographers employ this methodology to ‘improve cultural appropriateness of professional practice while anthropologists pursue ethnography to deepen understanding of a people’s social action’ (Muecke 1994, p.200).

Holloway and Wheeler (1996) elaborated that nurse ethnographers differ from other anthropologists, in that they only live with informants during their working day and spend their private lives away from the location of the study. In addition, nurses are familiar with the language and terminology used in the setting of their studies. DeSantis (1994) stated that in the nurse-patient interaction, at least three major cultures are implicated: the nurse’s professional culture, the patient’s culture and the context in which interaction occurs.

According to de Laine (1997), one of the problems for nurses doing ethnography is that professional nursing training which is focused on individual, may lead to some difficulty conceptualising the problem from a broader perspective. However, she also indicates that nurses have some characteristics (e.g. empathy, introspection and intuitive understanding) which are important in undertaking ethnographic research.

Ethnography is still a relatively new approach for nurse researchers, compared to other disciplines such as anthropology and sociology. Therefore, it is important for them to have a clear understanding of the major philosophical principles and issues concerning this methodology. In view of various forms of ethnography used in contemporary research, it is important to acknowledge that the focus on culture is the basic tenet of this research tradition.

Paradigms adopted for the study

The paradigm or world view underpinning a study is important to the overall structure, goals and methodology of the study (Monti and Tingen 1999). As stated in the previous chapter, interpretive and post-positive paradigms were the overarching theoretical and philosophical frameworks underlying this study. The following sections describe and discuss interpretive and post-positive paradigms, and the major criticisms attached to these perspectives. Following these, explanations on the triangulation between these two paradigms will be given.

Interpretive paradigm

Those who espouse the interpretive paradigm uphold the position of relativism. The ontological stance of interpretive approaches is that reality is gained through construction of the reality of those individuals participating in the research. The reality is complex, context-dependent, and multiple interpretations of reality are possible (Monti and Tingen 1999; Polit and Hungler 1999). Besides the observable verbal and non-verbal behaviour, the interpretive paradigm also takes researchers' intuition or tacit knowledge into account (Hardy 1997; Lincoln and Cuba 1985).

Epistemologically, the interpretive paradigm upholds that reality is best explored when the researcher has prolonged participation in the life and activities, and engages in personal interactions with those being studied (de Laine 1997; LeCompte and Priessle 1993). The methods of data collection commonly adopted are in-depth interviews and participant observations. Interpretivists are more concerned than post-positivists with understanding the meanings those involved give to social interactions. The interpretive researcher attempts to derive his or her construct from the field by an in-depth examination through exposure to the phenomenon of interest. In other words, interaction between the researcher and participant is necessary for discovery the meaning of these experiences. Through this approach, categories and themes that emerge are closely linked to the experiences of the study's participants.

The adoption of an interpretive perspective enabled the understanding of the meanings and contexts of violence in the ED. Interpretive approaches gave the research greater scope to address issues of influence and impact. In this study, the use of interviews and field observations to some degree were founded on this principle. The interpretive element of the investigation was designed to elicit a deeper understanding of the cultural group (i.e. ED nurses and patients/relatives).

The major criticism of the interpretive approach has arisen from the issue of lack of rigour or credibility (Ferguson 1993; Koch and Harrington 1998; Monti and Tinggen 1999) because some argue that 'it is merely an assembly of anecdote and personal impressions, strongly subject to researcher bias...' (Mays and Pope 1995, p.109). It is also widely argued that the data which interpretivists use is a product of their

participation in the field and the constructed reality is in and through the process of analysis by the researchers (Monti and Tingen 1999). Such problems with rigor also originate from the lack of focused variables or structure in framing the commencement and completion of fieldwork (Hammersley 1992). For this reason the post-positive approach was incorporated to counteract such criticism.

Post-positive paradigm

Empiricists or positivists seek objectivity in their pursuit of knowledge and they assume that there is one reality which transcends the individual perspective that can be studied precisely through measurement of variables and hypothesis testing (Crossan 2003; Monti and Tingen 1999; Polit and Hungler 1999; Wildemuth 1993). It is concerned with generalisation of findings from a representative sample to a stated population (Crossan 2003; Monti and Tingen 1999; Polit and Hungler 1999; Wildemuth 1993). Positivists commonly employ highly controlled and structured forms of data collection such as survey and experimental research.

On the other hand, post-positivism - a modern form of positivism – ‘provides an alternative to the traditions and foundations of positivism for conducting disciplined inquiry’ (Crossan 2003, p.52). Post-positivists uphold the position of realists. They maintain that objective knowledge of a natural and social phenomenon can be obtained (Crossan 2003; Monti and Tingen 1999). Using this approach, the study findings are not totally independent of a researcher’s perceptions. This aspect is indeed a surprising resemblance between interpretive and post-positive paradigms. In other words, post-positivists believe that ‘reality is constructed and that research is influenced by the value of investigators’ (Onwuegbuzie 2002, p.520). However, at

the same time, they also believe that ‘...reasonably stable relationships among social phenomena prevail’ (Onwuegbuzie 2002, p.520). The methods of data collection commonly adopted are surveys, interviews and observations.

The major criticism of post-positivism or positivism stems from the lack of means to study participants and their behaviours in an in-depth manner, and the important contexts that influence a given situation (Crossan 2003; Hammersley 1992). However, the criticism that ‘excessive control produces an artificial situation that bears no resemblance to reality and thus decreases generalizability’ (Monti and Tinggen 1999, p.70) for empirical studies is not so profound for the post-positive approach.

According to the post-positive position, it was believed that some observable characteristics and indicators of violence can be discovered. However, such a position alone might not be adequate because it does not acknowledge the holistic issues underpinning cultural aspects of violence in the ED, in particular the complex relationships among various factors that precipitate violence (i.e. nurse, patient and situation/environment). In response to these, it was believed that paradigmatic triangulation between interpretive and post-positive paradigms, which were compatible with the tenets of ethnography would be a pragmatic solution. A diagram for such paradigmatic triangulation (Figure 3.1) was developed to provide a better conceptualisation of the study methodology.

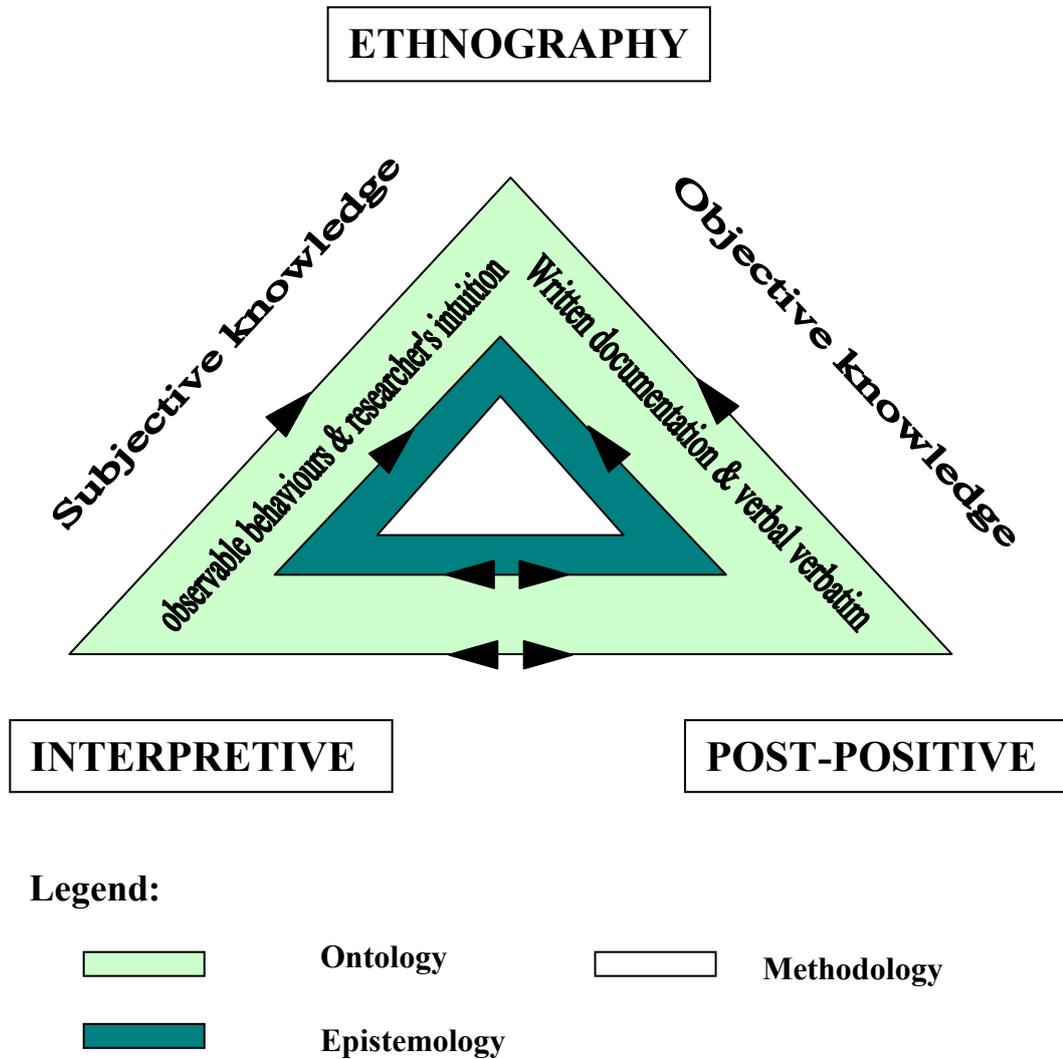


Figure 3.1: Paradigmatic triangulation underpinning the study

Ethnography and triangulation

Triangulation is a particular feature of ethnographic research (Agar 1996; Baillie 1995). Triangulation was originally described by navigators and surveyors to demonstrate how two known visible points were used to find the location of a third

point by forming a triangle (Thurmond 2001). In this study, triangulation was used to enhance the completeness of data collection and interpretation of findings. Triangulation enabled a more comprehensive understanding of issues related to the cultural aspects of violence in the ED. There were two types of triangulation underpinning this study: paradigmatic and method triangulation.

Even though ethnographers' theoretical perspective on a culture is situated in a synthesis of several paradigms, the use of paradigmatic triangulation is seldom made transparent in ethnographic writing. Method triangulation, which involves more than one method to collect data, is one of the widely recognised features of ethnography.

Paradigmatic triangulation

Onwuegbuzie (2002) indicated that such paradigmatic triangulation is feasible as there is no clear dichotomy between interpretive and post-positive paradigms, rather these philosophies lie on an epistemological continuum. Combining interpretive and post-positive paradigms can be effective because each paradigm can contribute to the understanding by addressing different aspects of research questions (Monti and Tingen 1999; Wildemuth 1993). Thus any inherent weakness stemming from the work within a single paradigm may be avoided, and the plausibility and cogency of research can be improved. Munroe and Munroe (1994, p.255) stated that '...field-based observational studies have their greatest value when they combine quantification with traditional ethnographic inquiry and when they are, at the same time, organised directly around a specific research question.'

Under such paradigmatic triangulation (see Figure 3.1), ontologically, the study upheld the view of dual realities where some of the objective knowledge about cultural aspects of violence in the ED is socially constructed and it could be achieved through systematic data collection such as questionnaires. In addition, the nature of reality such as the interaction between nurse and patient/relative during violent incidents was complex, context dependent and multiple interpretations of the reality were possible. Therefore, a deeper understanding could be reached through observations and interviews.

Epistemologically, paradigmatic triangulation had resulted in perceptions of staff and patients (either written or verbal accounts) being accepted as knowledge. The knowledge also derived from the observable verbal and non-verbal behaviours in the field, and the researcher's intuition. In other words, information about the cultural aspects of violence was obtained from surveying, interviewing and observing the staff and patients/relatives in the ED, and the researcher's field participation.

Methodologically, knowledge about the cultural aspects of violence in the ED was gained through a design that enabled the capturing or documenting of data from conversations between nurses and patients, and the observations of interactions among nurses, patients, environment/situations and researcher (see Figure 4.2). The next chapter will discuss this design in greater detail.

Implications of paradigmatic triangulation

Paradigmatic triangulation retains the post-positivist element of objectivity or substantiation of theoretical claims with valid data, while also acknowledging the difficulty in verifying the value-laden qualities of human interactions. Integrating the two (i.e. interpretive and post-positive) created a design that addressed internal and external validity. External and internal validity will be explained later in this chapter.

The post-positive approach addressed the objective knowledge and quantifiable issues (for instance patterns and prevalence of violence). The interpretive approach, meanwhile, mainly dealt with the subjective knowledge in the form of contextual issues (e.g. how and why violence occurred in a given situation) underpinning the cultural aspects of violence in the ED.

Methods triangulation

In this study, the methods triangulation involved the collection of data using more than one method to address the different dimensions of a topic, such as observations, interviews and questionnaires. This method of data collection is consistent with ethnography as Schensul, Schensul and LeCompte (1999) indicated that the collection of ethnographic data involves a continuum depending on the purpose of the research. Methods triangulation provides confirmation and completeness (Schensul, Schensul et al. 1999). It allows the researcher to capture a more complete, holistic and contextual portrayal and reveal the various dimensions of a given phenomenon.

Implications of method triangulation

In this study the field observations and interviews allowed the factors such as verbal and non-verbal human interaction (i.e. nurses and patients/relatives) and situations/environment, which had a role in violence, to be scrutinised. The descriptive part of the study based on the post-positive viewpoint consisted of a prospective survey: the 'violent incident questionnaire' (Appendix 1).

The questionnaires were not only able to provide a more accurate assessment of the nature of violence in the ED, but also contributed to an understanding of valuable characteristics that had been associated with violence. Interviews and questionnaires were necessary to check inherently ethnocentric observations. In other words, semi-structured interviews and questionnaires validated and completed the data from observations.

Rigour of ethnographic study

There has been much debate associated with how the interpretive study such as ethnography can be evaluated or judged. Some suggest that an ethnographic study should be judged using the same criteria as quantitative studies on the grounds that these are the criteria by which all scientific work should be judged (Goetz and LeCompte 1984; Mackenzie 1994; Schensul, Schensul et al. 1999). Long and Johnson (2000, p.30) further explain that '...there is nothing to be gained from the use of alternative terms which, on analysis, often prove to be identical to the traditional terms of reliability and validity'. For example, according to Rolfe (2006, p.305), 'credibility corresponds roughly with the positivist concept of internal

validity; transferability, which is a form of external validity'; dependability, which relates more to internal reliability.

The goals for interpretive research are different and therefore they cannot be judged using the same criteria and they should be evaluated using criteria that are tailor made for interpretive studies (Baillie 1995; Clayton and Thorne 2000; de Laine 1997; Hammersley 1992; Koch and Harrington 1998; Laimputtong and Ezzy 2005). This is because the philosophies underpinning and issues at stake for qualitative and quantitative research are different (Koch and Harrington 1998). Sandelowski (1993, p.2) argued that 'the quality of qualitative research should not be linked to 'truth' or 'value', but rather to 'trustworthiness' which become a matter of persuasion whereby the scientist is viewed as having made those practices visible and, therefore, auditable'. She refers to this process of auditability as 'leaving a decision trail' so that the reader would be able to track and verify the research process.

However, there is disagreement about what the appropriate criteria are since there is no unified body of theory, methodology or method that can be collectively described as qualitative research (Hammersley 1992; Rolfe 2006). For example, member checking (i.e. returning to the participants following data analysis) and peer checking (i.e. using a panel of experts or an experienced colleague to re-analysed some of the data) are viewed as important tools in demonstrating credibility in qualitative research by some but problematic for others (Bloor 1983; Sandelowski 1993).

Bloor (1983) stated that participants who are not trained in the field can be naïve about the concepts researchers use to make sense of interpretation and their views are

provisional, contingent and subject to change over time. Sandelowski (1993) argued that if reality is assumed to be ‘multiple and constructed’, then we should not expect either an expert researcher or respondents to arrive at the same themes and categories as the researcher.

Although this study was primarily interpretive in nature, there were also some elements of investigation that were quantitative. The assessment of rigour therefore should take into account both the interpretive and post-positive aspects of the study.

External and internal validity (credibility)

Considering the interpretive and post-positive paradigms underpinning the methodology of this study, it is important to acknowledge that violence in the ED is mainly context and setting dependent. According to Goetz and LeCompte (1984) and LeCompte and Schensul (1999), some ethnographers argued that the goals of ethnography are descriptive and generative, rather than verificative. Consequently, the ability to claim external validity (i.e. the degree to which such findings can be generalised) was not the goal for this study and the findings of this study might be limited to the ED with a similar culture (Goetz and LeCompte 1984). Hence, only the internal validity or credibility (i.e. the extent to which findings are authentic representations of some reality) will be discussed in the following paragraphs.

According to Goetz and LeCompte (1984) and Schensul, Schensul and LeCompte (1999), internal validity or credibility is the major strength of ethnographic work. They explain that this becomes evident when ethnography is compared to quantitative research designs such as experimentation to assess internal validity. This

is because some of the social constructs such as violent behaviour cannot be reproduced authentically in the experimental setting.

Goetz and LeCompte (1984) and Schensul, Schensul and LeCompte (1999) assert that the claim of ethnography to have a high internal validity or credibility derives from data collection and analysis techniques used. Ethnography commonly involves prolonged periods of data collection and incorporation of multiple data collection techniques. The triangulated nature of the study contributed to its rigour and validity of the findings. Data analysis begins as soon as data collection commences and this allows for refinement in data collection. Field observation, the ethnographer's key source of data collection, is conducted in natural settings enabling reflection of the reality of the life experiences of participants more accurately than research conducted in laboratory settings (Goetz and LeCompte 1984).

According to Goetz and LeCompte (1984) and LeCompte and Schensul (1999), there are many sources of threats to the internal validity or credibility (Table 3.1). Lincoln and Guba (1985) indicated that prolonged engagement and persistent observation in the field are the major strategies used to counteract such threats. It is widely debated that the presence of researchers in the cultural scene inevitably affects the participants' behaviour.

However, this may be of less important after repeated engagement with study participants and long hours of observation, because the study participants may become less sensitive to the presence of the researcher in the field and they may become more natural in their responses. In other words, prolonged engagement in the

field may desensitise the study participants. For example, in this study, after a period of time, some participants commented that ‘...*you* (the researcher) *have become part of the furniture*’ (Field notes on 6 June 2004, p.114: L19-20). Persistent observation in the field can therefore facilitate a thorough search and refinement of constructs or facilitate access to a wide range of actions and interactions that can promote an in-depth understanding of a reality (Goetz and LeCompte 1984; Lincoln and Guba 1985).

Lincoln and Guba (1985), and de Laine (1997) also indicated that triangulation is another strategy for evaluating internal validity or credibility of ethnographic studies. In this study the use of paradigmatic (i.e. interpretive and post-positive) and methods triangulation were believed to improve the probability that findings and interpretations of the study were credible.

Many researchers indicate that the inclusion of a reflexive account is a way to increase the plausibility of ethnographic work (Hammersley and Atkinson 1995; Koch and Harrington 1998; Manias and Street 2001; Pellatt 2003; Tham 2003). ‘Reflexivity involves the researcher intimately interacting with texts to make sense of their meaning’ (Manias and Street 2001, p.239). This can be achieved through the awareness of researcher effect on the phenomena observed (Tham 2003; Williams 1993) and self-critique (Marcus 1994) as well as the exposure of all phases of the research activity to continual questioning and re-evaluation (Goetz and LeCompte 1984).

Various strategies facilitated the production of a reflexive account for this study. These included the documentation of decision-making, perceived biases, preconceived ideas of the setting and participants, and feelings of researcher and participants in the journal after field observations and interviews. For example, ‘...*I (researcher) feel that he (triage nurse) is seeing violence as personal inadequacy. He is very conscious about my presence at triage...*’ (Field notes on 15 May 2004, p.4: L22-23) and ‘...*I am worried about becoming biased through my intense interaction with the staff in the ED...*’ (Field notes on 18 May 2004, p.12: L17-18). Such self-critique and awareness were important in helping the researcher to maintain a certain degree of objectivity by providing the context in which data were collected.

The strategies used to promote internal validity or credibility of the study are outlined in the following table.

Issues	Research strategies used
Observer effects; participants can withhold information, what they say and do may be different	Prolonged and persistent observation in the field to enhance participant comfort and trust. Awareness of factors that affect participant behaviour (e.g. gender of researcher, sensitivity of the incidents involved). Collecting data of different types and multiple sources other than direct observation.
Selection and regression effects; some component of the population/setting/data may be omitted from the study	Prolonged and persistent observation in the field. Observing at different times of the day. Remain open-minded in the observations and interpretations. Constantly search for conflicting evidence such as through the identification of ‘negative case’. Incorporating multiple data collection strategies; methods triangulation.
Researcher bias; being ethnocentric	Obtaining verbatim account from participants. Providing rich excerpts in text; let the data speak for itself. Taking systematic and detailed field notes and recording discrepancies among observations. Using key informants (i.e. triage nurses) to verify observations. Engaging in self-critique; providing reflexive accounts of the observations and interviews. Transcribing interviews. Providing an explicit framework for data analysis. Comparing and contrasting results or findings over time and with previous findings.

Table 3.1 Issues and strategies used to promote internal validity or credibility***External and internal reliability (dependability)***

External reliability addresses the issue of whether an independent researcher generates the same constructs in the same or similar settings (Goetz and LeCompte 1984). Internal reliability or dependability refers to the degree to which other researchers, given a set of previously generated constructs, would match them with the data in the same way as did the original researcher (Goetz and LeCompte 1984).

According to Schensul, Schensul and LeCompte (1999), the intention to duplicate the findings (external reliability) is of less concern to ethnography. It is more concerned with the ability for other ethnographers to approximate the research process (i.e. internal reliability) instead of the research findings.

Lecompte and Schensul (1999) and Jacobson (1991) indicated that an ethnographic study's reliability can be enhanced through a few strategies. The recognition of a researcher's roles and levels of participation are important to determine the quantity and quality of information obtained throughout the study (Jacobson 1991). In addition, careful selection of participants, and cautious and meticulous delineation of details (e.g. the physical, social, and interpersonal contexts) within which data are collected and analysed, are also critical to ensuring the external reliability of a study (Goetz and LeCompte 1984). The details of a researcher's roles and levels of participation, selection of participants, and methods of data collection and analysis will be explained in the next chapter.

Internal reliability or dependability focuses on the ability for other researchers to approximate the research process and it can be enhanced through explicit identification of the philosophical and theoretical assumptions, and definition of constructs that inform and shape the choice of study (Goetz and LeCompte 1984).

Approximation of research processes by other researchers can also be achieved through the decision trail (Lincoln and Guba 1985; Sandelowski 1993; Koch 2006). This refers to the provision of information on the sequences and logic of decisions made (e.g. the origin of interest in the topic, reasons for selecting and recruiting certain informants, strategies used to collect and record data, and social and physical contexts within which data has been collected) (de Laine 1997). All this information is made available in this ethnography.

In this study, internal reliability or dependability was also enhanced through low-inference descriptors and immediate recording of data after each observation (Table 3.2). Verbatim accounts of participant conversations, descriptions phrased as concretely and precisely as possible from field notes or recording of observations constituted the principal evidence for assessing this ethnographic study.

The strategies used to ensure the internal reliability or dependability of this study are displayed in Table 3.2 below.

Data collection methods	Rigour enhancing strategies
Field observations	Providing adequate definition of important terms (e.g. violence). Choosing key informant (i.e. triage nurses) and representative activities to help to develop the categories and themes. Recording exactly and immediately after the observations. Providing a reflexive account of the observations.
Interviews	Selecting a comfortable and private environment for interviewing participants. Avoiding being judgmental. Avoiding leading or bias questions. Recording the feelings of participant and researcher after interviews in the 'interview guide' (Appendix 8 and 9).
Questionnaires	Choosing appropriate language in the question according to the ED context. Providing adequate definition of the terms (e.g. physical, verbal, and threat/intimidation). Providing space for alternative answers. Asking succinct and clear questions to save time in answering the questions. Verifying missing answer with the participants when possible (e.g. during the interviews).

Table 3.2: Strategies used to ensure internal reliability or dependability

Summary

Ethnography provides a holistic and in-depth understanding about complex interaction between people (i.e. nurses and patients/relatives) and their behaviours (i.e. violence), the contexts in which the behaviour occurs, and this in turn offers a better way to manage and prevent the behaviour. For this research, it was considered that contemporary ethnography based on interpretive and post-positive paradigms was the most appropriate methodology for exploring the cultural aspects of violence in the ED.

This chapter began with a discussion about CTE and CE. It was then followed by the description of philosophical principles underpinning this research. The final aspect addressed the issue of rigour in this study. The detailed step-by-step procedures for conducting this study are the focus of the following chapter.

CHAPTER 4:

RESEARCH METHODS

Introduction

The purpose of this chapter is to describe the research methods employed in the study. The methods were designed to provide a comprehensive picture about the cultural aspects of violence in the emergency department (ED). Three months of fieldwork was conducted at a metropolitan public ED. As mentioned in the previous chapter, ethnography based on interpretive and post-positive paradigms is the theoretical framework underpinning this study. The principle data collection techniques used in this study were observations, questionnaires, and interviews.

This chapter is divided into two parts. Part one presents the research setting, identification of participants, ethical considerations and data collection methods. Part two discusses the method of data analysis.

Research setting

This study was carried out at a 650 bed tertiary hospital Emergency Department in South Australia. The ED had approximately 55,000 patient attendances per year and it is the major trauma centre in the region. The reasons for choosing this particular study site were because it was the largest metropolitan hospital in the state with a broad spectrum of patients. In addition, the researcher had worked in this hospital so it was easy to access the setting.

Participants

Identification of participants

In this ethnographic study, everyone in the ED was involved to a certain degree. No active procedure was used to select the participants except a purposive sampling technique plan that recruited participants for formal interviews. Only nurses and patients involved in a violent incident were invited to participate in the formal interviews. Purposive sampling was deemed useful for identifying the perceptions of patients and nurses who were involved in the same violent episodes.

The number of interview participants depended on the number of violent incidents, which was difficult to estimate since there had been no formal study conducted on the prevalence of violence in the particular ED. In addition, the findings from previous studies in other EDs could not be generalised for a number of reasons: (1) the geographical location of the ED, (2) nature and number of population attending the ED, and (3) nurses' violence reporting behaviour. Furthermore, the number of participants was also determined by the willingness of patients and nurses to participate.

Inclusion and exclusion criteria

In this study, the inclusion and exclusion criteria mainly focused on patients and nurses in the ED (Tables 4.1 and 4.2). Although there were no patients involved in interviews, the provision of its planned inclusion and exclusion criteria is important for the completeness of understanding the research methods.

PATIENTS	Criteria	
	Inclusion	Exclusion
<i>Observations</i>	<p>Patients older than 18 years old (legal age for independent decision-making)</p>	<p>Priority I patients with presenting symptoms that warranted immediate transfer to an acute or resuscitation area for medical attention (The interactions between nurse and priority I patients were not available for observation in the triage room).</p> <p>Patients experiencing episodes of severe psychosis, hysteria, and profound agitation for whom immediate measures, such as chemical and physical restraint was required (the interactions between nurse and this type of patients were not commonly available for observation in the triage room. If a patient was removed to the resuscitation, treatment or admission area for any of the above reasons, they were excluded from observation on the basis of cognitive impairment. Thus the cognitive status of potential participants was assessed subjectively, rather than an objective method such as mini-mental state examination which was neither practical nor appropriate.</p>
<i>Interviews</i>	<p>Older than 18 years old (legal age for independent decision-making)</p> <p>Living in Adelaide (in order to minimise costs)</p> <p>English speaking (use of translation services is expensive and beyond the resources of the study)</p> <p>Patient who had a violent incident questionnaire completed by a nurse</p> <p>Patients who consented to being interviewed</p>	<p>Patients who were not available for telephone interview (e.g. patients who were admitted into hospital)</p> <p>Patient who did not have access to a telephone</p>

Table 4.1: Inclusion and exclusion criteria for patients

NURSES	Criteria	
	Inclusion	Exclusion
<i>Observations</i>	Nurses who performed triage at triage desk	Triage nurses who refused to be observed
<i>Questionnaires and interviews</i>	Nurses who cared for a patient during a violent episode and who consented to participate	Nurses who refused to participate

Table 4.2: Inclusion and exclusion criteria for nurses**Gaining access**

The researcher did not work in the setting where the study was carried out. There was a continual effort by the researcher to create an identity for herself in order to become familiar and accepted by those being studied. This enabled her to gain additional data through questioning and observation.

According to Laimputtong and Ezzy (2005), gaining access to a cultural scene will not guarantee the success of a research study if good rapport with informants is missing. They suggested that the researcher can facilitate entry by being sincere and reassuring staff about the purpose of the study. As Schensul, Schensul and LeCompte (1999, p.75) have written, ‘The researcher’s appearance, use of language (including humour), perceived comfort level, growing knowledge of the setting, and reactions to difficult or challenging new situations are all important in building the personal relationships that mark the entry process in ethnography’.

In this study, entry into the cultural scene was facilitated by good rapport with the Clinical Nurse Consultant, Nurse Manager and nurses in the ED, and distribution of information about the study. Generally, gaining entry into the cultural scene was not problematic. While some nurses appeared to be self-conscious and suspicious of the researcher especially during the early stage of study, they were willing to be observed. This was evident by the defensive statement nurses expressed in the interviews such as ‘...I haven’t done anything wrong, you know; I didn’t approach

her aggressively...there was no inappropriate behaviour on my part that I have to change... (Interview with Nurse 19, p.97: L33-34; p.98: L1-2).

This may also indicate that they thought their performance was being judged and evaluated. The researcher did not react to such a statement because it is normal (i.e. human nature) to feel that way. It was believed that such a response would diminish after informants realised that the researcher was not there to judge their behaviours.

Some nurses were also sceptical about the study's usefulness. For example, one nurses remarked, '*...previous people (other researchers) did not achieve what they set out to do; nothing had changed...the study was not being published... what can you do for us now?*' (Field notes on 15 May 2004, p.4: L15-17). In view of such scepticism, the researcher was careful to explain to nurses the reason for this study in order to avoid further disappointment. However, there is an obligation to present at conferences and publish the results. Consequently, the findings of this study were presented and published in conferences and journals at international and national levels.

At the initial stage of research, it was very difficult to maintain a neutral interaction with patients/relatives because of the researcher's professional nursing training. This could potentially affect the observations of nurse-patient/relative interactions. For instance, the eye contact that the researcher initiated with the patient/relatives might have possibly moved the interaction in a positive direction or to the opposite side. A sense of guilt and uneasiness was very likely to prevail when the researcher became aware of patients/relatives dissatisfaction and was not allowed to intervene.

Moreover, the situation could put the researcher in a difficult dilemma when the patients/relatives at times had some requests such as letting them into the department without attention from triage nurses.

Ethical considerations

Permission was granted by the Medical Head and the Clinical Nurse Consultant of the ED prior to submission of the research proposal to the appropriate ethics committee for approval. (The letter of approval is provided in Appendix 2). Prior to the commencement of this study, information sheets (Appendix 3) regarding the study were distributed to the ED nurses. Posters (Appendix 4) were placed at various locations (i.e. triage room, waiting area, staff tea-room, treatment and admission area) to inform patients and staff about the study. Furthermore, two information sessions were held in the ED to notify nurses about the nature and purpose of the study.

Communicating this study's rationale was not a once-and-for-all declaration. The reasons were explained each time the researcher first met a nurse. This is important ethically because anyone who participates in a study deserves an explanation.

Prior to the commencement of each observation, nurses involved in triage would be informed of the observation. Throughout the study period, no staff member at triage refused to be observed. If they had done so the observation would not have taken place for that shift. An information sheet (Appendix 3) was attached with the violent incident questionnaire, but nurses involved in a violent incident could choose to

complete the form or not. A written consent (Appendix 5) from nurses was obtained before the taped-interview with them took place.

Information sheets (Appendix 3) were given to all patients by triage nurses to inform them about the study. Consent from patients and relatives was not obtained prior to the observation of nurse-patient/relative interaction at triage. The National Health and Medical Research Council (NHMRC) guideline has stated that ‘...obtaining consent would interfere with the strength of the “naturalist” approach of ethnography. Seeking consent from participants in these situations may lead to behavioural changes that would invalidate the research’. Furthermore ‘...it is ethically acceptable to conduct certain types of research without obtaining consent from participants in some circumstances, for example...observational research in public places...’ (Anonymous 2003b, p.E130).

Patients could refuse permission for the initial phone contact by completing the refusal form (Appendix 6). As stated in the pamphlet they had three days to submit this form. This opt-out method had been chosen to ensure the maximum number of participants. The telephone interview would only take place after patients gave their verbal consent over the phone and this would be audiotaped. If desired, the tapes would be returned to the participants or destroyed. If the patient was still emotionally upset about the incident, the patient would be asked if he or she wanted to stop the interview and talk to the patient adviser in the hospital.

A yellow sticker with the word ‘observer’ was worn by the researcher throughout the study to remind the study participants of the researcher’s role and identity. This was

important because when the researcher became more integrated in the field setting, the participants might forget that she was collecting data. Since the researcher was not in uniform, it could be argued that this was not always the case.

Confidentiality and anonymity was maintained at all times throughout the study. Participants' names were removed and an individual number was allocated to each of them. Participants and the institution involved were and will not be identified. No information that may identify an individual will be retained. The findings from this study were presented and published at conferences and journals without any identifiable source. The raw data collected has been stored in a locked cupboard and will be located at the Discipline of Nursing of the University of Adelaide for seven years.

Data collection methods

The evolving and constructive nature of ethnographic methods with progressive data collection and data analysis is widely recognised (Goetz and LeCompte 1984; Spradley 1980). In this study, ethnographic techniques employed were: observations, questionnaires and interviews (i.e. informal interviews for triage nurses, nurses, doctors, clerks and security officers and formal interviews for nurses and patients involved in a violent incident. None of the patients involved were recruited for a formal interview in this study).

Observation

Nature of observations

The goal of the observations was to systematically observe and record the interactions that any other observer would perceive. There were two major foci of observation in this study: firstly, the unstructured observation of the overall environment in the ED; and secondly, structured observation of nurse-patient/relative interactions at triage. The unstructured observation also included the recording of the number of patients in various locations (i.e. treatment, admission, resuscitation and seclusion area), the number of people in waiting rooms and the presence of security officer/s. This was made at least once during each observation.

For this study, the structured observation of nurse-patient/relative interactions at triage constituted the major part of the observation. During such observation, the researcher did not ask triage nurses or patients questions because that would potentially jeopardise the naturalistic approach by influencing the interaction between them (Adler and Adler 1994). The researcher stood behind the triage desk (see Appendix 7 for the layout of the cultural scene) during the observation without interrupting the interaction between nurse-patient/relative. The researcher only spoke to the nurses to verify some of the observations after they had finished triaging the patients.

As the interactions between nurses and patients/relatives at triage counter were often very short (i.e. less than one minute), the ability to record would have been severely compromised if the researcher attempted to write and observe simultaneously. In addition, if the recordings were postponed to a later stage, it was possible that some

important observations would be lost. In view of this, the initial observations of the interaction between triage nurses and patients were guided by the draft tool; ‘Guide for observations’ (Appendix 8). The draft listed general descriptors of observable variables (i.e. patients/relatives’ and nurses’ behaviours, and situational/environmental factors). This guide was informed by the researcher’s previous experience as a nurse in the ED and the literature (Brookes and Dunn 1997; Hinson and Shapiro 2003; Jenkins, Rocke et al. 1998; Lyneham 2000; May and Grubbs 2002; Mayer, Smith et al. 1999; Rose 1997; Stirling, Higgins et al. 2001; Winstanley and Whittington 2002b).

However, after a few pilot observations it became clear that the draft tool was too general and lacked focus on specific observable behaviours (e.g. eye contact, nodding of head, greetings, saying things like ‘thank you’ or ‘sorry’ and the participants’ posture). Therefore a more appropriate and concrete guide was constructed (Appendix 9). The revised observation guide focused more on the specific observable behaviours during the initial interaction.

All the unstructured and structured observation details together with a reflexive account were systematically typed and saved in a MS Word document immediately after each fieldwork episode.

Duration of observations

In planning for this research, three months of observation was allocated (from 15 May till 15 August 2004). The decision for a three month study period was influenced by previous studies in the ED (Brookes and Dunn 1997; Crilly, Chaboyer

et al. 2004; Fernandes, Raboud et al. 2002; Morgan and Steedman 1985) where on average, 20 hours of observation per week was conducted. A total of 242.5 hours of observation were conducted. The minimum duration of each observation was half an hour and the maximum duration was five and half hours with a mean of two hours.

The duration for each observation was primarily influenced by two factors: the levels of activity in the ED and inevitably, the convenience for the researcher. The duration of each observation was extended when: (1) the department was busy, (2) there was a long waiting time in the ED, (3) there were more patients with psychiatric problems, and (4) there were presentation of patients with violence alert on the computer system. The decision to extend observation duration when there were more patients with mental health issues was difficult as it may infer a bias. Nevertheless, as discussed in the literature review chapter, nurses assert that intrinsic factors such as patients' cognition play an important role in violence and it is crucial to observe how nurses react to these patients.

The time to begin each observation was informed by several factors. Firstly, anecdotal evidence suggests that violence was more likely to occur during 'peak hour' (i.e. 1300-2400 hours) where there were more patients in the ED and early morning (i.e. three-hour period between midnight and 3am) when the staff-patient ratio was higher. Attendance data from the hospital ED confirmed that peak attendance was 1300 to 2300 hours daily (Figure 4.1).

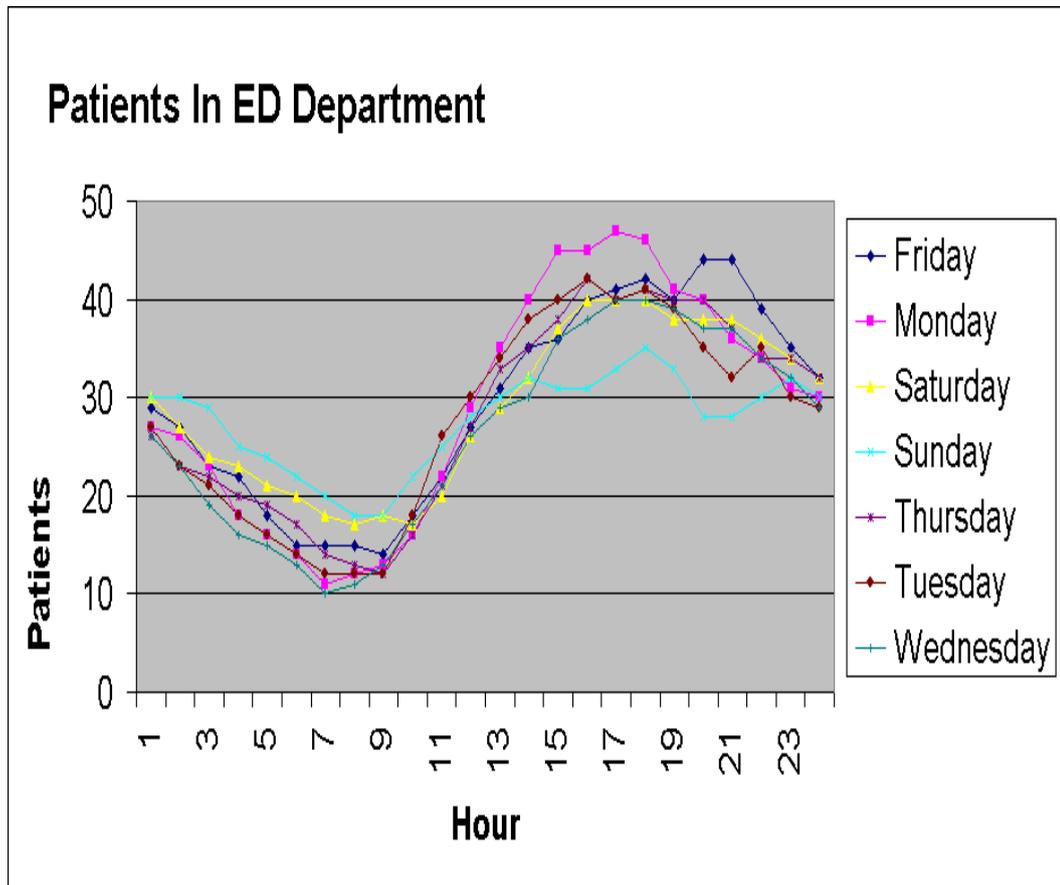


Figure 4.1: Attendance of patients in the proposed hospital ED

Secondly, findings from previous studies indicated that the highest number of violent incidents are reported between 1500 and 2400 hours (Brookes and Dunn 1997; Crilly, Chaboyer et al. 2004). However, it should be noted that observations were not strictly restricted to ‘peak times’. Around-the-clock observations were conducted in order to have a comprehensive picture about the cultural aspects of violence in the ED. For this study the majority of observations were conducted between midday and midnight.

Definition and philosophy underpinning observation

Observation is the most commonly used research method in ethnographic enquiry and although it varies in the levels of such participation, it is usually regarded as participant observation (Goetz and LeCompte 1984; Spradley 1980). Examination of the literature revealed that there was a lack of consensus with regard to the boundary and scope of participant observation. For example, Denzin (1989) described it as a field technique involving a combination of various strategies, namely document analysis, interviewing of respondents, direct participation and observation, and introspection which operates simultaneously.

However, Atkinson and Hammersley (1998) argue that participant observation is not a field technique, but a mode of physical presentation of the researcher in the world of respondents. They state that participant and non-participant refers to active and passive participation of observer in the field respectively. The participant observer plays a significant role while the non-participant observer plays no recognised role (Atkinson and Hammersley 1998).

Some disagree with such a division as they argued that all social research is a form of participant observation because we cannot study the social world without being part of it and in social situations, interactions are impossible to avoid (Atkinson and Hammersley 1998; Goetz and LeCompte 1984). For example, in this study, even though the theoretical tradition underlying the observations was based on its naturalistic and non-interventionism principle (i.e. the researcher neither manipulates nor stimulates the participants in the study and did not wear a nursing uniform at the cultural scene), she still acquired a role when she interacted with participants, for

example patients/relatives who at times approached her for enquiries such as directions.

Types of observations

This study adopted three types of observation described by Spradley (1980): descriptive, focused and selected observation. Descriptive observation was the first and most important type of observation. It involved asking general questions to record as much as possible of a social situation, for instance what are the activities of triage nurses?.

During focused observation the researcher made new observations and collected additional data regarding a domain. The meaning of domain will be explained later in this chapter. Focused observation involved the asking of structural questions, which made use of the semantic relationship of a domain with the cover term, for example what are **all** the places for triaging patients?.

During selective observation, the researcher collected further observations to refine the data. Contrast questions, which are based on the differences and similarities that exist among the terms in each domain were asked, such as how are all the places for triaging patients **different**?. More examples of structural and contrast questions will be provided in the 'data analysis' section.

Questionnaires

A questionnaire was used to document violent incidents. The questionnaire (Appendix 1) was developed by combining information from previous studies, anecdotal evidence and the literature (Brookes and Dunn 1997; Hinson and Shapiro 2003; Jenkins, Rocke et al. 1998; Lyneham 2000; May and Grubbs 2002; Mayer, Smith et al. 1999; Rose 1997; Stirling, Higgins et al. 2001; Winstanley and Whittington 2002b). One hundred and three questionnaires were completed by nurses throughout the three months study period. The questionnaire consisted of ten questions (i.e. nature, who was involved, type of referral to the ED, duration between patient presentation and occurrence of violent incident, warning signs, severity of injuries, contributory factors, response to violence, and action required). It also contained nursing staff's descriptions of details of the incident. Spaces were provided for answers other than those specified in the questionnaire. This was important to ensure that all the possible responses were obtained from the participants.

Interviews

All ED staff such as nurses, doctors, clerks, security officers, orderlies and volunteers were involved in some form of informal conversation with the researcher. In particular, the researcher also talked to key informants (i.e. triage nurses) informally to verify the observations and obtain their demographic data (e.g. qualification and years of experience).

This study also involved formal semi-structured interviews (i.e. face-to-face interview for nurses), which were based on a clear plan in mind, but were also

characterised by a minimum of control over the informant's responses. The semi-structured form of interview was chosen because it allowed the researcher to target information that would complement the observations. Moreover, it provided an opportunity for the researcher to seek both clarification and elaboration on the answers given in the questionnaires.

The formal semi-structured interview for nurses involved in violent incidents utilised an interview guide (Appendix 10) where questions that needed to be covered were listed. The researcher was fully in control of what was intended from an interview (i.e. to obtain specific information about the particular violent incident), but the possibility existed for both the researcher and informant to follow new leads. In other words, all nurses were asked similar questions but in the order in which they were posed may be changed according to how individuals reacted. Having flexibility in the order of questions allowed the researcher to be more natural and responsive.

The questions for nurses involved in the specific violent incidents included:

- Tell me about the violent incident you had reported recently?
- How did it make you feel?
- Do you think your interactions with the patient have any influence on the incident?
- What do you think might have contributed to the incident?
- Has anything changed after this incident?

Face-to-face formal semi-structured interviews were conducted with nurses who were involved in thirty-four reports (33% of incidents). The majority of these

interviews were conducted within seven days of the incident and the remainder were conducted within two weeks. There was only one report where the nurse involved refused to participate because of his or her perception that the experience was not serious compared to another staff member involved in the same incident. The other nurses involved in the incidents (67%, N=103) were unable to be interviewed typically for reasons such as not on roster, on leave, and busyness.

It was also hoped to interview patients involved in violent incidents by using the interview guide (Appendix 11), which had a similar set of questions. However, the researcher did not manage to recruit any patients for interviews. This was because the majority of patients involved did not have access to a telephone.

In addition, the researcher also failed to recruit patients for various reasons which are common in the psychiatric setting. This included mental inability (i.e. too psychotic or demented) and refusal to participate (Daffern 2004; Lanza, Kayne et al. 1996). The refusal of patients to participate in the interview could be associated with feelings of shame. High levels of anxiety and frustration might impact on the behaviours of individuals during their presentation to the ED, but later when they had enough time to reflect, they may be embarrassed by their impulsive behaviours. They might also be fearful of the possible influence of 'complaints' on their future treatment in the ED.

Even though no patients were recruited for formal interview, from observation of nurse-patient interactions at triage there were certain perspectives of patients (e.g. perceptions on waiting time and pain relief) that were able to be included.

Structured data collection procedures

There were three components of structured data collection and these consisted of observations, questionnaires and semi-structured interviews, as displayed in Figure 4.2. When patients who fulfilled the inclusion criteria presented to the triage desk, the researcher observed the interactions between nurse and patient/relative behind the triage desk (Appendix 7) and recorded it in the 'Guide for observation' (Appendices 8 and 9)

Posters regarding the study were posted near the triage desk so that patients would see them when they came to triage desk. Before a priority was assigned, a refusal form for telephone contact (Appendix 6) and information sheet regarding the study (Appendix 3) were given to patients by the triage nurses.

Violent incident questionnaires for nurses were placed at triage desks, treatment and admission area in the ED throughout the period of study in order to capture all the incidents and more importantly to avoid confusion as to when to complete the questionnaires. If the patient was subsequently involved in a violent episode, it was hoped that the violent incident questionnaire (VIQ) would be completed by the nurse involved. After completion, the questionnaires would be placed in the sealed collection boxes, which were placed at triage, treatment and admission area.

The patients who were involved in a violent incident and did not complete the refusal for telephone contact form (Appendix 6) would be contacted to request a telephone interview after a 'cool-down' period of at least three days (i.e. when the patient had time to reflect on their experience in the ED). The Clinical Nurse Consultant of the

ED made all the initial phone calls. If the patient had consented to participate in the study, the researcher would have then contacted him or her for a telephone interview. The interviews were to be conducted from the Discipline of Nursing at the University of Adelaide and guided by the 'Telephone interview procedures and questions for patient' (Appendix 11). However, as mentioned before, in this study, unfortunately, no patients participated in an interview.

Face-to-face interviews with nurses involved in a violent incident and who agreed to participate were scheduled in the ED after a written consent (Appendix 5) had been obtained. These interviews were guided by the 'Semi-structured interview questions for nurses' (Appendix 10). All the interviews were tape recorded for analysis.

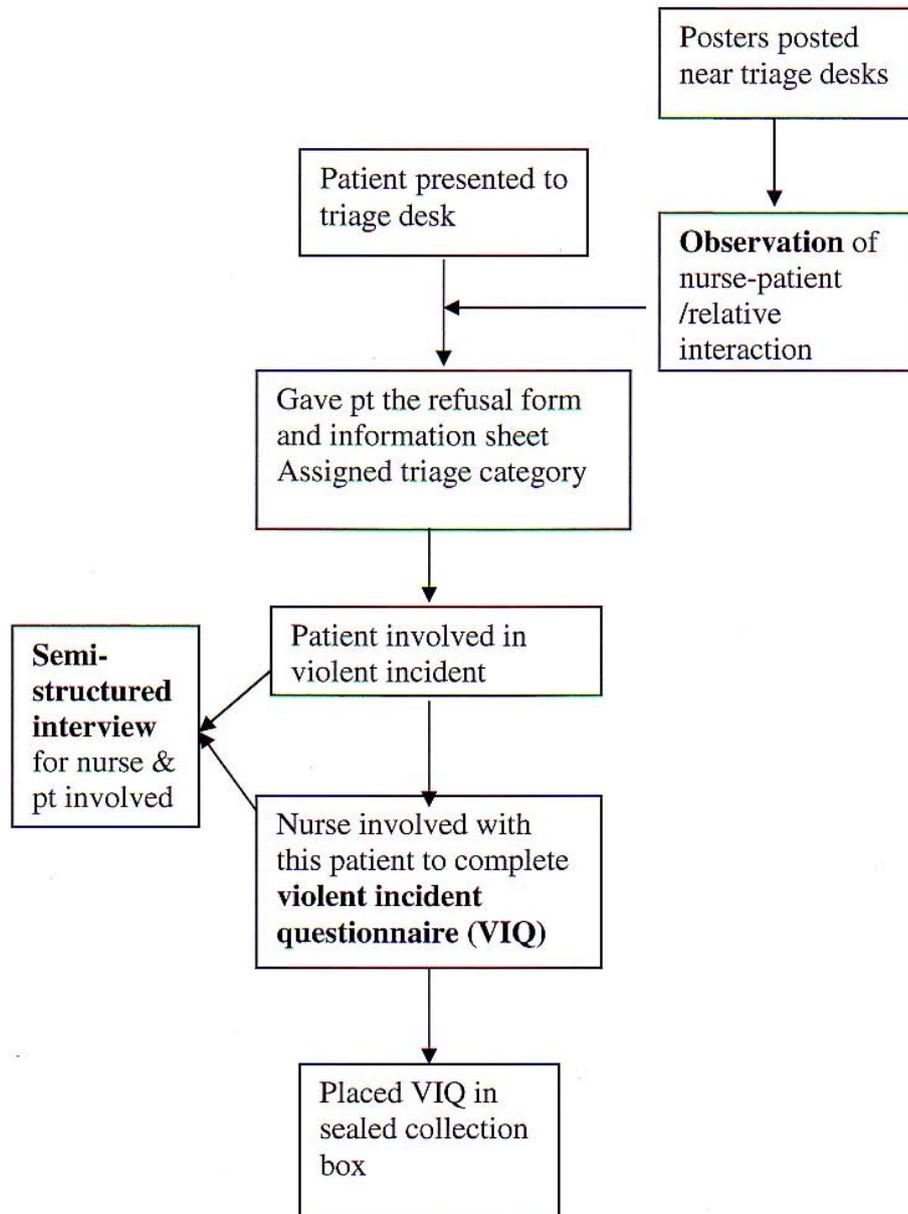


Figure 4.2: Flow-chart for structured data collection procedures

Data analysis

This section is divided into four main sections. Section one outlines the nature of data analysis in ethnographic research. Section two describes the cognitive processes involved in data analysis. Section three concentrates on the sequential selection that

integrated data collection and data analysis. The final section discusses the integration of LeCompte and Schensul's (1999) (i.e. item, pattern and structural), and Spradley's (1980) (i.e. domain, taxonomic, componential and discovery of cultural theme) approaches, which were used in this study.

Nature of data analysis in ethnographic study

Data analysis especially for those implementing the interpretive tradition is the most complex, mysterious and labour-intensive phase of a research (Polit, Beck et al. 2001; Thorne 2000). LeCompte and Priessle (1993, p.154) stated that 'the way that ethnographers and other qualitative researchers analyse data are diverse, idiosyncratic, and tailored to the nature of the material being examined and the questions asked of it'. However, all the analytic approaches used by ethnographers and other qualitative researchers have some similarities (LeCompte and Priessle 1993; Morse, Miles et al. 1994). According to LeCompte and Priessle (1993), the difference is that ethnographic analysis is always informed by some notion of culture.

The techniques used for ethnographic analysis commonly include 'thematic analysis' (Laimputtong and Ezzy 2005; Leininger 1985; Rice and Ezzy 2001), 'content analysis' (Cavanagh 1997; Laimputtong and Ezzy 2005; Leininger 1985; Priest, Roberts et al. 2002; Rice and Ezzy 2001), 'domain, taxonomic, componential analysis and discovery of cultural theme' (Spradley 1980), and 'item, pattern, and structural levels of analysis' (LeCompte and Schensul 1999). Although these techniques use similar processes, there are differences in terms of focus and scope.

The problem is selecting methods that will meet the specific needs of the ethnography being conducted.

Cognitive processes

In addition to the techniques or steps used in data analysis, it is important to elaborate the cognitive process or thinking that was involved. Such detail is important as it is the fundamental tool the researcher used to develop or confirm explanations for how and why things happened as they do. Thus, it enables the provision of a thorough and transparent picture of data analysis that had been undertaken in a study.

Comprehending, synthesising, theorising and recontextualising were the common cognitive processes or the generic mode of thinking used throughout this research process (Goetz and LeCompte 1984; Morse and Field 1995; Morse, Miles et al. 1994). Comprehending was where the researcher strived to make sense of the data and find answers to the question: 'what was going on?' Synthesising involved sifting the data and putting pieces together by comparing, contrasting, aggregating and ordering (Goetz and LeCompte 1984; Morse and Field 1995; Morse, Miles et al. 1994).

During theorising, the data was systematically sorted and integrated. The linkages and relationships were then established and speculated on in order to develop a theory. Finally, recontextualising involved the further development of the theory where its applicability to other contexts was explored. For example, in this study,

during the comprehending phase, the researcher realised that some observable warning signs of violence manifested in patients' verbal (e.g. *'I can't wait for long'*) and non-verbal behaviours (e.g. pacing, not making eye contact). Then during synthesising, it was observed that some triage nurses reacted to verbal and non-verbal warning signs promptly by using empathetic communication skills (e.g. calling of patient's first name in a calm manner and friendly body language; leaning forward slightly).

During theorising, it was found that triage nurses were able to react to patients' verbal and non-verbal cues better when the situation in the ED was less busy or chaotic and therefore it was probably less likely for violent incidents to occur. In the final cognitive process - recontextualising - it was found that such a theory is more applicable to less obvious or covert warning signs (i.e. non-verbal). In view of the researcher's previous experiences in the emergency department and the extensive review of the literature, she was able to make sense of the data quickly. However, the synthesising, theorising and recontextualising processes took longer than expected due to the researcher's inexperience.

Sequential selection

In ethnography, data analysis is not linear; it is an iterative process (de Laine 1997; Schensul, Schensul et al. 1999). In other words, data collection and analysis tend to be concurrent and cyclical where new analytic steps inform the process of additional data collection, and new data in turn prompts further analytical process, etc. (Thorne 2000).

In view of the uniqueness of simultaneous data collection and analysis phase in an ethnographic study, it is pivotal to illustrate what kind of technique is employed in integrating these phases of the research process. This is called sequential selection (Goetz and LeCompte 1984; LeCompte and Schensul 1999).

There are a few common strategies for implementing sequential analysis: (1) constant comparison which involves looking for similarities and differences in behaviours, settings, actors, and other dimensions of cultural activities and then to make inferences about these differences, (2) analytical induction or negative-case selection (i.e. exception to the emergent case), (3) theoretical sampling (i.e. search for best matching theory), and (4) selection of theories relevant to various stages of research (Goetz and LeCompte 1984; LeCompte and Schensul 1999). These strategies can be used alone or in combination in the different stages of data collection and analysis (Goetz and LeCompte 1984; LeCompte and Schensul 1999).

This study mainly used constant comparison and analytical induction throughout the data collection and analysis exercises. However, the applications of these techniques were more apparent during the pattern level of analysis. This will be explained in the following sections.

Data analysis framework for the study

Two types of data were generated in this study: quantitative and qualitative. Initially, the quantitative data (i.e. mainly from the questionnaires) were analysed using

descriptive statistics from SPSS (Statistical Package for the Social Sciences). Then, the findings of the quantitative data were incorporated into the qualitative part (i.e. primarily from interviews and field observations) and analysed accordingly. To assist in the clarity of data analysis, a framework was conceptualised as shown in Figure 4.3.

The data analysis framework (Figure 4.3) adopted in this study incorporated Spradley's (1980), and LeCompte and Schensul's (1999) approaches. The overall concept and structure of analysis was mainly derived from LeCompte and Schensul's method but the actual steps in analysing the data used Spradley's strategy. Spradley's ethnographic analysis involves domain, taxonomic, componential analysis and discovery of cultural themes. LeCompte and Schensul's technique consists of item, pattern and structural level of analysis.

The steps involved in Spradley's (1980) approach are more structured and concrete while LeCompte and Schensul's (1999) approach is more global, providing greater flexibility. Spradley's method is efficient in sorting out large chunks of segmented data because it provides 'the systematic examination of something to determine its parts, the relationship among parts, and their relationship to the whole' (Spradley 1980,p.85). LeCompte and Schensul provide more choices in terms of techniques and concepts used to determine the constructs and the relationships among them. For example, LeCompte and Schensul (1999) acknowledged that one of the most useful strategies for identifying items is using 'domain analysis'. However, they also suggested that identification of items can also be achieved through other methods such as using constant comparison and analytical induction.

The levels of analysis as described by LeCompte and Schensul provided a broad framework for the analysis, and Spradley's steps were used within the framework to assist with more detailed analysis. The following sections describe the process of data analysis in this study.

NOTE:
This figure is included on page 102
of the print copy of the thesis held in
the University of Adelaide Library.

Figure 4.3: Data analysis framework for the study

The item level of analysis

The item level of analysis and domain analysis are similar. Both are the first step in analysing the ethnographic data and are typically reductionist in nature because large chunks of data are converted to smaller manageable segments (LeCompte and Schensul, 1999). The application of LeCompte and Schensul's (1999) approach was useful because it provided the necessary cognitive processes and sequential analysis

involved to accommodate the concurrent and cyclical data collection and analysis processes.

Domain analysis

In this study, the identification of items was achieved through domain analysis. Domains are made up of three basic elements: the cover term (name), included terms (smaller categories), and semantic relationship (linking together two categories). The most common semantic relationships described by Spradley are:

Strict inclusion; X is a kind of Y

Spatial; X is a place in Y, X is a part of Y

Cause-effect; X is a result of Y

Rationale; X is a reason for doing Y

Location-for-location; X is a place for doing Y

Function; X is used for Y

Means-end; X is a way to do Y

Sequence; X is a step (stage) in Y

Attribution; X is an attribution (characteristics) of Y

The domain analysis as described by Spradley (1980) is particularly valuable especially for novice ethnographer as it provides a more concrete and systematic way of analysing ethnographic data. The process for this level of analysis included the steps as described below (It is important to emphasise that the steps involved were not linear; it was cyclical and recurrent):

Step 1: Selecting the first sample of data (field note entries or interviews). For example:

2210 hours-- ...The triage nurse started with *'Hi'* and made eye contact with patient. Elizabeth (Pseudonym-patient) replied, *'Hi, I need to see a doctor'* with a firm tone. Her companion said, *'She's got a letter from hospital...she's got fluid retention...'*. *'Can I have your letter, please?'* .Then the triage nurse asked, *'Are your legs red, Elizabeth?'*...and directed her to the clerical counter ... (Field notes on 24 May 2004, p.45: L11-32).

Step 2: Underlining and giving meaning to all the basic categories/items/included terms. For example:

2210 hours-- ...The triage nurse started with *'Hi'* (*Greeting*) and made eye contact (*Eye contact*) with patient. Elizabeth (Pseudonym-patient) replied, *'Hi, I need to see a doctor'* (*Reciprocated the greeting*)(*made a request*) with a firm tone. Her company said, *'she's got a letter from hospital...she's got fluid retention'*. *'Can I have your letter, please?'* (*being polite*). Then the triage nurse said, *'Are your legs red, Elizabeth?'* (*Assessing*) (*Showing concern*)(*calling of patient's her first name*) ...and directed her to clerical counter (*Instructing/Directing*)... (Field notes on 24 May 2004, p45: L11-32).

Steps 3: Searching for possible cover terms for all the basic categories/items/included terms that fit the semantic relationship. For example:

INCLUDED TERMS	SEMANTIC RELATIONSHIPS	COVER TERMS/NAME
Greeting the patient Instructing/directing Giving/receiving information Assessing	was a kind of	Work that triage nurses did
'Hi' 'Hello' 'Can I help you?' 'What can I do for you today?' 'Good day' 'I need to see a doctor'	was a kind of	Verbal response during the initial interactions
Making eye contact Calling patient's his or her first name Joking	was a way to	establish rapport with patients

Step 4: Listing all the domains identified for the first sample of data. For example:

List of domains identified
1. Kinds of work triage nurses did
2. Kinds of nurses' or patients'/relatives' verbal response during the initial interactions
3. Ways to establish rapport with patients

Step 5: Repeating the steps to search for more included terms for the existing domains and creating new cover terms from further data collected.

The pattern level of analysis

LeCompte and Schensul (1999) stated that pattern level of analysis is mainly constructionist because it involves putting segments together into a meaningful

conceptual pattern. They proposed that patterns emerge as a result of their frequency of occurrence, omission, similarity, and co-occurrence.

This level of analysis is similar to Spradley's (1980) taxonomic and componential analysis. LeCompte and Schensul (1999) provide the general cognitive principles in doing the pattern level of analysis, whereas Spradley (1980) provides the actual process of conducting this level of analysis. In addition, Spradley's strategy is able to accommodate the cyclical and concurrent nature of ethnographic data collection and analysis. This level of analysis was achieved through taxonomic and componential analysis.

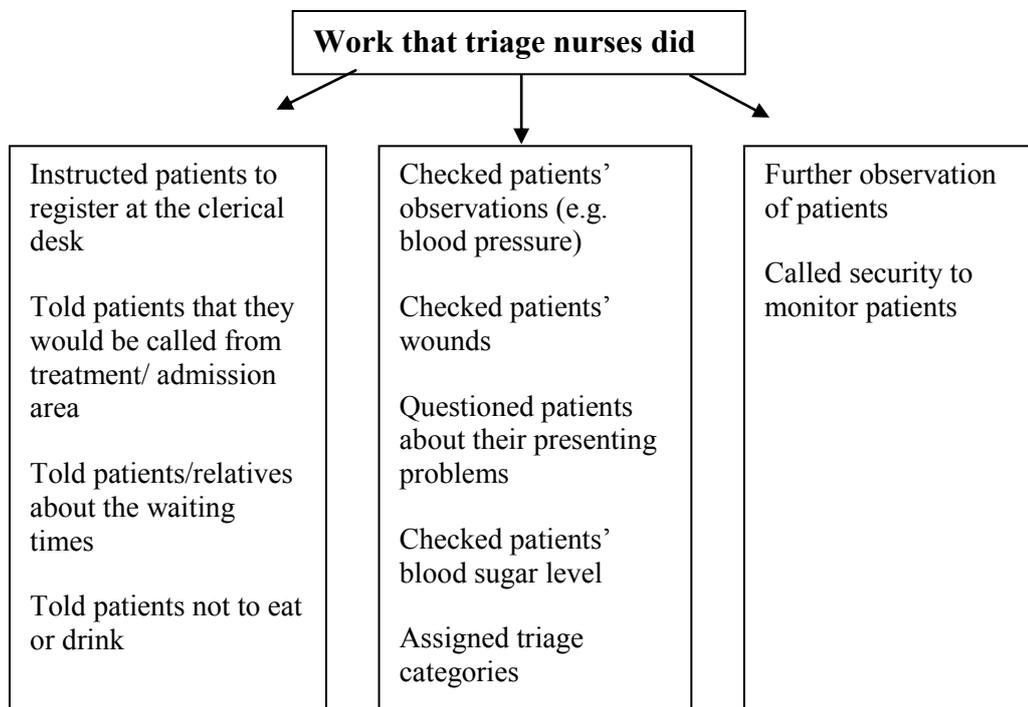
Taxonomic analysis

Like a cultural domain, a taxonomy is a set of categories organised on the basis of a single semantic relationship. The major difference between the two is that taxonomy shows more of the relationships among the included terms inside the cultural domain (Spradley 1980). The steps involved were:

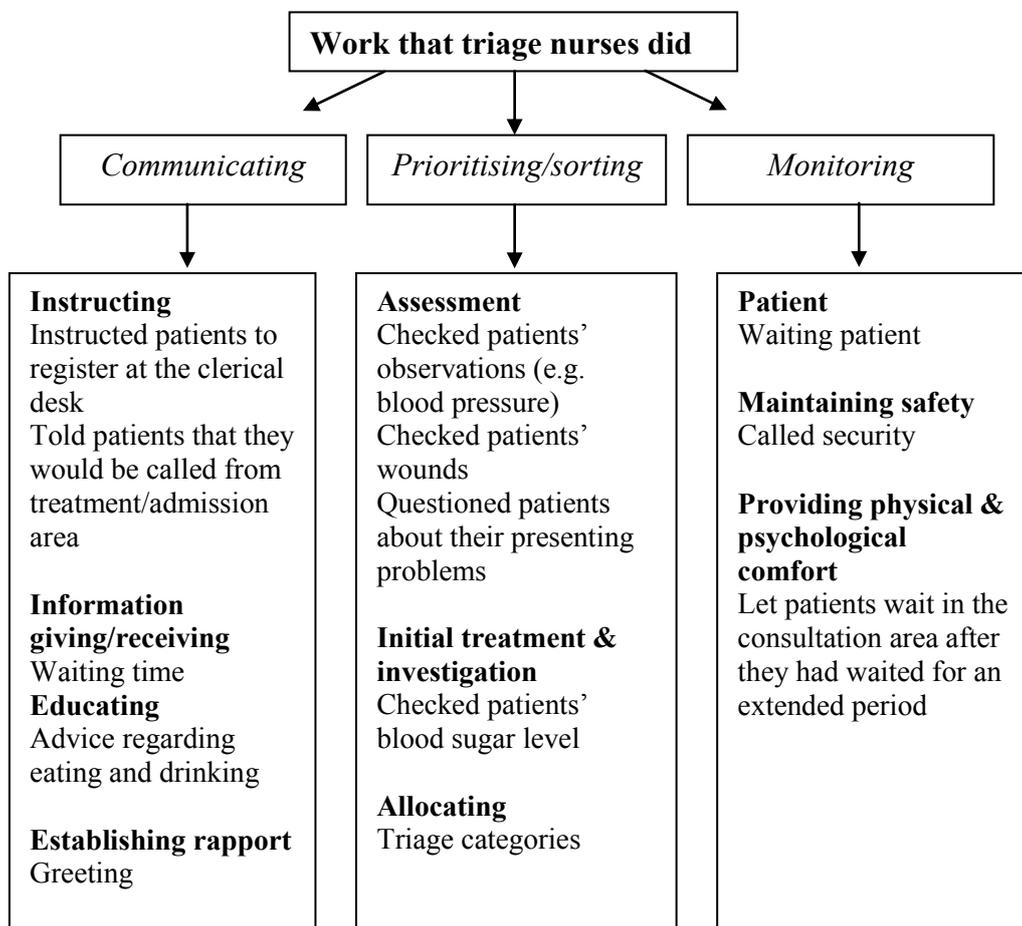
Step 1: Looking for additional included terms for all the domains by asking structural questions relating to each included term (Spradley 1980). For example, for the domain kinds of work triage nurses did, the structural question was: 'What were **all** the different kinds of work triage nurses did?'

Work that triage nurses did
<p>Instructed patients to register at the clerical desk Checked patients' observations (e.g. blood pressure) Observed patients' wounds Questioned patients about their presenting problems Checked patients' blood sugar level Assigned triage categories Called security to monitor patients Told patients not to eat or drink Gave visitors a 'visitor' sticker Told patients that they would be called from the treatment/admission area Applied arm slings to patients Asked patients to elevate his/her leg Told patients/relatives about the waiting times</p>

Step 2: Looking for similarities for the included terms and putting them in a taxonomy. For example:



Step 3: Searching for larger, more inclusive subset. For example: ‘communicating’, ‘prioritising/sorting’ and ‘monitoring’.



Step 4: Making further focused observations to confirm the analysis (Spradley, 1980). For instance, during earlier observations the researcher did not realise that letting patients who had waited for a long time into the treatment/admission area was a measure used to reduce patients' frustration associated with long waiting time. Again, Spradley's approach may not be as flexible but it does provide greater structure for the researcher.

Componential analysis

Following the taxonomic analysis, componential analysis took place. Componential analysis is the systematic search for the attributes (components of meaning) associated with cultural categories (Spradley 1980). It includes the entire process of searching for contrasts, sorting them out, grouping some together as dimensions of contrast, and entering all this information onto a paradigm (Spradley 1980). This is important for identifying negative cases and this will be clarified in the following paragraphs. The steps involved in componential analysis were:

Step 5: Identifying dimensions of contrast that had binary values by asking contrast questions and putting them in a worksheet. One of the great values of a worksheet is that it will quickly reveal the kinds of information that needs to be collected. For example, for the domain 'kinds of work the triage nurses did', the questions for this type of contrast dimension were:

- (a) In terms of the communication of what to expect after triage/waiting time, how did all the nurses **differ**? Did all the triage nurses communicate to patients/relatives what to expect/waiting time? The answer was no because not all triage nurses did this. Why or how did this happen?

- (b) In terms of assignment of triage category, how did all the nurses **differ**? Did all the nurses assign a triage category to a patient? The answer was yes. Did all the nurses give 'visitor' stickers to the visitors? The answer was no. (Sometimes they ran out of the stickers).

From here, the nurses who did not communicate to patients/relatives what to expect and waiting time (i.e. the negative case) would inform the process of additional data collection. In some cases although the contrast question could be answer yes or no further data was required. This is noted as ‘missing’ in the remark column.

Cultural domain Kinds of work triage nurses did	Contrast questions		
	Yes	No	Remark
Communicated to patient what to expect after triage		*	missing
Assigned a triage category to patient	*		ED procedures
Gave visitor an identification sticker (i.e. red sticker)		*	Ran out of stickers
Communication of waiting time		*	missing

Step 6: Combining the closely related dimensions of contrast into ones that had multiple values. For example, for the domain ‘kinds of work triage nurses did’, the communication of what to expect (dimension of contrast) had multiple values such as undefined nature of work, medium level of perceived importance by nurses and associated with high propensity for violence.

Cultural domain Kinds of work triage nurses do	Dimensions of contrast		
	Nature of work	Perceived importance	Propensity for violence
Tell patient what to expect	Undefined	Medium	High
Priority 3 for non-aggressive psychiatric patient	Protocol driven	High	missing
Visitor sticker to visitor	Defined	missing	missing

Step 7: Conducting further selective observations to discover missing information.

Spradley (1980) stated that there is nothing wrong if some of the missing information cannot be found.

Step 8: Preparing a completed paradigm

Cultural domain Kinds of work triage nurses did	Dimensions of contrast		
	Nature of work	Perceived importance	Propensity to contribute to violence
Communication	Extensive & undefined	Medium	High
Prioritising/sorting	Protocol directed & defined	High	Moderate
Monitoring	Defined	Medium	Low

The structural level of analysis

The structural level of analysis attaches meaning and significance to the preliminary results from the pattern level of analysis. This level of analysis is parallel to Spradley's (1980) discovery of cultural themes. However, the structural level of

analysis appears to be more comprehensive, as it integrates the findings with broader frameworks in order to recognise the implications of the study (Goetz and LeCompte 1984). Such comprehensive or in-depth level of analysis is important because it demonstrates how the research findings contribute to knowledge in the field and how to bridge the gap between knowledge and practice.

Strategies used to discover cultural themes as suggested by Spradley (1980) are both general (i.e. immersion by cutting oneself from other interests, and listening and reading the data over and over again) and specific (i.e. making a taxonomic analysis of cover terms for all the domains to see if they might fit into a taxonomy, examining the dimensions of contrast for all the domains that have been analysed in detail and making a schematic diagram of the cultural scene).

In this study, the discovery of cultural themes involved making a taxonomic analysis of cover terms for all the domains. A final taxonomy (Figure 5.4) was developed for explaining the cultural aspects of violence in the ED. Three major cultural themes emerged from this ethnographic analysis: ‘problems and solutions’; ‘them and us; and ‘requests and demands’. The description of these themes will be presented in the following chapter.

Summary

This chapter has provided a detailed description of the research setting, data collection methods, identification of participants, and data collection procedures. Gaining access into the cultural scene and the ethical considerations for the study have also been discussed. In addition, the comprehensive data analysis framework

for the study based on the integration of Spradley's (1980), and LeCompte and Schensul's (1999) data analysis techniques were also explained and justified. The next chapter describes the findings of the study.

CHAPTER 5:

FINDINGS

The waiting room was quite crowded and busy that evening. More than ten patients had been triaged in the past hour. The triage nurse was busy with telephone triages, and phone calls asking for her co-workers. She had just helped to fetch a patient from the car park. Suddenly there was a male voice shouting in the waiting area. The man was not alone; he had a tired-looking woman standing beside him. He was wearing a white hospital gown and a pair of jeans and had used a hospital blanket to cover his shoulders. A wristband indicated his recent admission to ED. He was leaning slightly forward and grimacing indicating he was in pain. With the commotion, all activities in the area paused. He had the full attention of the waiting room.

The triage nurse did not talk to the patient, but immediately called security to come to the waiting area. When he saw the security officer, the patient threw the blanket onto the floor and shouted but soon quietened down. Five minutes later, the woman approached the triage nurse and said in a loud tone, '*...he is in pain...he needs to lie down...*' She repeated this a few times as if pleading for a response. The triage nurse said, '*...he has been discharged...this is the medical decision...*'. The woman shook her head and said, '*This is unbelievable*'. The triage nurse appeared 'cool' and calm and for her the patient required no further attention.

Apparently, the patient had come to the department suffering chronic lower back pain. He had been given analgesia during his stay in the treatment area. He was asked to wait for transport to take him home. The man continued shouting in the waiting

room after the security officer left. Finally, the triage nurse decided to give him a bed to lie down in the ambulance transfer bay, which was normally only used to receive ambulance cases. Peace was restored (Field notes on 18 May 2004, p.10: L9-34; p.11: L1-5).

Introduction

This incident was typical of violent episodes in the ED in that a patient becomes violent after his or her request was refused. ‘Rejection of request’ was one of many critical elements that underlay violent incidents in the ED. This chapter will explore these critical elements. The chapter consists of two main parts. Part one briefly describes the cultural scene, the purpose of which is to orientate the reader to the setting. Part two focuses on the elaboration of issues concerning the three major themes: ‘problems and solutions’, ‘them and us’, and ‘requests and demands’.

Cultural scene

The scene

This study was conducted in a major public hospital in Australia. Although it was confined to the ED, this place was not an island. Adjacent to the ED were the Radiology Department and Emergency Extended Care Unit. There was constant movement of patients and staff between these departments.

The hospital was originally established over a hundred years ago. It was located in the city centre and therefore its ED attracted many patients with social problems inherent in most cities (e.g. homelessness, drug abuse, alcoholism and mental

illness). The ED was situated at the very front of the hospital, with only a car park separating it from the main road. It has approximately 55,000 attendances each year. Many of the hospital buildings were quite old and some were heritage listed, in contrast to the ED was relatively new.

The ED had one main door facing the car park. An enormous number of people came into the ED through this automatic door operated via a sensor. After entering the main door, they would see a large waiting area located to the left (Appendix 7). The waiting area had a spacious open-plan setting and slightly dimmer lighting than other parts of the ED.

There were two triage desks; one mainly for walking patients and the other for stretcher cases, near the waiting room. The one for walking cases directly faced the main door. It was specifically designed in this way so that people who came to the ED would go straight to the triage desk and triage nurses could easily observe and keep track of those who were present. From the triage counter, it was quite easy to see the standing patients, but harder to see those who were sitting in wheelchairs because the desks were about one metre high.

The ED waiting room, like many others, had chairs, a television, vending machines for drinks and snacks, magazines, educational pamphlets, toys, toilets, public phone booths, security cameras, a waiting time display and priority signage. All these facilities were intended to provide comfort, information and safety for patients/relatives in the ED. However, at times, they were also a source of frustration. For instance, the patients/relatives could not turn off or lower the volume of

television when they felt annoyed in the middle of the night. Not all felt comfortable under the surveillance of security cameras.

Triage desks were separated from the waiting area by a glass panel and a key-coded security door leading to the rest of the department. It was clear that triage nurses controlled who was allowed to come into the inner part of the ED. Generally there was only one nurse assigned to the triage area, except from 1200 noon to 2000 hours when two nurses were allocated.

Next to the triage desks were clerical counters. The security control room, which could be seen by those in the waiting area, was located behind the triage desks. This provided triage nurses with some level of reassurance in regard to their safety. Many nurses expressed the view that the old ED had a higher level of violence compared to the new ED because it did not have on-site security and a protective glass window.

Not all patients were triaged at the desks. Occasionally, they were triaged in the waiting area or examination room (which was located behind the triage desks). The waiting room was used when patients were not fit enough to come to the triage desk and the examination room was used when the triage nurse decided to assess patients privately. Patients who were brought in by ambulance were triaged at the ambulance transfer bay that was located next to the triage area. The triage desks and waiting room had less privacy than the examination room and ambulance transfer bay.

Along a short corridor from the triage was the treatment area. This area was usually used for patients who were less seriously ill and who needed short medical

interventions. This area had 18 general cubicles, an ACIS (Assessment and Crisis Intervention Service) office and an interview room that was used for all the psychiatric presentations. The ACIS office was operated by mental health nurses daily from 8am till 10pm.

The treatment area was usually closed between two and ten o'clock in the morning. During this period, all the patients were seen in the admission area which was located nearby. The admission area was usually used for patients who were in a more serious condition and required more extensive medical attention and possibly admission to the inpatient wards. This area had 22 general cubicles, four resuscitation bays and two seclusion rooms for violent patients, in particular psychiatric patients. The admission area functioned 24 hours a day. The treatment and admission areas were not visible from the waiting room. Notably, the patients/relatives in the waiting room could not see what happened behind the closed doors.

In addition to on-site security, the ED violence prevention strategies also included signage warning the public about 'zero tolerance' for abusive behaviours in the setting and a 'flagging' system where previously aggressive patients were put on 'violence alert'.

The environment in the ED was quite unpredictable; one minute it could be calm and quiet, and next chaotic. Often there was only one triage nurse managing the area and there was a flood of people who came through all at once. Nevertheless, it was not only large numbers that could lead to chaos. Serious cases of trauma brought in by ambulance, or even a single problematic case could raise the tempo. Accordingly,

nurses would usually process their patients as soon as possible, because they never knew when they might need time to deal with unexpected or unusual circumstances.

Many patients and relatives or friends would experience anxiety in such an unfamiliar environment. Interactions between the patients and triage nurses occurred through a panel of bullet-proof glass. All the doors were closed and access to the department was not possible without the permission of triage nurses. The means of control could make the patients/relatives feel isolated and frustrated while they waited for their problems to be sorted out.

The actors

There were many actors found in the ED and these included nurses, doctors, clerks, security officers and volunteers. The doctors usually worked in the treatment and admission areas, and were not generally visible to those in the waiting room. They did not wear white coats and their attire was commonly more casual than that worn by those who worked in the other areas of the hospital. For example, most did not wear ties; these tended to get in the way with hands-on treatment and when dealing with trauma.

Normally, there were two to four clerks working at the registration desks. Their interactions with patients/relatives were usually straight forward because they focused on gaining some demographic information. They routinely referred all patients/relatives' inquiries, for example waiting times, to triage nurses.

There were usually a few burly security officers on duty each shift. They did not have guns but they wore light-blue tops and dark-blue trousers and were sometimes mistaken for police officers. Usually one of the security officers would observe the monitors in the control room behind the triage counter. Often they were busy guarding psychiatric patients who were restrained under the Mental Health Act 1993. One to two volunteers wearing 'lavender' uniforms usually helped around in the department during morning and afternoon shifts. These elderly volunteers were very friendly and helpful.

The patients/relatives

The main actors in this study were the patients/relatives in the waiting room and the triage nurses. Patients presented to the ED with a variety of problems. Some came to the ED with physical problems, for example, non-trauma; backache, headache, breathlessness and dental pain, and trauma; sports injuries and motor vehicle accidents. Others came to the ED with emotional problems, for example situational crisis; suicide, drug overdose, seeking narcotics, and psychiatric problems; depression, aggression, hallucinations and psychoses. Some presented without any obvious physical or emotional complaint, such as those who came to obtain a sick certificate for work-related reasons.

These divergent individuals did have some important similarities. What typified the patients in the ED was that they were transient; they generally only stayed in the treatment or admission area for a few hours. Most were discharged home. Some were admitted to the ward or to another institution. From a psychological point of view,

typically they appeared anxious and worried about their problems, and vulnerable in an environment where they had little control.

The patients who waited in the triage area had some characteristics in common. Primarily, they all waited for the triage nurses' initial assessment and doctors' consultations. Some of them also waited for review of treatment outcomes and wounds, availability of blood results, and arrangement and arrival of transport. However, most commonly they waited to see a doctor following triage by the nurse. Some people waited for their relatives who were inside the treatment or admission area. Generally, patients in the waiting room were those with less serious conditions, because more seriously ill patients were sent directly to the admission area by triage nurses.

The nurses

The nature of work nurses did in ED was quite different from that in the hospital wards. They did not perform routines such as taking patients to the shower, attending doctor's ward rounds or have long personal involvement with patients. Because of the nature of work in ED, their shifts varied from those in the ward areas. The usual starting time was 7am for the morning shift, but some started at 11am or midday. Although all the nurses in the ED wore a name badge, only their first name could be seen. This was a security measure as they interacted with a large number of people at the frontline.

There was a team leader who was responsible for the whole team in the shift. The team leader for each shift allocated a specific numbers of nurses to each location in

the ED. Nurses were usually not allocated to the same area for two consecutive days, in particular the triage area.

The triage nurses' role was unique in that they acted as door-keepers to the hospital. They made decisions and filtered all the patients who came to the triage desks. They had to make hundreds of decisions during each shift. Some of these decisions were not easy and many had potential for serious consequences. For example, a patient's life might be at stake when the extent of his or her injury was under-triaged due to concurrent alcohol intoxication. Conversely, other patients might not receive timely treatment when the extent of a patient's condition was over-triaged. The consequences of the triage nurses' decisions were often immediate and the scrutiny from patients and colleagues was intense.

They were also the face of the hospital. They were expected to remain calm and cheerful even when they were under stress. Triage nurses were usually experienced nurses (i.e. 6-9 years), all had completed a three years basic undergraduate nursing training, two years advanced emergency training and a triage course. Therefore, it was quite frustrating for these nurses when their unique and highly complex triage role was seen by the public as simply clerical. Figure 5.1 shows some of the most prominent views of nurses and patients/relatives concerning triage. Their views were usually different and at times diametrically opposed to each other.

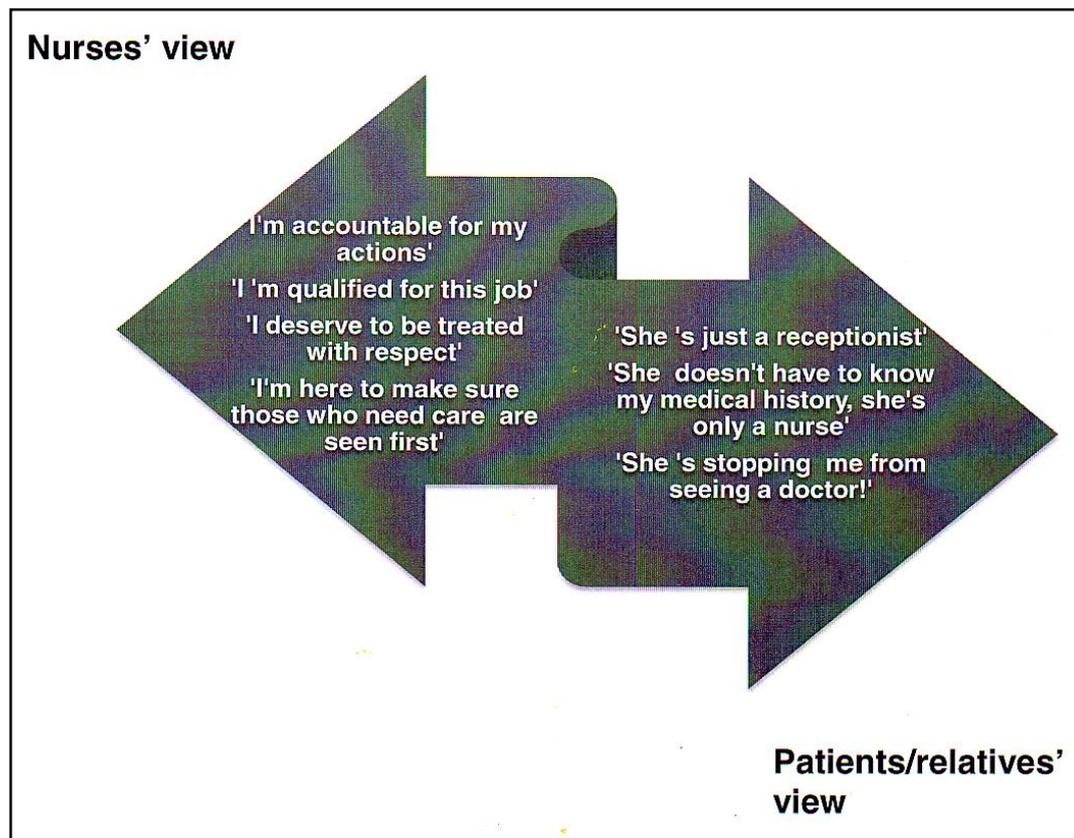


Figure 5.1: Nurses' and patients/relatives' views of triage

Triage nurses mainly concentrated on three major types of work: communicating (e.g. directing patients to register at clerical desks, receiving and giving information); prioritising/sorting (e.g. assessment, allocating); and monitoring (e.g. condition of patients). The prioritising and monitoring roles were largely protocol driven and reasonably well-defined. For example patients with acute asthmatic attacks who were not able to speak in full sentences were consistently allocated priority 1.

In contrast, the communicating role was mostly undefined, being influenced by many factors. It was apparent that most of the triage nurses' time was spent in communication during interactions with patients/relatives. Nevertheless, they seemed to consider that the prioritising role was more important than communicating. As one

triage nurse stated, '*...the ability to allocate accurate triage category is the most important role for a triage nurse...*'.

What goes on in this place?

Many activities occurred in the ED and the majority of these were positive with good outcomes. For instance, patients had their wounds attended to and their pain alleviated. Some of these activities were unique, in particular triage. Other activities did occur elsewhere but not at the same frequency. For example, most patient observations were usually assessed at half hourly to hourly intervals. Activities such as resuscitation, counselling (e.g. suicidal patients), and handling of intoxicated patients were common. Unfortunately, not all that happened in the ED was positive and in particular violence did occur all too often. The following sections describe the nature and characteristics of violence which happened in the ED.

During the study, one hundred and three violent incident questionnaires were completed by nurses. Verbal violence was the type of violence most frequently reported. Only a quarter of physical violence happened without concurrent verbal violence. Although many incidents occurred in the admission area, one third happened in the waiting and triage areas. It was not surprising that there were many incidents in the admission area because this had two seclusion rooms for psychiatric patients.

According to reports, incidents peaked during the three-hour period between midnight and 3am. The least number of incidents were reported between 6am and

midday. During the study, Thursday was the day with the most incidents reported, and Wednesday had the least reported. However, nurses commonly indicated that they experienced more violence on Friday, Saturday and Sunday evening or night.

Eighty-four patients/relatives were involved in violent incidents during the study with nearly two thirds being male, mostly of 21 to 40 years of age. However, one fifth of patients involved were aged more than 61 years old. Among the hundred and three reports, the majority of those involved were patients, rather than relatives. Nearly half of the patients involved in violent incidents presented at emergency on their own accord. More than half of violent incidents occurred at presentation to triage or after patients had been in the department for less than one hour. The majority of the patients involved in violent incidents were discharged from the emergency department.

The majority of nurses indicated that they experienced violence from patients/relatives daily. According to these nurses, the major factors that determined the number of incidents were: the time of the day in a week and the activity levels in the ED, for example, '*... depends on how busy the department is*'. The role undertaken by nurses, which in turn determined the levels of interaction they had with patients/relatives was also a factor (e.g. '*at least once every shift at triage*'). Compared to nurses working in other areas in the ED, triage nurses interacted with a greater number of patients and relatives. Such levels of patient/relative interaction might have subjected them to more interpersonal conflict in particular when they were seen as the cause for any delay in medical consultations.

The cultural domains

The next section will examine the elements that were pivotal to the violent incidents in the ED. To facilitate this, a conceptual framework which brought together the elements that were comprised of the cultural aspects of violence in the ED was developed (see Figure 5.2). Three main elements that were important to the understanding of cultural aspects of violence in the ED were identified, namely ‘problems and solutions’, ‘them and us’, and ‘requests and demands’. The first element addressed generally how the problem was experienced and managed and the remaining two elements specifically looked at how the problem of violence arose in the ED.

‘Problems and solutions’ (‘...communication is the key...’)

The first element relates to how violence in the ED was experienced and managed. Nurses’ ability to identify the indicators of violence and the way that they responded and managed incidents were affected by their perceptions of violence. Not all nurses perceived violence in the same way. Some viewed it negatively and felt frustrated, while others saw it as a challenge to be managed. Consequently, their response to violence also varied. Some nurses adopted negative responses such as physical or chemical restraint more readily, while others employed strategies that involved good communication skills such as giving eye contact.

‘Them and us’ (‘...I don’t like your attitude...’)

‘Them and us’ addressed behaviour when one group in this culture (i.e. patients/relatives) encountered another (i.e. the nurses). Behaviour that occurred had a reciprocal relationship. The behaviour of an individual resulted in a response from another, setting up a cycle of action and reaction. For example, a nurse who appeared to ignore a patient’s pain or who did not have good rapport establishing behaviours, was more likely to elicit negative responses (e.g. violence) from patients. Nurses in turn were influenced by the behaviours of others. Nurses’ first impressions of patients/relatives and the manner in which patients presented were the important factors that affected nurses’ behaviours.

‘Requests and demands’ (‘I want to see the doctor ASAP’)

The next element - ‘requests and demands’ - relates to aspects of culture that directly affected the behaviours of nurses and patients/relatives. A duality emerged in this element. For example, a request for food, which from the perspective of patients/relatives was a reasonable request, sometimes appeared to be an unreasonable demand to the nurses.

This element included aspects that relate particularly to patients’ requests and waiting time. Requests and waiting time were closely linked to each other. Long waiting times occasionally resulted in a request such as a bed to lie down or earlier consultation. Patients/relatives who were already frustrated or agitated appeared to have a lower tolerance to a long waiting time. In these circumstances,

patients/relatives could respond to rejection of their requests in an aggressive way. At times, they also used violence as a means for them to attempt to fulfil their demands.

There were certain techniques used in communication about waiting time and rejection of requests which were more likely to result in violence from patients/relatives. These will be explained in detail in the following sections.

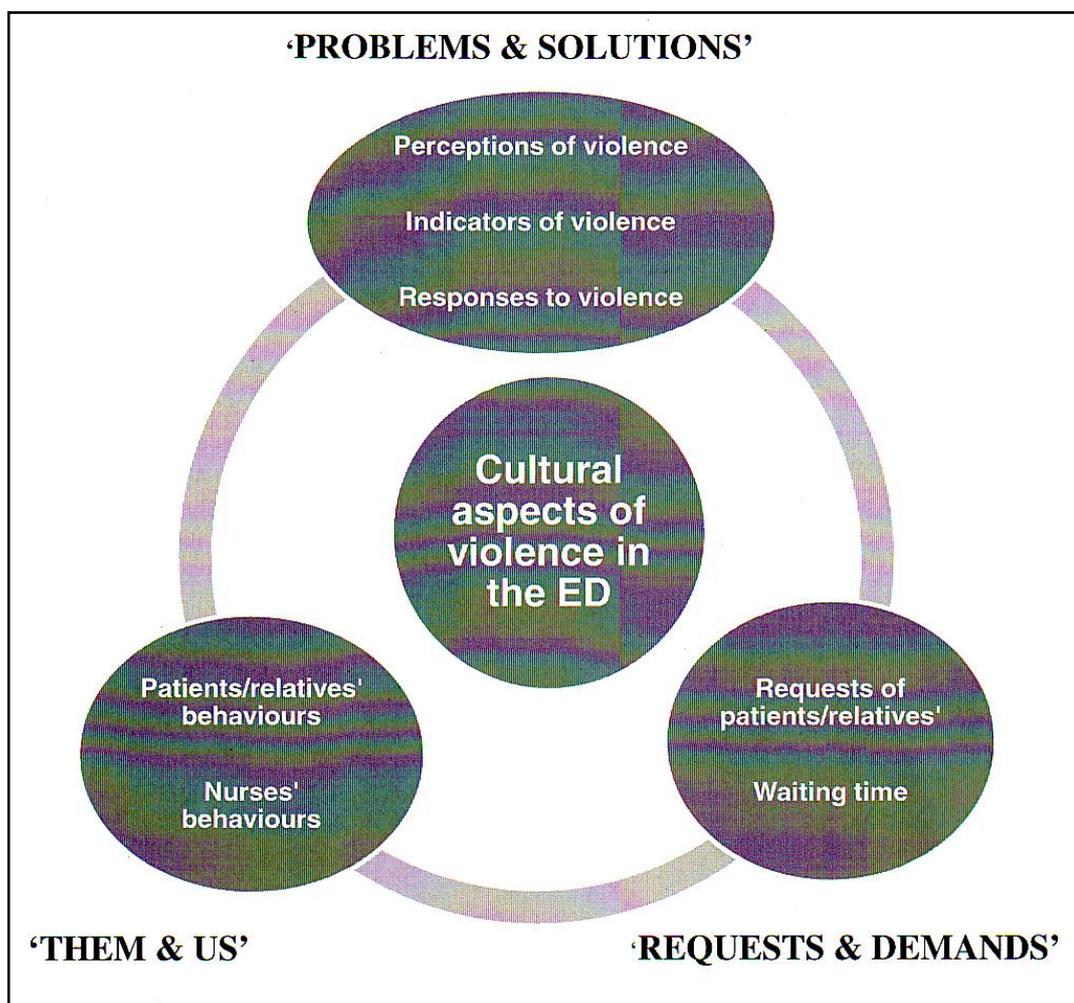


Figure 5.2: Framework of nature of violence in the ED culture

‘Problems and solutions’

A man was sitting alone very still in a wheelchair near the entrance of the main door. His clothes were wet and his face could not be seen. Upon seeing this man, the triage nurse came out and bent down to talk to him. There was still no response from him. When the triage nurse tried to touch the man’s forehead, he grabbed her wrist and twisted it so hard that she nearly cried out. She struggled for quite a while but was still not able to free her hand. She lifted her head and looked around to see if any help was available. Unfortunately, nobody came to assist her.

At that time, there were a few people sitting in the waiting room. She did not want to *‘make a scene’*. At last, she managed to pull her hand away and walked inside the department slowly pretending nothing happened. When she was inside the treatment area, she sobbed and she told the team leader about the incident. A hospital incident form was completed. The nurse was not able to work for a few weeks due to her physical injury and emotional stress. According to her, *‘...at least...for a while, I’ll not go outside (waiting room) to talk to a patient without the company of the security’*.

Apparently, this was not the first time this man behaved in this way. Other nurses had also experienced abuse when he came to the department a few hours earlier (Field notes on 18 June 2004, p.152: L27-33; p.153: L1-12).

Perceptions of violence

This case raises many issues about the way nurses responded to violence. This incident may have been avoided if those who had earlier violent encounters reported the incidents. The nurse did not perceive the patient as a threat because she was concerned about his physical condition. Her handling of violence in public without an intention to *'making a scene'* might indicate that she was not confident or prepared to deal with violence. Her response after the event was to modify her future behaviour in approaching such a situation.

Perceptions of violence were not uniform. Even for the same individual, they were not static. For example, a nurse might perceive violence as a challenge one day but the very next day, he or she might view violence as something bad. Five common themes of perceptions of violence were identified in this study: 'that's not violence, this is violence', 'violence –inevitable and unpredictable', 'I can handle violence', 'It was not my fault', and 'victim blaming'.

'That's not violence, this is violence'

For many nurses, what constituted a 'violent episode' was directly reflected by the severity of the incident. For example, nurses who were subjected to verbal violence or an incident without physical injury perceived that violence had not occurred. There were a number of situations that nurses typically felt 'that was not violence'. When the patients involved were not perceived to be responsible for their behaviour, then, it was not considered to be violence. For instance, a confused elderly patient

who spat at a nurse was not considered to be violent. The same behaviour from a young patient under the influence of alcohol was considered to be violence.

Many nurses also considered an incident not to be violent when the behaviours were expected (e.g. psychiatric patients and ‘frequent flyers’; patients who visit the ED regularly). For example, it was observed that Mr Will (pseudonym), a ‘frequent flyer’, had an angry expression and raised his voice at nurses and doctors on many occasions after his requests (e.g. admission) were refused. His behaviour was not considered to be violent by most of the staff in the ED. They just brushed it off by saying things like, ‘*Oh! That’s just him*’.

Nurses also considered certain actions as not being violent if there was a lack of a perceived target (e.g. ‘*...not directed at me*’ or ‘*...not directed at anyone*’) or when they were directed at a group and not an individual. For example, a patient who was involved in a motor vehicle accident and under the influence of an illicit drug shouted, ‘*...I’ll kill all of you*’ in the resuscitation room. The threat was directed generally at the group. However, when the same behaviour was directed at one individual (e.g. ‘*... I will kill you*’), often this was deemed to be violence.

On some occasions, ED nurses who personally experienced a violent incident, disputed that they had been subjected to violence. However, those who witnessed the incident disagreed. For instance, nurses who experienced the shouting and screaming in the resuscitation room did not consider the incident to be violent, but other nurses who witnessed the incident disagreed.

The understanding of such interpretations of violence was important because it directly influenced the nurses' reporting behaviour. They tended to report the incident if the incident involved a young person who was considered to be responsible for his or her actions. The reporting of an incident was more likely if it involved physical violence. In addition, nurses were also more likely to report a 'witnessed' incident.

Violence - inevitable and unpredictable

Emergency nurses often thought that 'violence was inevitable' in the ED and they came to this view through their perception about certain characteristics of the environment in which they worked. A sudden surge in the number of patients presenting to the ED with needs and requests put pressure on staffing and resources. Nurses often expected violence to occur when patients' needs or requests could not be met. Nurses also expressed the view that violence was inevitable when they dealt with certain categories of patients. That is, patients with drugs/alcohol, psychiatric and social problems; typically those with low cognition, high anxiety and who were more difficult to deal with.

Emergency nurses also commonly perceived that 'violence was unpredictable'. They attributed this to the flow of work in the ED, as some nurses just '*walked into a situation*', and were unaware of any warning signs which indicated the potential for a violent outburst. For example, a nurse who returned to the department after escorting a patient to the ward would not necessarily be aware of what had happened and that a patient was already disgruntled; '*...I didn't have much to do with him (patient), I*

basically just walked in there (treatment area) to help...unfortunately, in the ED, you don't...you are not always looking after that patient... (Interview with Nurse 2, p.1: L8-9; p.3: L28-29).

As a consequence of such inevitability and unpredictability, many nurses indicated in the reports that *'nothing can be done'*; they did not expect any changes from the patients/relatives; *'patients will not change'*. They perceived that *'nothing can be done'* as they had very little control over when and who presented to the ED. Due to the nature of the work flow in the ED, they often did not have prior interaction with patient to enable them to pick up the cues of potential violence.

'I can handle violence'

Violence was seen as one of the challenges of working in the ED. Some professional pride was frequently referred to when violence had been dealt with efficiently, in particular with the nurses who had worked in the department for a period of time. This was evidenced by statements such as: *'If you work here long enough, you will know how to handle it'* (Field note on 5 July 2004, p.193: L30-33); and *'I think we can deal with it...that was not the first time anything like that happened to me or anyone I work with...'* (Interview with Nurse 4, p.13: L1-3).

Even though nurses working in the ED considered violence as something inevitable and unpredictable, they perceived that they *'...can handle violence'* by saying things like *'...he was really cross...but I managed to talk him down...'* (Interview with Nurse 23, p.39: L33-34) and *'...it was hard to talk to him...he barely listened...he*

got angry and he banged the table...so loud! ...I talked to him patiently...I showed him that I was acting in his best interests ...he finally settled down...' (Field notes on 7 July 2004, p.203: L22-25).

'It's not my fault'

Nurses in the study often stated *'it was not my fault'* when they described an incident. Such a perception was clearly demonstrated in many reports. In more than two thirds of the violent incident questionnaires nurses indicated that patient/relative factors were considered to be the sole cause of violence. This view was often justified by descriptions that patients/relatives did not comprehend and were not listening prior to the violent incidents. For example, *'They were not listening...they were too busy wanting to argue'* and *'They should not argue in a critical situation'*. Patient/relative factors mainly included drug/alcohol intoxication, psychiatric problems, dementia and frustration/anger. Alcohol alone or in combination with another factor such as personality and psychiatric problems, was the most frequently causal factor stated.

The staff rarely seemed to recognise the part they played in contributing to violent episodes, particularly in relation to skills deficits such as interpersonal skills (e.g. not making eye contact and invasion of personal space; *'...I touched him...he...got angry with me and showed his fist at my face. He said he was going to punch me in my face'*) (Interview with Nurse 18, p.45: L11-14). Not recognising these deficits then led nurses being unable to understand that their behaviours did have an impact on the incidents.

Such a perception consequently affected how the nurses interacted with patients/relatives and how they handled violence. They perceived that they did not need to change the way they approached patients. For example, '*...I haven't done anything wrong, you know; I didn't approach her aggressively...there was no inappropriate behaviour on my part that I have to change...*' (Interview with Nurse 19, p.97: L33-34; p.98: L1-2).

Victim blaming

As previously discussed, perceptions of violence were influenced by direct or indirect involvement. There were certain cases where nurses observed their colleagues being subjected to violence and perceived that the victim was at fault. This was demonstrated by statements such as, '*she was too trusting*' or '*she was naïve to approach the patient in that manner*'. Some also indicated that the handling of a violent incident by their colleague was not appropriate as they '*... should have called the security before anything happened*' and '*... should be more consistent in the way she (nurse) treats him (a 'frequent flyer')*'.

So far, all these were relatively overt forms of 'victim blaming' and there were also some subtle remarks suggestive of 'fault'. For instance, when other nurses in the ED came to know about the nurse who was abused by the patient in the above story, some said '*...her (nurse) again? ...*' and '*...her luck is not good*'. Such remarks seemed to imply that the nurse involved was more prone to violence due to her personal behavioural traits.

The consequence of this ‘victim blaming’ was that some nurses felt uneasy explaining to colleagues about their experiences of violence. They sometimes even chose not to report the incidents to their superior because of fear of being criticised as not functioning adequately in the ED. For instance, a senior nurse stated that ‘...you’ve got to be able to handle violence...if you want to work here (ED)’. ‘Victim blaming’ also seems to be responsible for the behaviour of the nurse in the above story, where she considered handling of the incident in the public area as ‘*making a scene*’. She might have thought that others would blame her and therefore she was too embarrassed to let others know about the incident.

Feelings about violence

The majority of nurses in this study as might be expected had negative feelings about violence. These included being shocked, frightened, disturbed, frustrated, annoyed, embarrassed, worried, guilty, isolated and powerless. For instance, ‘...*I was shocked because I didn’t know it was coming. I felt frustrated because I knew I had to take charge of the situation and work out something quickly...I was frightened as well...I felt like I was managing the situation on my own...it was so stressful*’ (Interview with Nurse 57, p.142: L26-34; p.143: L1-12; p.144: L9). They also felt helpless because they perceived that the situation during a violent incident had quickly ‘*gone beyond the point of no return*’ and nothing could have been done to prevent it.

Some also felt disappointed, for example, ‘*I was probably upset more than anything because you just...you know...you don’t have to come to work here...to have to deal*

with this sort of thing...I was actually trying to do the best I could for him (patient) but this is what I get [soft tone]' (Interview with Nurse 46, p.92: L18-21; p.93: L1-3).

A number of nurses also felt that they were treated unfairly and without respect. For example, *'...he was threatening and abusive...he wasn't abusive or anything to the doctor ...'* (Interview with Nurse 17, p.26: L27-32). They believed that they deserved to be treated with respect because they also had undergone extensive professional training. For instance, *'...you feel sort of...you got to try...I don't know...prove yourself...I just feel like saying to people like him "well, you know, I have done my graduate diploma and my degree. I am probably one of the most qualified nurses on the floor" ...'* (Interview with Nurse 31, p.64: L24-30).

A few nurses had more positive feelings in they did not feel threatened. Instead, they felt secure and satisfied with their encounters with patients/relatives. For example, *'...I'm quite...sure of my decisions...I'm quite comfortable with my judgement...'* (Interview with Nurse 2, p.1: L24-28) and *'...I'm glad that I handled it and went down that path with him. I think we have got respect for each other on a certain level...'* (Interview with Nurse 23, p.42: L5-7). Such feelings about violence seemed to be closely related to the professional pride in dealing with violence which was described previously.

Indicators of violence

Indicators of violence encompass a variety of direct (e.g. warning signs; antecedents) and indirect factors (e.g. characteristics of patients and situations; causes) which are

often learnt from previous violent incidents that can provide insight into future violence prediction. The ability to identify the indicators of violence in turn was tied closely to perceptions of violence. For instance, a nurse who perceived that aggressive behaviours from a 'frequent flyer' was 'normal' might fail to alert his or her co-worker of any warning signs of violence exhibited by such patient. The following paragraphs will describe the two major sources of indicators of violence: firstly, characteristics of patients and situations (i.e. causes); and secondly, warning signs of violence (i.e. antecedents).

Characteristics of patients and situations

A man in his thirties was staring at the triage counter without saying a word. He had multiple healed facial wounds. The triage nurse initiated the interaction by 'Hi'. There was no response. Then, the triage nurse said, 'Can I help you, sir?' He said '...colds for few days...' (very soft and poorly articulated). After having to repeat it a few times, the man got agitated and banged his hands on the triage desk and said loudly, 'Forget about it!' He walked away without waiting for the triage nurse to respond. The nurse just ignored the man and carried on with her duties. He looked very restless and paced up and down in the waiting room. He did not wait and left the department after ten minutes. Throughout the interaction there was no eye contact from this man. At times, he seemed preoccupied (Field notes on 15 June 2004, p. 145: L11-22).

This was an example of violence from a patient who had difficulty in communication and may be due to psychological problems. The nurses in the ED recognised that it

was important to know the indicators of violence. As described earlier, nurses in the study reported that more than two thirds of incidents were solely caused by patient/relative factors.

Nurses in the study, particularly the triage nurses, perceived that there were five major characteristics of patients which were more likely to contribute to violence. These included patients who had difficulty in communicating related to physical (e.g. patients with visual or hearing deficit, physical pain/discomfort, and dementia) or psychological problems (e.g. psychotic and psychiatric patients) and patients who were drug/alcohol intoxicated. Patients with social problems (e.g. family violence, patients who came to ED for shelter and food), past encounters (i.e. those who came to ED regularly; frequent flyers, and patients with violence alert) and certain cultural or socio-economic backgrounds were also included. In addition, certain scenarios also provided important indirect indicators of violence. They often consisted of factors such as long waiting time, overcrowding, prior dissatisfaction or complaint because of rejection of request/needs, un-cooperative with the treatment, and conflict with other personnel.

Warning signs of violence

Warning signs of violence are more specific behavioural indices (e.g. agitation or restlessness) that were observed prior to an incident. Awareness of the indicators of violence is important in short- and long-term violence management and prevention. On the other hand, knowledge of warning signs of violence is critical in the immediate response to violence.

The nurses in the ED also acknowledged that it was important to know the warning signs of violence. There were two main categories of warning signs perceived by nurses working in the ED. These were comprised of non-verbal signs (e.g. grumpy demeanour, tense posture, restless, squinting the eyes, not giving eye contact, pacing, smelling of alcohol, non-specific gaze or penetrating staring) and verbal signs (e.g. frequent requests to see the doctor, saying, *'I can't wait for long'*, shouting, whispering or mumbling).

In this study, the most frequently reported warning signs for violent incidents were a combination of non-verbal and verbal signs. For example this would include restlessness, agitation, staring and verbal signs such as swearing, raising voice and tone, crying. However, nearly one third of the reports indicated that there were no warning signs prior to the violent incidents.

Patients' characteristics and warning signs matched

As mentioned earlier, nurses in the ED commonly attributed violence to patient/relative factors (e.g. drugs/alcohol and psychiatric problems). It is important to assess whether patients/relatives with such a factor exhibit any observable warning signs which may facilitate an accurate prediction of violence.

The reports indicated that for those patients/relatives with alcohol intoxication alone, there was often no warning sign reported. In contrast, for patients/relatives with alcohol and a combination of factors (e.g. psychiatric problems), the majority of

reports indicated a combination of warning signs. It may be that covert warning signs (e.g. agitation or smell of alcohol) displayed by patients/relatives with alcohol the only factor, had gone unnoticed especially when the department was busy. Thus, there were some limitations in the ED setting which, at times might have prevented nurses from identifying such covert cues. For instance, a nurse who was busy handling multiple patients at once might not be aware of the non-verbal warning signs, for example staring.

The ability to identify warning signs prior to a violent incident depended on a variety of factors, in particular the characteristics of a sign itself and the environment. Some of these warning signs were more overt or obvious and some were more covert or subtle. The obviousness and timing in picking up a sign were related to each other. Overt signs (e.g. verbal) were usually picked up early in the nurse-patient/relative interactions. For instance, *'...you can tell within a couple of second how your interaction with someone (i.e. patients with certain cultural group) is going to go...basically when someone arrived...'* (Interview with Nurse 23, p.42: L28-31). Covert signs (e.g. non-verbal), on the other hand were often recognised either late or not at all in such interpersonal exchanges.

Responses to violence

An unkempt man in his early forties came to the triage counter. Tension showed on his face. He squinted his eyes and looked at the triage nurse. The triage nurse initiated the interaction by asking, *'Yes, can I help you?'* The man did not respond to the question the first time. Then, he mumbled, *'I want to*

get a script for morphine' The triage nurse replied, *'You cannot get a morphine prescription here'* Then he asked, *'Do I need to get admitted in order to get it?'* The triage nurse said, *'No, they (doctor) won't give it to you if they think you don't need it'*. Without a second thought, he said, *'I need it...I have not been sleeping...have been puking...'*

He refused to go away. *'No point standing around, they won't write the script...sir, I want to see the people behind you'*. He said loudly, *'Yeah...come through...'* without any intention of going. The triage nurse asked, *'Are you going to leave the premises or not? If not, I'll call the security'* (Firm tone). *'Yeah...(loudly)...thank you for your help'* in a threatening tone and he stormed out of the main entrance. The triage nurse felt threatened and she called security. The security officer stood in the waiting room for the rest of her shift (Field notes on 2 July 2004, p.145: L26-33; p.146: L1-11).

This was an example of how emergency nurses reacted to difficult interactions. Nurses' responses to violence could be classified into direct and indirect responses. The direct responses could either diffuse or inflame the situation. Techniques such as trying to get patients/relatives to listen, giving warnings of removal or other consequences, demanding patients/relatives to leave the premises, and showing authority by talking to patients/relatives firmly were likely to inflame the situation.

The majority of nurses at times adopted strategies that were likely to diffuse violence such as empowering patients/relatives (e.g. letting patients/relatives make decisions and speaking slowly to the patients/relatives); acknowledging patients' feelings (i.e.

physical, psychological or emotional); showing concern for patients (e.g. providing comfort/attention); and using empathetic communication skills (e.g. friendly body language, smile, and calling patients by their first name).

Apart from direct interaction, nurses also employed some indirect responses that could either be passive or aggressive. The indirect-passive responses included self-protection (e.g. *'I use the duress alarm freely'*), self-withdrawal/avoidance (e.g. *'I don't expose myself'* or *'...not taking it personally'*), desensitisation (e.g. *'getting used to it'* or *'immune to it'*), and denial of violence via rationalisation (e.g. *'she was OK, just not cooperating with treatment'*, *'she was not that violent'*, *'he is a psych patient'*, or *'violence is normal in ED'*). They commonly denied (ignoring/shrugging off) incidents by avoid thinking about them and *'just keep moving on'* because

'...You just let them go. They can believe what they want to believe because no matter what you say to them, it is not going to change their perspective because what they believe err...that they saw and...you just can't do anything about it, you just let them go...' (Interview with Nurse 19, p.96: L28-33).

Nurses in this study also adopted indirect responses which were aggressive such as withdrawal of care (e.g. refused to provide care or interact with the same patient after violent incidents), and ignoring the patients or situations (e.g. *'if they threaten to kill themselves, I just let them do it'*).

The choice of response mainly depended on the characteristics of those involved (i.e. patients/relatives) and nurses' experience. For mentally sound patients/relatives,

nurses usually employed direct responses. When patients/relatives involved were not mentally sound or nurses perceived that their direct responses would potentially fail or had failed, then, they either avoided the patient all-together or worked with others to resolve the problem. Commonly, they called security to remove, restrain and monitor the patients, or transferred the patients to the seclusion room.

Besides the characteristics of those involved, nurses' responses to violence also reflected their seniority and violence handling experiences. For example, junior nurses were more likely to get support from others in handling violence. When they handled the violent incident alone, they were also less likely to give warnings of removal or ask patients/relatives to leave the premises. In fact, they were more likely to use techniques such as empowering patients/relatives and showing concern for patients. In addition, nurses who had experienced severe physical violence from patients/relatives seemed more likely to engage in indirect-aggressive responses, such as retaliation.

The element 'problems and solutions' highlighted the fact that at times nurses' perceptions of violence made dealing with the problem quite difficult. The view that violence was inevitable and unpredictable, for instance, did not provide for solutions. Identification of indicators of violence was important in violence prevention but in some cases the perceived indicators were covert and difficult to determine. The final aspect of this element indicated that responses to violence vary; some responses could inflame while others diffuse situations, suggesting that at times that solutions were available.

‘Them and us’

The element ‘them and us’, mainly focused on patients/relatives’ and nurses’ behaviours. It was apparent that both nurses and patients/relatives responded in certain ways to actions from others; actions resulting in reactions. The examination of how individuals behaved and then how the other responded was important in understanding how violence occurred.

Patients/relatives’ behaviours

As previously described, patients/relatives in the ED might feel anxious and vulnerable in such an unfamiliar environment. Such negative emotions might be expressed through a range of transgressive acts or violent behaviours. Naturally, not all patients/relatives who appeared anxious and vulnerable behaved aggressively. In fact, the majority of patients/relatives observed at triage displayed positive behaviours such as being friendly (e.g. smiled at triage nurse), cooperative (e.g. saying, ‘OK, mate’, ‘Yes’), attentive (e.g. making eye contacts, bending forward and nodding their head to show agreement and understanding) and appreciative (e.g. saying, ‘Thank you’).

The following paragraphs will describe the features of violent behaviours. There were three major types of violent behaviours observed: verbal (e.g. yelling, threatening, swearing), threat/intimidation (e.g. staring) and physical (e.g. biting, kicking, spitting). These behaviours occurred alone or simultaneously. For example, as mentioned earlier, verbal violence without any accompanying type was the most common type of violence reported.

There were, however, many incidents involving more than one type of violent behaviour. Some patients/relatives started with threat/intimidation and progressed to verbal and/or physical violence. The need to reveal personal information at triage could provoke anger in some patients. For example, ‘...*he (patient) didn’t like the fact that...the fact I (Nurse 31) asked him whether he had any pre-existing medical problems. He said... “you don’t have to know...you don’t need that...” he didn’t want to discuss his information, you know... to the rest of the department...*’ (Interview with Nurse 31, p.62: L29-34; p.63: L1-3). Such behaviours could happen suddenly or progressively, with or without provocation. For instance, ‘*When I was going to confirm his name...suddenly, he hit me in the left chest...the breast area...and punched it quite hard and sort of knocked me back a little bit...*’ (Interview with Nurse 4, p.10: L15-17).

The initial interactions

The last section described the general behaviours of patients/relatives in the ED. This section focuses on specific behaviours during their initial interactions with triage nurses. The majority of patients/relatives who became violent were reported to be so at presentation or after less than one hour in the department. In view of the short period of time between presentation and occurrence of violence from patients, assessment of the initial interactions (which concentrated on what patients/relatives first said/did) between nurse and patient/relative at triage was important.

The things that patients/relatives first said/did at triage can be divided into two categories: patient initiated interaction; and patient reaction to a triage nurse’s

greeting (Figure 5.3). There were four major types of patient/relative initiated interactions which included greeting, enquiring (e.g. *'How long am I supposed to wait?'*), requesting/demanding (e.g. *'I want to see doctor ASAP'*), or stating condition (e.g. *'I'm dying'*). There were three common reactions to a triage nurse's greeting: reciprocating the greeting, requesting/demanding (e.g. *'I need to have an X ray'* and *'I need to see the doctor'*), or making a statement about their condition (e.g. *'I have chest pain'*).

It was observed that patients/relatives who reciprocated the greeting or who initiated the greeting appeared to have low propensity for violence and triage nurses often felt good about the interactions. There appeared to be a greater propensity for violence when patients initiated an interaction with an enquiry about waiting time, and making a request or demand. Triage nurses were often less likely to feel satisfied with these interactions.

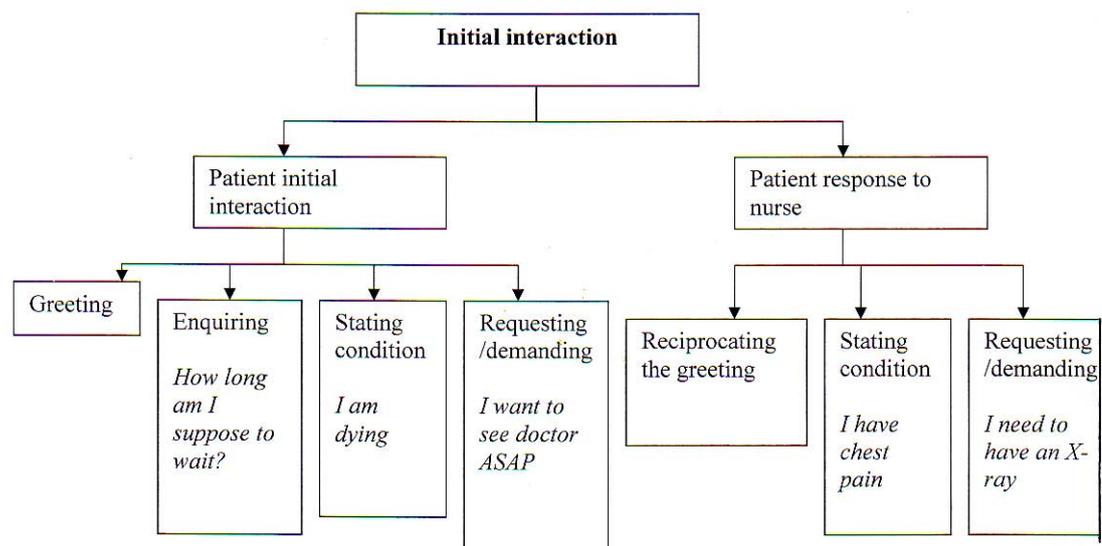


Figure 5.3: Taxonomy of a patient's initial interaction

The first impressions of patients/relatives

During the initial nurse-patient/relative interactions, first impressions of patients/relatives were formed. These impressions would influence nurses' subsequent behaviours toward patients/relatives. The importance of first impressions of patients/relatives came through strongly in interviews with nurses who completed the violent incident questionnaires. It was realised that nurses' first impressions of patients/relatives involved in violent incidents could be either positive or negative. However, negative first impressions seemed evident in most of the violent incidents.

The positive first impressions were often developed from patients/relatives' with a calm and cheerful demeanour, and cooperative behaviours. Such positive impressions were more likely to be associated with a stronger sense of control and satisfaction of nurses. Conversely, negative impressions were derived from patients/relatives' agitated, abusive and non-cooperative behaviours (e.g. poor history; 'the patient could barely talk'). The negative impressions appeared to generate a feeling of lack of control and dissatisfaction with the interactions. As a result, nurses reacted to this with various behaviours that were often also negative.

Nurses' behaviours

It was very busy as the man walked through the automatic door in front of the triage desk. He was obviously in pain but no-one seemed to notice. He had been passing blood in his urine and this was the second time he had sought help in two weeks. He explained this to the triage nurse. After a brief exchange there was a request for a urine sample, but the nurse offered no pain

relief. With a frustrated tone, the man shouted, '*Can you stop the pain first!*' The triage nurse firmly stated, '*No, I can't.*' No explanation was given and the triage nurse did not tell him whether she planned to give him a bed to lie down on after he had given the urine sample.

After producing dark-red urine, the patient was brought to the treatment area. Ten minutes later, this man was shouting and throwing furniture in the treatment area. He shouted, '*Give me the pain killer...*'. However, no pain relief was given until he was seen by doctor twenty minutes later (Field notes on 23 May 2004, p.38: L5-29).

It seemed that there were some nurses' behaviours which were more likely to contribute to violence. Such behaviours included: being overtly authoritative (e.g. refusing a request without explanation and insisting on gaining information from patients/relatives); being judgemental and confrontational (e.g. confronting the patients/relatives for their behaviour such as reading of case notes); and being indifferent to patients' physical complaints.

Naturally, nurses did not always behave in this way. Behaviours such as (1) acknowledging the patients' arrival or lengthy wait (e.g. '*Sorry for the wait*'), (2) not being unnecessarily authoritative, (3) using friendly body language (e.g. leaning forward slightly with open arms), (4) thanking patients when they responded to questions, (5) empathising with patients or showing concern for patients, and (6) providing comfort and foreseeing patients' needs in advance usually resulted in very positive interpersonal relationships.

Behaviours relevant to the establishment of rapport

It was two hours before midnight and the triage nurse had just begun her shift when two anxious looking women came to the triage desk. Their facial expressions were very tense. The triage nurses started with *'Hi'*. The younger female replied, *'Hi, I need to see a doctor'* with a firm tone. The other woman added, *'She's got a letter from hospital...she's got fluid retention...'*. The triage nurse asked politely, *'Can I have your letter please?'*. After reading the letter, she asked, *'Are your legs red, Elizabeth?'* (pseudonym). Then she asked, *'Have you had cellulitis before?'*. Elizabeth mumbled something and seemed to have a problem with the medical terminology. The patient was able to make eye contact, but she blinked her eyes excessively (she had a bipolar disorder).

After that they were directed to go to the clerk so that the administrative details could be formalised. About ten minutes later, Elizabeth came and leaned on the triage desk while the triage nurse was talking to an ambulance officer. The triage nurse acknowledged Elizabeth's waiting by saying, *'Just be a sec, al'right'*. The patient said, *'...am I allowed to drink?'*. The triage nurse replied, *'Up to you, you can do whatever you want...but don't drink a gallon...'* in a joking tone. The patient responded with a smile. She was seen by doctor one hour later (Field notes on 24 May 2004, p.45: L11-32).

This was the case where nurses' effort to establish rapport had ended in good outcomes. Joking with this patient appeared to be more powerful than other rapport establishing techniques. That is, calling the patient by her first name, politeness, and acknowledgment of this patient's lengthy wait/concern.

The previous section dealt with more general empathetic behaviours (e.g. acknowledging the patients' arrival, using friendly body language) which had an important role to play in nurse-patient/relative interactions. This section is concerned with the behavioural techniques that ED nurses used to develop rapport with patients/relatives, in particular when they perceived that patients/relatives had become agitated or unhappy. Nevertheless, it is crucial to note that the categories described in these two sections are not mutually exclusive; the context and the purpose behind its usages are significant.

As mentioned earlier, first impressions of patients/relatives were developed during the initial interactions. More importantly, the observations revealed that triage nurses employed many ways to establish rapport with patients/relatives during the initial interaction, in particular the difficult interaction. Successful empathetic strategies often used included friendly body language (e.g. bending forward slightly while talking to patients/relatives, maintaining eye contact with patients/relatives, nodding head), showing concern, showing humanity, greeting the patients/relatives and calling patients by their first names. These methods were acceptable in most situations.

Care needs to be taken with rapport establishing techniques. For example, joking with distressed patients/relatives would not be appropriate. However, at times, nurses' efforts to establish rapport did not necessarily result in satisfactory interpersonal relationships. For instance, eye contact was interpreted negatively by a schizophrenic patient: '*...don't you (nurse) stare at me again...*'.

'Turning point'

Different behaviours impacted on how the other person reacted. However, the resulting behaviour could go a number of ways. It was not inevitable that a negative behaviour elicited a negative response. On numerous occasions, a 'turning point' was observed during the nurse-patient/relative interactions. For example, a 45-year old woman presented with a male relative or friend. She appeared to be very tense and she was wearing a pair of sun glasses. The triage nurse initiated the interaction by saying, '*Hello*'. The female responded, '*I need to see a doctor...I got nose bleed...*'. Further into their conversation, the woman revealed that she had 18 episodes of nose bleed within a couple of days. When the triage nurse acknowledged her feelings by saying, '*Oh, that's not good...are you stressed, Judith?*' (Pseudonym). Upon hearing this, the woman took her sun glasses off and nodded her head, smiled and remarked, '*Yes, I'm...I have an exam coming up...*'. The outcome of this turning point was positive. The action of the nurse resulted in a positive response from the patient.

For the man passing blood in his urine, the 'turning point' went the other way. Had the nurse responded to the man by acknowledging his pain and organising timely pain relief, the resulting behaviour might have been quite different. If an explanation

was provided for the rejection of his request, he might have felt less agitated and angry.

Patients' presenting problems

The first impressions described earlier were often related to the manner in which patients presented to the ED. An important indicator of triage nurses' behaviour was the patients' presenting problems and in particular the levels of visibility of the problem. Patients with highly visible injuries or obvious physical pain/discomfort such as a fracture were assigned to a higher priority and more time was given to the triage process. Triage nurses appeared more empathetic and worried about patients especially when patients had more serious conditions. Such a positive behaviour often resulted in a reciprocal positive response from patients (e.g. '*...thank you for your (nurse) help*').

However, when some triage nurses were presented with a patient whose condition was not highly visible such as migraine or renal calculi, they sometimes became sceptical and this was reflected in their behaviours. They did not acknowledge patients' pain and concerns. When this happened, patients sometimes became agitated and aggressive. This group of patients were generally classified as lower priority (e.g. Priority 3 for non-violent psychiatric cases) and less time was given to the triage process or fewer questions were asked for details of their emotional state than patients who presented with obvious physical injury. Some of these actions taken by nurses were not judgemental as they arose from protocols that had to be

followed. However, patients often considered this as bias and it provided justification for their aggressive response.

The element 'them and us' highlighted the importance of reciprocity in nurse-patient/relative interactions. It was observed that negative behaviours or actions from one party often elicited negative responses or reactions from another party, which would then potentially escalate to violence. However, this was not always the case. Critically, there was often a point where the reaction could go either way; a turning point.

From the observations, it was realised that the use of suitable responses, for example empathetic communication skills, could lead to a more positive outcome. The next element, 'requests and demands', examines very specific issues (i.e. requests of patients/relatives) that often precipitated violence. It will explore how the handling of patients/relatives' requests, in particular the request for shorter waiting time which impacts on nurse-patient/relative interpersonal relationships.

'Requests and demands'

'Requests and demands' was the specific cultural domain that directly affected nurse-patient/relative interaction. There was a duality in this element. On one hand, patients/relatives sometimes perceived their requests as reasonable, while nurses may perceive them as being unreasonable (Figure 5.4). Figure 5.4 illustrate patients/relatives' and nurses' views of requests. These views were often dissimilar and conflicting. Besides describing the requests in general, this element was particularly concerned about requests and demands in relation to waiting time.

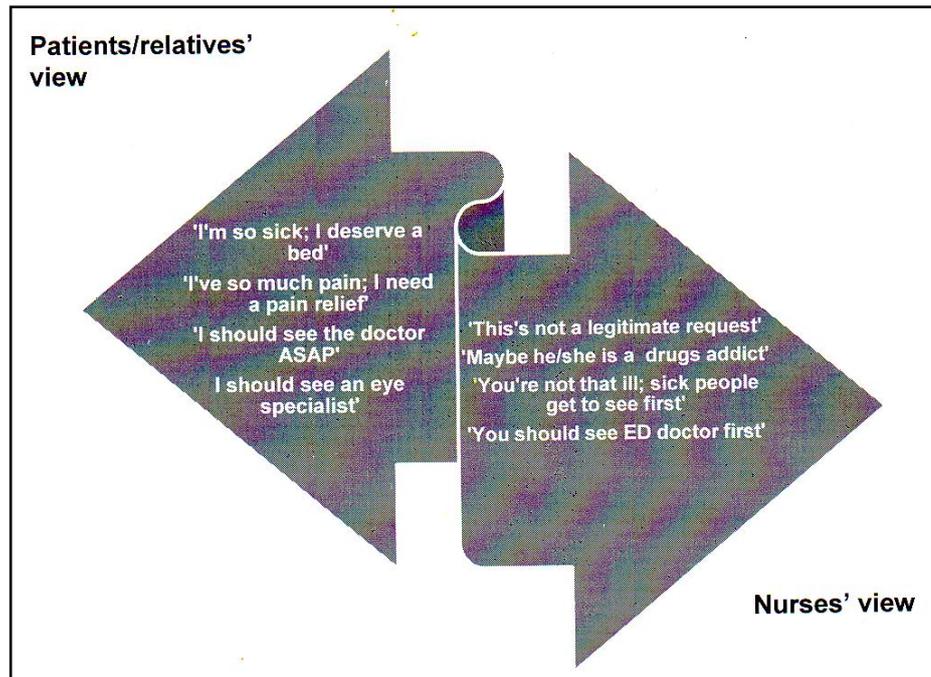


Figure 5.4: Patients/relatives' and nurses' view of requests

Requests from patients/relatives

Individuals varied in terms of their concerns and needs, and not all the needs of patients/relatives could be met in the ED, particularly when the department was busy. Requests from patients/relatives were often prompted by unmet needs. Not all patients/relatives requests were considered legitimate and reasonable by nurses. The following section will detail how nurses perceived the requests and how they then responded to them.

Nurses' perceptions about the requests

There were many types of requests made by patients/relatives at triage. Patients/relatives requested sick certificates, directions, assistance to bring patients from the car park, blanket, wheelchair, morphine prescriptions, accommodation, food, and referral to a specialist. The most common requests, however, related to an earlier doctor's consultation, prompt pain relief or wanting a bed to lie down.

These requests were perceived by nurses as either legitimate or illegitimate. Nurses took in a range of information and cues and then determined the legitimacy of such requests. This usually depended on a triage nurse's judgement and the patient's condition. For example, a nurse refused to give morphine to patient with knee pain due to the perception that the patient might have had a history of drug abuse. Nurses also appeared to believe that some patients exaggerated their symptoms in order to gain an earlier consultation and therefore they imposed their own judgement when making decisions on the requests.

The perceptions of nurses about the requests were complex. The same type of request could be perceived as legitimate or illegitimate by the same nurse depending on the context. For example, a patient's request for a bed because he/she had lower back pain was considered reasonable, but the same request by another patient with lower back pain who had been treated earlier was considered as unreasonable. The difference between the two cases was that the nurses might perceive that the former patient's pain was legitimate and the latter was not because he or she had been treated.

There were some requests that were more likely deemed illegitimate regardless of a patient's condition. The types of requests that were perceived as strictly illegitimate were morphine prescriptions and requests for accommodation or shelter in the ED. Rejection of such illegitimate requests was usually associated with frustration and aggression. It appeared that patients making such requests already had a higher propensity for violence (e.g. homelessness, mental health issues and addiction).

When nurses considered the approach by a patient as being legitimate, then the request was granted. If the request was considered as illegitimate, then it was commonly rejected. The legitimacy of the requests perceived by nurses was not the only factor determining whether a request was granted. Other factors such as availability of resources and departmental protocols were also considered.

At times, a legitimate request could not be fulfilled as the department was busy and there was a lack of resources to grant the request. For example, a perceived legitimate request (e.g. a bed to lie down) from a patient with shoulder dislocation was denied as there was no vacant bed available. ED protocols and procedures also played a part in deciding the possibility of granting a request. For example, a request to see an eye specialist without seeing the ED doctor was against the departmental protocols. Clearly, nurses' perceptions about the requests were not the only guide in determining responses.

Rejecting patients/relatives' requests

As mentioned above, requests were responded to in a number of ways: (1) request was legitimate and could be met, (2) request was legitimate but could not be met, and (3) request was considered as an illegitimate demand and was refused. Triage nurses used many methods to reject the requests made by patients/relatives.

For the perceived reasonable or legitimate request, nurses commonly used: (1) explaining (e.g. *'...I cannot give you any injection now because the doctor needs to check your tummy first'*), (2) apologising, or (3) providing alternatives. At times, the alternatives were simply a statement such as, *'Unfortunately, all our beds are occupied. Is there anything I can do for you?'* or *'Please take a seat there (waiting room), if you need any help, just give me a yell'*. Triage nurses usually spent time explaining why these requests (i.e. reasonable or legitimate) were rejected by giving rational such as unavailability of resources.

On the other hand, nurses often responded to what they perceived as being illegitimate or unreasonable requests with less diplomatic approaches. They used techniques such as: (1) discouraging (e.g. at triage, some patients enquired about waiting time first and then decided whether to see doctor or not. Under such circumstances, nurses often exaggerated the possible duration of waiting), (2) avoidance (e.g. a request was refused by not making eye contact with patient), (3) calling reinforcement (e.g. calling security and other staff member), (4) direct refusal (e.g. *'not here for social reason'*), and (5) standing one's ground (e.g. using firm tone). In addition, it seemed that less time was spent with the patients/relatives when

such requests were rejected. It seemed that these types of refusal resulted in a reaction from patients that was often violent.

Waiting times

Only two people were sitting in the waiting room. The waiting time display in the waiting room indicated three hours. The waiting room was calm and quiet and this differed from the inner part of the ED which was very chaotic. This was because there were three trauma patients and one unconscious patient in the resuscitation rooms. A man with thumb injury and smelling strongly of alcohol came to the ED.

The triage nurse started the interaction with, *'Hello'*. The man said, *'I want to see the doctor ASAP'* and handed over the referral letter to the triage nurse. The triage nurse explained that he needed to wait. He stared at the triage nurse and raised his voice saying, *'I can't wait...I'm going to lose my thumb like that...'*. He wanted to come back the next day and insisted the triage nurse gave him a call so that he did not have to wait. The triage nurse said, *'You're going to wait whenever you come back'*. Sarcastically, he said, *'Thank you'* and stormed out of the main entrance. Several minutes later, he came in and asked again, *'How much longer do I need to wait here? (Swearing) Am I going to wait here the whole night?'*. The triage nurse said, *'About half an hour...'*. This was very unlikely because there were a few patients waiting ahead of him and he was a priority 4; lower priority. This

particular patient said, *'Is that it?'* (in a suspicious tone). The triage nurse replied, *'Probably, I can't guarantee'*.

This man came to the triage desk 35 minutes later and he shouted, *'When are you going to **let me** see the doctor?'*. At that time, another triage nurse was on duty. The triage nurse had no idea about the prior difficult interaction between this patient and his colleague. He said, *'Half an hour...you are on top of the list'* and showed him the computer screen. The patient was really angry, *'I'm going. I'll hold you responsible; if something happens to me'*. The triage nurse said, *'It is your decision. I think you should stay...I want you to stay...and that hand needs to be checked. This is the reality of the hospital and...your injury is not life-threatening'*. The man seemed settled down a bit but shortly after that he continued to approach the triage nurse and kept pestering him for the waiting time every few minutes. At one stage, the triage nurse got agitated and simply said, *'You'll be seen'* and continued doing his work (Field notes on 4 June 2004, p.106: L2-34; p.107: L1-6).

In this case, the patient perceived conflicting messages about the waiting time. The waiting room was quiet and nearly empty and yet the waiting time signs indicated a long wait. The nursing staff also provided him with conflicting and uncertain information, which aggravated his anxiety and agitation.

Situations leading to prolonged waiting time in the ED

There were many situations which led to prolonged waiting time in the ED. These included the incorrect patients' status on the computer, delays in consultation/review, shortage of staff, no bed/bed blockage, low priority, arrival of serious trauma patients in the ED, unwanted attendees and the '*therapeutic wait*' during weekend mornings just before changing of shift.

In some cases, triage nurses believed that patients with certain conditions did not warrant emergency services. Triage nurses assumed that there was a specific waiting time that should apply to non-emergency cases. For example, there was a view that all non-emergency cases should be made to wait. This they called the '*therapeutic wait*'.

There was a particular issue that resulted in the incorrect patients' status on the computer which then increased the waiting time. Patients with eye injuries frequently required the attention of eye specialists. The medical staff in the ED might have called the eye specialists to see the patients without seeing the patients first. The computer record would indicate that these patients had been assessed and were waiting to be reviewed by eye specialists. From the patient' perspective, nothing had been done and this caused considerable frustration.

It was apparent that some of these situations were avoidable (e.g. incorrect patients' status on the computer) and some were not (e.g. shortage of staff, no bed/bed blockage, delay of consultation/review, and arrival of serious trauma patients in the

ED). For example, waiting times for ‘unwanted attendees’ might have been reduced if nurses and doctors did not ascribe to the ‘*therapeutic wait*’.

Judging and reacting to waiting times by patients/relatives

It was apparent that all the patients/relatives were concerned about how long they would have to wait. A long wait or uncertainty about how long caused much anxiety and agitation. During early observations, waiting times for consultation were noted from the signage displayed in the waiting area. Later, it became apparent that these times were commonly not up-to-date because the monitor always showed 1.5 or 3 hours. The computer reading provided a more accurate waiting time. This was because the waiting time shown in the waiting room was subject to triage nurses or clerks’ availability to update the system. According to the computer, the longest waiting time recorded during the observations was 4.5 hours. On average, the waiting time to see doctor was half an hour. It should be noted that the patients/relatives did not have access to the computer and accurate information could only be obtained by asking the triage nurses.

Commonly, the first step used by patients/relatives to estimate waiting times was simply counting the number of people in the waiting room when entering the waiting area and approaching the triage desks (Figure 5.5). During this time, they would often then look at the priority signage that explained ‘The sickest people get seen first’. Subsequently, they sat in the waiting room. They also looked at the ‘current waiting time display’ and observed the people in front and behind them. If the stated waiting time expired or the people in front and behind them had gone in, they would

employ a more explicit method by asking the triage nurses when they would be able to see a doctor.

The figure below illustrates the differing sources of information about waiting time and the actions that were taken in response to this information. Even though there were some patients/relatives who asked about waiting time at presentation to the triage desks, the majority asked much later or after they had gone through all the steps described above. When this happened, the degree of frustration was high compared to other means of estimating waiting time, as there had been more time for it to build. The main message here was that all paths eventually led to the triage nurse and the longer the path the greater the uncertainty and the greater the frustration.

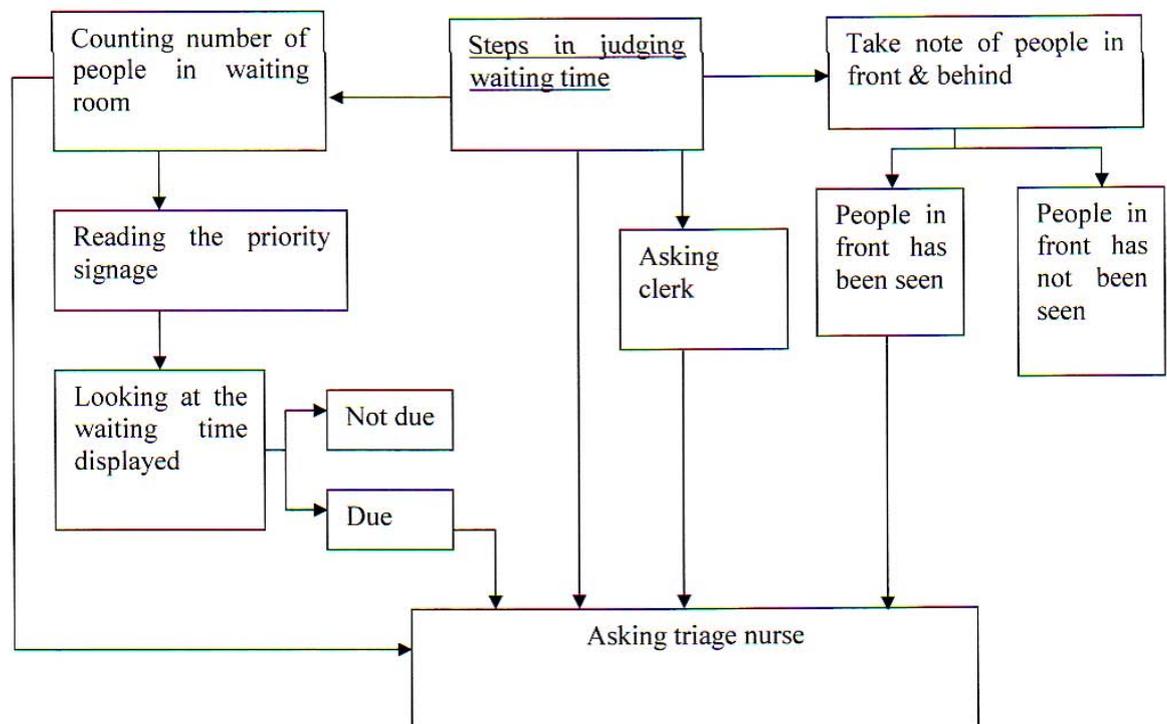


Figure 5.5: Taxonomy of steps in estimating waiting time

Communication of waiting times by nurses

While they waited, many patients/relatives asked when it would be their turn to see a doctor. Triage nurses communicated to patients/relatives the waiting time in many ways. Various ways that triage nurses adopted were classified into:

- specific (e.g. *'the next one to go'*, *'two people ahead of you'*)
- ambiguous (e.g. *'may wait for hours'*)
- explanatory (e.g. showing the triage computer screen where the list of patients' names were available, *4-5 hours for non-emergency'*)
- optimistic (e.g. *'shouldn't be long'*)
- pessimistic (e.g. *'you are going to have a hell of wait today'*)
- fallacious, where patients/relatives were told the incorrect estimated waiting times because triage nurses appeared to succumb to the pressure in providing them with a more acceptable answers in view of their agitation.

Being 'specific' was the most common way to communicate waiting times to patients/relatives. The levels of patients/relatives' satisfaction appeared to be influenced by the type of response. Patient/relatives usually felt more satisfied with the explanatory, optimistic and specific responses. The fallacious response seemed to only produce short-term satisfaction, because the patients/relatives soon realised the given waiting times could not be guaranteed or were incorrect resulting in increased frustration.

It seemed that the choice of communication of waiting time was determined by a few factors, particularly the duration of patients' arrival in the ED. If the patients/relatives asked about the waiting time immediately after their presentation to the triage counter, ambiguous and pessimistic ways were usually used to convey the waiting times, particularly when the situation in the department was busy. If the patients/relatives had waited for a period of time, triage nurses were more likely to use explanatory, specific and fallacious ways.

It appeared that nurses acted subjectively when conveying the waiting time to patients/relatives. This could be linked to their role as 'door-keeper' to the ED. As 'door-keeper', they appeared keener to employ the less satisfactory methods which could possibly help them to deter the 'unwanted attendee' from seeking treatment in the ED from the very start. It was observed on many occasions that after nurses used these less satisfactory methods, some patients either left the department or got angry. The more satisfactory methods were used after patients had waited for a period of time. This could be related to the view that these patients were more determined to get treatment at the ED and a better response was needed to prevent them from getting agitated about the long waits.

Justification for waiting times

Generally, patients were more likely to accept the need to wait if they knew the reasons for waiting, although this was not always the case. Triage nurses did not routinely justify or explain the reasons for further waiting. However, they were more likely to do so when patients/relatives demonstrated dissatisfaction with the waiting

times provided. Some justifications related to priority indicating that the patient was a low priority (i.e. not classed as an emergency) or that others were a higher priority, for instance *'sick people get seen first'*. Other justifications related to throughput such as *'unfortunately, we are really busy...'*.

The 'non-emergency justification' appeared to convey a judgement about the appropriateness of the patients' presentation to the ED. The 'priority rationale' where 'the sick people have the first priority' seemed to impose a moral pressure on patients/relatives to have them accept a long waiting period. In both cases, it personalised the justification inferring that the patient was the problem. In other words, it shifts the responsibility for accepting the wait to the patient. The justification relating to activity level was most commonly used and it seemed that it was used to convey the message that waiting times expected were beyond control.

The nurses' explanations were often treated with scepticism, which was often due to the patients' inability to verify the information (Figure 5.6). Figure 5.6 illustrates patients/relatives' and nurses' conflicting views of waiting. For example, often patients/relatives were not convinced by the 'priority rationale' because often the person being attended first did not appear to be sicker than them. The justification relating to activity level was not usually welcomed by patients/relatives. The number of people in the waiting room was not always consistent with the claim of 'busyness' in the ED. The set-up of the ED meant that patients/relatives could not judge what was going on in the rest of the ED. The negative reaction to this justification was usually related to a lack of confidence in the information given.

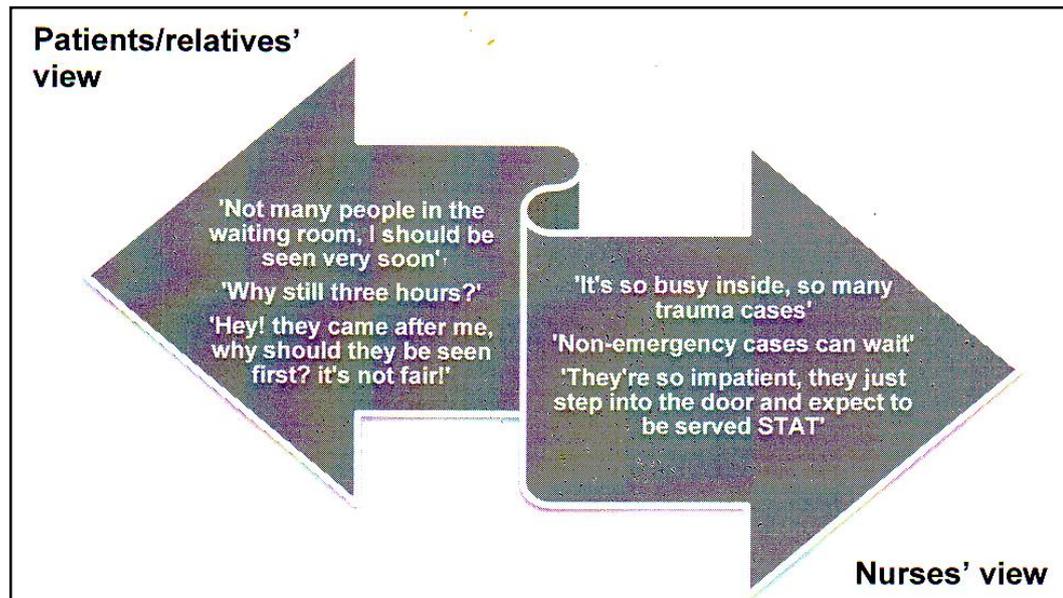


Figure 5.6: Patients/relatives' and nurses' view of waiting

Patients/relatives' response to waiting times

As indicated in the model of activities around waiting times, it was mostly up to the triage nurse to deal with patients' response to a long wait. Patients/relatives' responses to waiting times could be either positive or negative. When patients/relatives accepted the waiting times or the reasons provided for the wait, they generally had a more positive response. However, it was observed that many patients/relatives did not respond to a perceived lengthy wait positively. They did not accept the waiting time and got frustrated and angry. This was especially demonstrated by those patients/relatives who enquired about waiting time more than once.

More importantly, it was observed that negative responses to waiting time were not exclusively dependent on the duration of waiting. For example, some patients

became frustrated after waiting for less than five minutes, whilst some only became agitated after waiting three hours. Clearly, the individual patients/relatives' tolerance levels for waiting differed. The perceptions of their own needs and priorities, processing of differing information sources and confidence in those sources could also have been a factor.

The element 'requests and demands' highlighted issues that directly influenced the relationship between nurses and patients/relatives. Requests from patients/relatives were perceived by nurses as legitimate or illegitimate. Nurses' perceptions of requests were complex and it was affected by a few factors (i.e. nurses' judgment, patients' condition and departmental protocols). Provided that there was no limitation in the resources and staffing levels, a perceived legitimate request was more likely to be granted than an illegitimate one. Patients' reactions to the denial of requests in turn depended largely on how the rejection was made and conveyed.

Summary

This chapter has described the cultural scene, actors and activities in the cultural setting. The physical layout of the ED was designed in such a way so that it could accommodate the needs and safety of patients/relatives and nurses. The environment in the ED was constantly changing and unpredictable. Many patients/relatives who waited in the waiting room experienced anxiety in this unfamiliar and controlled environment. Such a negative emotions were not exclusive to patients/relatives, nurses working in the ED, in particular the triage nurses also appeared to feel anxious and stressed as they had to make many decisions, and handle multiple tasks and responsibilities simultaneously. Even though many activities that occurred in the ED

were positive with good outcomes, negative incidents such as violence did occur all too often.

This chapter has also explained in detail the three cultural domains that were important to understanding the cultural aspects of violence in the ED: ‘problems and solutions’, ‘them and us’ and ‘requests and demands’ (Figure 5.7). ‘Problems and solutions’ was the element that described in general how violence in the ED was experienced and managed.

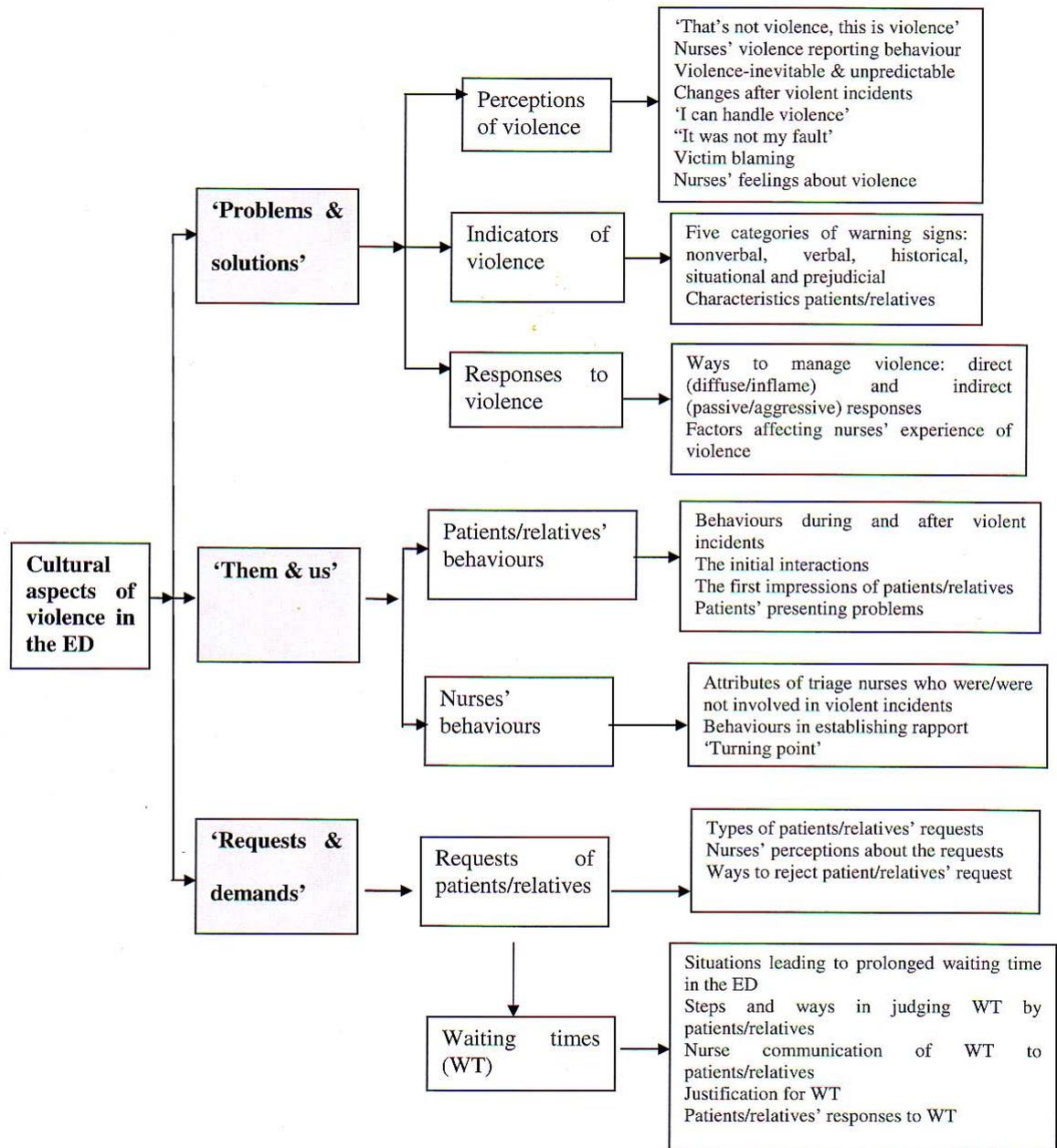


Figure 5.7: Taxonomy of cultural aspects of violence in the ED

‘Problems and solutions’ emphasised that nurses’ perceptions of violence played an important role in identification of indicators and management of violence. At times, nurses’ perceptions of violence made dealing with the problem quite difficult. The perceived indicators of violence in some cases were covert and difficult to determine.

In a constantly changing and busy setting like an ED, the less obvious or covert signs (e.g. agitation) could be easily overlooked. The final aspect of this domain indicated that nurses who perceived violence as a positive experience tended to adopt direct responses such as empowerment of patients/relatives or acknowledging patients' feelings/concerns. In contrast nurses who perceived violence as a negative experience tended to call the security to remove or restrain patients more often. Some of these responses could inflame while others diffuse situations, suggesting there were solutions available.

The last two cultural domains - 'them and us' and 'requests and demands' - focused specifically on how the problem of violence occurred in the ED. These elements were characterised by duality. 'Them and us' highlighted the importance of reciprocity in nurse-patient/relative interactions. Some behaviour from nurses, for example judgemental and confrontational, was more likely to elicit patient violence. Observations revealed that patients who initiated the greeting or reciprocated the nurses' greeting were less likely to become violent. Critically, there was often a point where nurse-patient/relative interactions could go either way; a turning point. The use of empathetic communication skills (e.g. making eye contact and calling patients by their first name) could lead to a positive outcome where violence could be contained or prevented.

'Requests and demands' were mainly concerned with request of patients/relatives and in particular waiting time. The conflict in the nurse-patient/relative interaction often arose because of the duality in the perceived requests; patients/relatives perceived their requests as reasonable, while nurses perceived them as unreasonable

demands. Nurses' perceptions of these requests played a very important role in how they responded. If they perceived a request as legitimate, the request was more likely to be granted. However, at times, due to limited resources and staffing levels, a perceived legitimate request could not be met. The important point to acknowledge here is that the rejection of requests and long waiting time did not equate to violence. The manner in which nurses rejected the requests and conveyed or explained the waiting times was critical. The next chapter will explore the significance of these findings within a broader framework in order to identify the implications of the study.

CHAPTER 6:

DISCUSSION

Introduction

In recent years, the corpus of nursing research on patients/relatives violence towards nurses has continued to grow. Even though there are an increasing number of studies investigating this problem, it seems that a comprehensive understanding has not been achieved. It appears that many cultural aspects of violence in the emergency department (ED) have not been explored. Violent incidents in the emergency departments are common in all cultures. However, as Ferns (2005) pinpointed, there are some differences in the nature of violence, for instance in some cultures, violence is more likely to involve weapons than in others.

Violence in the ED is an increasing problem that attracts much attention from nurses and administrators. The ED is not an isolated subculture, but rather it is a microcosm of a wide spectrum of culture. In other words, violence in the ED is also influenced by wider societal factors such as ethnicity, socio-economic status, and political environment. The increased incidence possibly relates both directly and indirectly to cultural changes in the society at large. Anecdotal evidence suggests that frequent exposure to violence in the media and the rising use of recreational drugs/alcohol may lead to a more aggressive society. In addition, the closure of some mental health facilities and the process of de-institutionalisation and mainstreaming of mental health in the wider community may contribute to this phenomenon (King, Kalucy et al. 2004). Such a societal influence may indicate that there is an increase acceptability of such behaviours.

This study examined and explored the cultural aspects of violence in the ED. This chapter is divided into four parts. The first and second parts discuss the cultural meaning and context of violence-. Subsequent parts will examine the phenomenon within the broader framework of conflict management and more importantly, the value of communication and empathy.

The cultural meaning of violence

A consideration of cultural meaning is an important aspect of understanding violence. Cultural meanings provide a comprehensive and sophisticated understanding of violence in the ED. They are complex and dynamic entities which are deeply internalised in nurses' beliefs, behaviours and perceptions of violence. Even in the same individual, cultural meanings may fluctuate according to their emotional well being. In other words, the cultural meaning of violence interrelates with personal emotions. According to Fry (2004), a lack of understanding of personal emotions can prejudice thinking and result in unrealistic assumptions and expectations. This study demonstrated several important aspects underpinning the cultural meaning of violence in the ED. The following sections will discuss these in detail.

The spectrum of violence

As mentioned in the introductory chapter, the definition of what constitutes violence differs from person to person and between groups. According to the literature, violence is mainly divided into verbal, physical and threat/intimidation (Whittington

1996; Winstanley and Whittington 2004a). Such a division of violence in terms of its quality was commonly recognised by nurses in the study. However, their perceptions of violence were much broader than this. Besides quality, they also categorised violence according to its quantity. For them, violence was not just a simple dichotomy between ‘physical’ and ‘verbal’, but also a continuum between ‘non-violent’ and ‘violent’. There were different levels of intensity of violence; some acts were more violent than the others. For example, physical violence was considered more violent than verbal. Some nurses did not consider verbal violence to be violence at all.

It was not the behaviour *per se* that determined the categorisation of an incident. In addition to the severity of injury, other factors such as characteristics of the person involved, the involvement of a ‘target’ and whether the incident was personally experienced or witnessed might also come into play. This will be further elaborated in the subsequent sections.

The violent person

This research found that violence was a person-specific phenomenon. For example, nurses in the study often did not regard incidents as violent if the patients involved were elderly and confused due to dementia. However, the same behaviour of those who were under the influence of alcohol was considered to be violent. It might be because these intoxicated patients were perceived to be responsible for their behaviour and therefore accountable for their own actions (Johoda and Wanless 2005).

In this study, nurses generally did not consider aggressive behaviours (e.g. threatening to kill) from ‘frequent flyers’ and psychiatric patients to be violent. Such a viewpoint may have two possible reasons. Firstly, it was possible that nurses became desensitised to the behaviours of these patients. Secondly, it seemed that these patients’ behaviours were predictable and, as a result, nurses were able to judge what these patients were capable of doing; nurses could put the behaviours in context and they knew that the situation would not escalate.

Violence and ‘I’

The meaning of violence for nurses was indeed very intriguing. It was strongly intertwined with the perception of their being a target. In other words, violence was target-oriented. There must be a specific target for an incident to be considered violent. When the violent incidents happened in a group situation, for example, a patient threatened to kill the nurses in the resuscitation room, this was not considered to be violent. On the other hand, when a patient threatened to kill a particular nurse, it was deemed violent. It might be that one-to-one violence was less acceptable compared to violence occurring in a group, because nurses might feel more threatened with the perception that the violent act was directed at him or her.

Experiencing and witnessing of violence

This research suggests that there are great differences in terms of the meaning of violence, depending on whether the incident is experienced or witnessed. Sometimes patients who behaved aggressively towards a group of nurses directly involved in

their care were not considered to be violent. However, those nurses who were outside the group who witnessed the behaviours considered it to be violent.

Such an attribution of meaning to violent incidents might be related to the perceived threat. Nurses who experienced the incidents rationalised that the consequences of patients' behaviours would not be serious, as staff outnumbered the patient (i.e. 'flock mentality'). However, those who witnessed the incidents 'experienced' it alone and perceived a higher level of threat in comparison to their counterparts. Clearly, negative feelings about violence such as threat can happen from either a direct or indirect exposure to the incident. For this reason, the impact of violence on nurses could be greater than expected.

A challenge or threat

Many nurses regarded violence as a threat or something negative to be avoided. However, a number of nurses in the study viewed it as a challenge to be managed; '*I can handle violence*'. This could be partially explained by the fact that there was some professional pride in dealing with violence efficiently. Such a perception appeared to be closely linked to more positive feelings about violence and pro-active approaches in dealing with difficult situations before they accelerated into 'full-blown' violent incidents.

Such a view might be explained by self-efficacy theory (Bandura 1977b). This theory contends that people with a strong sense of self-efficacy will regard challenging problems, such as violence, as a task to be mastered, and they tend to achieve a

successful resolution of violence (Bandura 1977b). According to Lee's (2001) study of 130 ED staff, increased self-efficacy in managing violent behaviour was observed in senior staff. In line with the work of Lee (2001), this study also indicated that such a belief was more likely to occur after nurses had worked in the ED for a period of time. Inferred from the study findings, it was apparent that the senior staff who had been exposed to violence and experienced in handling it, would be more skilled in dealing with it. It seems that it is important to be able to explicate these violence handling skills, so more junior staff can also gain these skills.

Regarding violence as a challenge may affect how nurses perceive an impending threat or risk of violence and subsequently affect the way they handle violence. It may not be exclusively positive. For example, a nurse may underestimate the risk a patient is capable of posing as he or she is overwhelmed by the belief that '*I can handle it*'. An overwhelming self-confidence in the handling of violence may compel a nurse to adopt certain repertoires (e.g. showing authority and setting limits) in his or her action without actually analysing the situation and subsequently may fail to handle the incident in a more satisfactory way.

On the other hand, nurses commonly identified violence as a threat to themselves, their co-workers and other patients. Such opinions correlate with a more negative feeling about violence. Like many of the previous findings, the negative feelings (e.g. being shocked, annoyed, frustrated, angry, guilty, helpless, fear, disappointed and vulnerable) constituted the majority of the nurses' feelings about violence in the ED.

Such a negative outlook may create a tendency to avoid dealing with violence. This may result in nurses not being sufficiently pro-active in dealing with a situation which then becomes worse. For example, some nurses appeared to rapidly adopt an attitude of helplessness and retreating from or avoiding further interaction. The absence of any effort to ameliorate the intense interaction might consequently cause increased aggravation and frustration for patients/relatives.

Violence: predictable and avoidable?

Can violence be predicted? Is it a random problem? Does it have a pattern that can be used to avoid the problem? These are critical questions for those who intend to prevent and solve the problem. Nurses in the study often perceived that 'violence was unpredictable and inevitable' based on the nature of their working environment (*'just walked into a situation'*) and the type of patients they encountered in the ED. This refers, for example to patients who used drugs and abuse alcohol, patients with psychiatric, family and social problems.

The view that violence was unpredictable due to the nature of their working environment seemed to correlate with the identification of warning signs. It was commonly reported by nurses in the study that there were no warning signs prior to the violent incidents. This is in clear contrast to the prospective study conducted by Owen, Tarantello, Jones and Tennant (1998). In their study of five psychiatric settings, they had found that most of the violent incidents were preceded by agitation. The discrepancy may be attributed to the setting and the lack of prior substantial interactions with patients/relatives in the ED before the incidents, which is critical to

the identification of more covert signs such as agitation. In addition, most of the patients who presented to the ED had an unknown context or background.

Nurses in the ED perceived that violence was unpredictable and inevitable. The logical progression to this view was that '*nothing could be done*'. The paradox is that many nurses also discussed predictors or indicators of violence which could be used to predict and prevent violence. From their perspectives, there were four major categories of such predictors or indicators: (1) triggers/causes (e.g. patient factors – drugs/alcohol intoxication, psychiatric problems; long waiting time); (2) warning signs/antecedents (i.e. non-verbal signs; not giving eye contact, staring, mumbling, pacing and verbal signs; shouting, yelling); (3) patients with past encounters (e.g. '*frequent flyer*' alert and violence alert); or (4) patients of certain cultural or socio-economic background.

Identification of verbal and non-verbal signs is consistent with Luck, Jackson and Usher's (2007) study who found that staring, tone and volume of voice, anxiety, mumbling and pacing were five distinctive elements of observable behaviour indicating potential for patient violence in the ED. Various investigations have highlighted that a previous history of violent attack is the most reliable predictor of a future attack (Hill and Petit 2000; Keely 2002; Steinert 2002a; Zeiss, Tanke et al. 1996). However, the predictive value of some of these predictors (e.g. patients of certain cultural or socio-economic background) was not able to be verified from the data or from previous studies and therefore further investigations may be needed.

Rationally, violence may not occur if the indicator is identified or the cause/trigger is removed. However, some nurses perceived that even when the incidents were thought to be predictable, they were still deemed as unavoidable due to situations that impede the removal of likely causes of violence (e.g. a patient's drinking problem). Such a viewpoint was closely linked to a culture of blaming. They felt that the cause or trigger of violence was mainly the fault of others. They commonly blamed the patients/relatives, the management for lack of support, other colleagues and the context in which violence occurred (e.g. long waiting time and busy ED).

In the majority of incident reports, nurses indicated that patient/relative factors were the sole cause of violence. This is similar to previous studies (Derlet and Richards 2000; Garnham 2001; Hinson and Shapiro 2003; Jenkins, Rocke et al. 1998; Jones and Lyneham 2001; Lyneham 2000; Morrison 1998; Stirling, Higgins et al. 2001). There is an element of truth in this argument, but it ignores a more essential fact that some other factor may precipitate violence. Lanza and Carifio (1991) assert that placing blame solely with individuals (i.e. patients/relatives) is likely to increase the risk than other important factors which precipitate violent episodes; factors such as interactional factors will be ignored. This aligns with Adams and Murray's (1998) proposal that the tendency to attribute violence in the ED exclusively to patients could hamper successful management and prevention. Indeed, emotional responses of nurses to difficult patients/relatives can exert considerable influence on violent incidents.

Nurses rarely seemed to recognise that their own behaviours (e.g. being overtly authoritative, inadequate skills/knowledge in handling violence) and interactional

factor (e.g. denial of a request without explanation) were also contributors to violence in the ED. It is worth noting that the survey carried out by Indig, Copeland, Catherine and Conigrave (2009) at two EDs in Sydney showed nurses' lack of confidence or clinical responsibility to fully and appropriately manage ED patients with alcohol-related problems had inevitably contributed to more violent incidents.

Clearly, cultural meanings of violence are complex issues with many paradoxes. Exploration of such cultural meanings is pivotal especially in understanding nurses' perceptions, feelings and management, in particular reporting of violence. Nurses' reporting behaviour will be discussed later in this chapter.

The cultural context of violence

In the previous section, nurses perceived certain factors/triggers that led to violence. These perceptions were not always uniform and in many cases not verifiable. This section examines the factors within the culture that actually resulted in violence. It is mainly concerned with the circumstances and factors contributing to violence. The cultural context of violence suggests that violence occurs more frequently at triage, with certain categories of patients/relatives such as those with drugs/alcohol or psychiatric problems, and when the department is busy and chaotic. There are many issues underlying the context of violence in the ED and the following sections will scrutinise and discuss these issues accordingly.

Influence of environment

The environment plays an important role in violence. As mentioned before, violence can be affected by societal factors, but it is the influence of the local milieu in the hospital and the ED that is of interest. As described in Chapter Three, nurse-patient interaction is primarily influenced by the nurse's professional culture, patient's culture and context or environment in which the interaction occurs (DeSantis 1994).

Patients/relatives may feel anxious and isolated in an unfamiliar and controlled environment like the ED, particularly when they first arrive at triage. This study showed that more than one third of the incidents happened at triage and the waiting area, which is consistent with the findings of Crilly, Chaboyer and Creedy (2004). The results of this study indicate the lack of privacy at triage and waiting area might have contributed to some of the violent incidents that happened in these locations. In addition, the high bullet-proof counter designed to protect triage nurses might have signified lack of accessibility and induced a sense of isolation with an increased possibility of violence.

Adams and Murray (1998) indicated that emotional and social environment in the ED are also important in the incidence of violence, apart from physical environment. In this study, it was observed that the majority of patients came to the ED with a companion. The companion could be an important source of support for patients during such a vulnerable time. However, it is worth pointing out that family members were usually asked to wait in the waiting room at the time patients were brought to the treatment area.

The presence of patients' family members in the emergency department, especially in the resuscitation room, is a controversial issue and has been intensely debated over the past decade (Barratt and Wallis 1998; Goodenough and Brysiewicz 2003; Redley and Hood 1996). Axelsson, Zettergen and Axelsson (2005) reviewed 12 original papers published between 1995 and 2003 and concluded that familiar presence during resuscitation and acute care has a positive effect not only on patients and their significant others, but also on the health professionals involved. Nonetheless, it is undeniable that the presence of a large group of patients' family members in the emergency department and particularly the treatment area, can pose a threat to privacy, safety and cause space problems.

The situation in the ED not only impacts on the behaviours of patients/relatives, but also influences the behaviours of nurses and in particular the triage nurses. The nature and levels of activity in the ED are the most immediate environmental factors that affect nurses' behaviours. The need to assign a triage code to patients, which involved complex decision-making could be a source of stress and anxiety for nurses in the study (Gerdtz and Bucknall 2001). In addition, anxiety and stress could also be associated with the pressure to make prompt decisions, perform and attend to multiple tasks and interruptions concurrently in a busy and chaotic ED environment (Fry and Burr 2001).

In this study, it was likely that when nurses felt anxious and stressed, they may have been less empathetic in their response to patients/relatives. Subsequently, they may have exhibited behaviours that were more prone to trigger patients/relatives' violence such as being easily agitated/stressed, overtly authoritative (e.g. reacting negatively

to a patient's refusal to cooperate), task-orientated and judgemental (e.g. being indifferent to patient's physical complaints, and denial of a patient's special needs without explanation). It was possible that these nurses might not be aware of any covert non-verbal cues of violence (e.g. pacing) when they were working in a busy and chaotic environment. In addition, when they struggled to cope with numerous patients, some patients' needs might have been neglected with consequent anger and frustration.

Indicators of violence

Understanding the indicators of violence is important because it helps to create a complete picture of the situations where violent incidents are more likely to occur. An insight into these indicators can be obtained from the characteristics of violent incidents and patients/relatives involved, and triggers of violent incidents.

Characteristics of violent incidents

This section focuses on the indicators of violence by looking at the characteristics of violent incidents. The research demonstrated that nearly half of the violent incidents occurred between 1500 and 2400 hours and this is consistent with the findings from previous studies (Brookes and Dunn 1997; Crilly, Chaboyer et al. 2004). It was also found that Wednesday had the lowest rate of incidents reported. This is clearly different from the finding by Brookes and Dunn (1997) in a different cultural setting in which violent incidents were highest on Wednesday. Such divergence could be a result of the societal and ED culture where the study was conducted. Clearly, cultural

context may influence patterns of violence and it is critical to explore such patterns in individual settings before initiating violence management and prevention interventions.

This study found that more than half of the patients/relatives who were reported to be violent were violent at presentation or became so after less than one hour in the department. This is similar to the two previous studies which looked into this aspect (Brookes and Dunn 1997; Crilly, Chaboyer et al. 2004). Such a finding could be important because it suggests that there may be some indicators of violence observable during the early stage of a patient's presentation to the department. An effort to identify these indicators on an ongoing basis may benefit violence prevention and management in the ED.

This study found that verbal violence was the most common type and a similar view has been expressed by other researchers (Brookes and Dunn 1997; Crilly, Chaboyer et al. 2004; Pawlin 2008). More importantly, this study showed that three quarters of physical violence happened with concurrent verbal violence. Such a co-existence is congruent with the findings of previous studies (Brookes and Dunn 1997; Crilly, Chaboyer et al. 2004). Even though, to date, there have been no data indicating how often verbal violence progresses to physical assault, the correlation between verbal and physical violence may indicate that verbal violence may act as a useful sign of impending physical violence.

Characteristics of patients/relatives

Characteristics of violent incidents give an indication of when, where and how violent incidents are more likely to occur. Characteristics of patients/relatives involved in violent incidents reveal information on who is more likely to become violent.

As mentioned in previous section, violence occurred more frequently with certain categories of patients/relatives such as those with drugs/alcohol or psychiatric problems. It would be useful to identify the warning signs these patients displayed in order to predict and prevent violence. However, this study showed that there was commonly no warning sign observable prior to violence for patients/relatives when alcohol alone was a contributing factor. This may be due to alcohol intoxication, and there would be various degrees of manifestation which might be too subtle to be identified. Furthermore the lack of prior interaction could lead to an inability to pick up such transient and subtle warning signals.

It is worthwhile clarifying that warning signs were commonly noticed for patients/relatives who had alcohol and other concurrent factors such as personality and psychiatric problems, which were less 'transient'. Lanza, Kayne, Pattison, Hicks, Islam, Bradshaw and Robin (1996) concur that the diagnosis of alcohol dependence alone is not associated with assault, yet the behaviours resulting from more persistent personal traits such as threatening language and increased motor activity are better predictors of assault.

More importantly, the study indicated that the immediate and direct personal behaviours such as a basic social opening statement and levels of cooperation were better predictors of violence than patients/relatives' problems (e.g. alcohol dependence). The analysis of the initial interaction between nurse and patient/relative at triage indicated that the basic social opening statement or greeting was important because it provided crucial cues for the direction of the subsequent interaction. The patients/relatives who reciprocated the nurses' greeting or who initiated the greeting appeared to have lower propensity for violence.

In addition to the basic social opening, the study also indicated that violent incidents were often preceded by a lack of cooperation during the nurse-patient/relative interaction. Typically, this occurred with patients who had difficulty in communication related to physical problems (e.g. pain), psychological problems (e.g. depression), and drugs/alcohol use. There were also patients who could but chose not to cooperate. Some examples included patients with social problems and those who had multiple encounters with the ED (i.e. 'frequent flyers' and patients with violence alert).

Triggering factors

An understanding of indicators of violence is incomplete if the causes or triggers for violent incidents are unknown. On numerous occasions, it was observed that there were several triggering factors that set off the violent incidents. A common trigger was the rejection of a request made by patients/relatives, in particular rejection of requests without explanation and rejection of requests involving morphine

prescription, shelter and food. Other triggering factors included unwanted personal touch, long waiting time, and prior dissatisfaction with the service of other staff members.

These observations are compatible with previous studies. As Shepherd and Lavender (Shepherd and Lavender 1999) stated, 60% of incidents were preceded by external factors such as refusal of a patient's request. Daffern, Mayer and Martin (2004) asserts that aggression is usually precipitated by identifiable events such as denial of a request, which is perceived by patients as being provocative. The rejection of request clearly was a significant triggering factor, however, more importantly, the way of rejection was critical. Similarly, a retrospective study by Taylor, Wolfe and Cameron (2002) concluded that one third of complaints in the ED were related to other interactional factors such as poor staff attitude, discourtesy and rudeness.

Besides these interactional factors, dissatisfaction with waiting times was seen as a significant trigger for violence throughout the study. This study has shown that the negative response to waiting time is not exclusively dependent on the actual duration of waiting. Such a finding is consistent with previous investigations. Watson, Marshall and Fosbinder's (1999) study concurs that perceptions of waiting time are more likely to influence patient satisfaction in the ED than the actual waiting time.

The study seems to imply that providing information on waiting time promptly, regularly and accurately is critical and it could be a step toward minimising the dissatisfaction or aggressive behaviours associated with waiting time. This implication is linked with the main points in previous studies. Presley and Robinson

(2002) emphasise that explanations about waiting time can reduce the patients' impression that they are forgotten or being ignored and therefore reduce the risk of violent attack. With this view in mind, Nielson (2004) conducted a six-week pre-and post-study in a rural 40-bed hospital where the triage nurses were instructed to make waiting room rounds and explain delays or waiting periods to patients. It was found that the level of patient satisfaction rose two-fold.

The study also puts forward one more crucial factor in regard to communication of waiting time and this will be explained in the following section.

Conflicting messages: waiting times

The study indicated that patients/relatives were getting conflicting messages about waiting time. As shown in the results chapter, patients/relatives used several ways to obtain information about waiting time in the ED. Primarily, they gained information on waiting time by counting the number of people in the waiting room, looking at the waiting time display, taking note of people in the queue and asking the triage nurses.

The major source of confusion leading to dissatisfaction with waiting time was the information on the waiting time display. The waiting time display in the waiting room was rarely changed (i.e. often showed 1.5 and 3 hours) and was often incorrect because it depended on the availability of nurses and clerks to update the system. Patients/relatives might feel confused and frustrated when they could not make sense of further waiting time indicated by the waiting time display. As a result, they might

experience a sense of deception, which in turn provoked their subsequent aggressive behaviours.

When patients/relatives saw that there were only a few people waiting in the waiting room, they expected that they would be seen by a doctor within a short period of time. Knowing the waiting time was beyond their expected time frame, they asked the triage nurses. Meanwhile, the patients were unable to see what was happening behind the closed doors of the ED. In these circumstances, they were likely to become confused and agitated by the claim of '*we are very busy*' of triage nurses after having an unexpected long waiting time. Clearly, the study indicates that it is important for nurses to explain the overall situation in the ED when communicating further waiting time to patients/relatives.

Conflicting roles

Up to this point, the discussion has focused mainly on the interactional factors underlying the context of violence, which lead to poor nurse-patient/relative relationship. This section is concerned with the conflict between nurses' and patients' roles affecting the interpersonal interaction.

As discussed in the result chapter, nurses in the ED have multiple roles such as decision-makers, door-keepers and communicators. The triage nurses' primary role is to ensure that patients receive appropriate and timely care. Since there are resource constraints, in order to manage tasks efficiently, triage involves a filtering or ranking role. Filtering/ranking is operationalised by the door-keeping function. The door is

opened for the patients who have the most urgent need and is closed to those with a less urgent need until resources are available.

Even though the communicator role of triage nurses was possibly most extensive and less defined, it appeared to be valued less than the triage role of deciding who needed medical intervention and how long the patient could afford to wait without medical consequences. This is consistent with the results of a study conducted by Fry and Burr (2001): Three quarters of triage nurses agreed that the basic components of triage were rapid patient assessment, First Aid and prioritisation of medical urgency. McBrien (2009) takes a similar view that emergency nurses regard their role as one, which is predominantly concerned with providing urgent physical care, rather than one that espouses the theories of holistic health care.

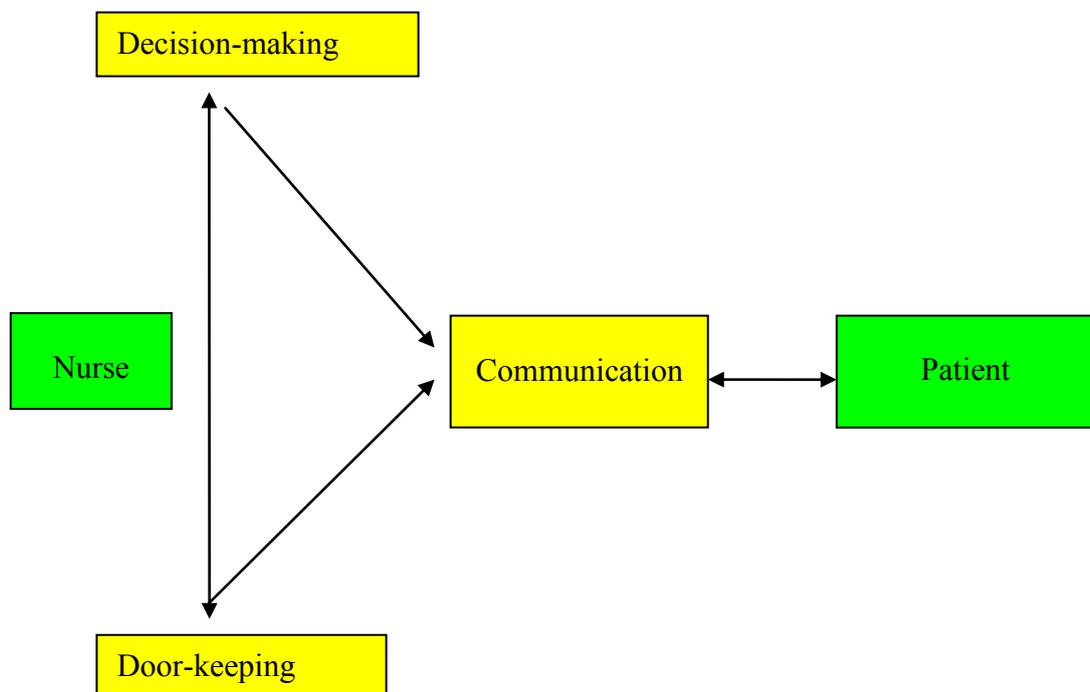


Figure 6.1: Relationships between nurses' roles and their implications for patients

In fact, it is crucial to acknowledge that the role of decision-maker, door-keeper and communicator are interrelated (Figure 6.1). In this study, the ability to communicate well might have affected the allocation of an appropriate triage category. Conflict between nurse and patient/relative might have arisen from the lack of communication in regard to how and why the decisions were made, such as an allocation of low triage category. In view of the fact that the allocation of priorities and organisation of care is complex and almost impossible to understand for patients, a simple explicit explanation of what will happen next after triage is likely to lessen the anxiety of patients/relatives (Frank, Asp et al. 2009).

From the patients' perspective, the nurses' role was to facilitate care (i.e. opening the door) which was often contradictory to what they saw (i.e. keeping the door closed). Some patients/relatives might even see triage nurses as an obstacle for them to get to the doctors and according to frustration-aggression theory, such frustration might have subsequently generated aggressive behaviours at triage. In other words, being sick at ED, they believed that it was their right to see a doctor promptly and they were not supposed to wait for a long time. Some patients might also consider themselves to have adequate self-knowledge of their medical conditions and they knew what the most imminent needs were for themselves (Frank, Asp et al. 2009). This, however, conflicted with nurses' perception that with their professional training and experience, they were the ones able to provide the best care to these patients.

Violence within the broader framework of conflict management

Every culture tends to have its own set of formal and informal conflict management process and options. The ED under study also had formal and informal operating mechanisms for handling violence.

Formal conflict management

In this study, the formal conflict management for handling violence was categorised into direct and indirect measures. The direct measures mainly consisted of restraint and seclusion. Restraint is the ‘restriction of movement of a person’s body by the use of any mechanical means or by physical force for behavioural or medical purpose’ (Anonymous 2002, p.6). Seclusion refers to the ‘sole confinement of a person at anytime in any room or space where the exit(s) are locked from the outside and cannot be opened by the person from the inside...’ (Anonymous 2002, p.6). The use of restraint or seclusion was mainly driven by hospital policy or protocols to protect the person or others from immediate or imminent risk to their safety.

At times, nurses perceived that patients would still become or remain aggressive despite the employment of empathetic communication skills. Thus, they called security to restrain or seclude the patient promptly without further interaction. At times, they did not initiate the interaction with patient at all. Nurses might feel secure in gaining control of patients with such non-therapeutic use of restraint or seclusion (Horsfall 1998; Maier 1996). However, this approach is not in line with that proposed by Daffern, Mayer and Martin (2003). The use of seclusion to contain

aggressive patients may contribute to more frequent aggression and injury to staff as the intervention may not be effective in acknowledging patients' concerns and feelings.

Indirect intervention was mainly comprised of reporting violent incidents. During the 12-week study period, a total of 103 violent incident questionnaires were completed. The prevalence of violence for the ED estimated was 8.6 cases per week and it appeared to be higher than that in a descriptive study conducted by Crilly, Chaboyer and Creedy (2004) with only five cases per week reported. This could result from the difference in data collection methods used in the two studies. The presence of a researcher in the field for this study was likely to encourage more nurses to express their experiences, and subsequently increase the rate of case reporting.

It is also highly possible that the discrepancy may be due to the difference in the setting and numbers of patient presented. For this reason, such a comparison of prevalence may not be accurate due to significant discrepancies involved in the study of violence in the ED. Even though it is difficult to compare the prevalence of violence with previous studies, this is still an important issue that requires clarification.

The study results indicated that the number of incidents reported might not correlate well with the actual number of violent incidents. For example, the highest number of incidents reported occurred on Thursday, yet the majority of ED nurses verbalised that Friday, Saturday and Sunday evening were associated with a considerable number of violent incidents. The contradictory results based on both written and

verbal accounts could be explained by the fact that reporting of violent incident is subject to nurses' availability and their willingness to complete an incident form. It was possible that there was more violence on Friday, Saturday and Sunday evenings, but nurses might not have the time to complete an incident form. This may also mean that they expected violence on these nights and were less likely to report it or that the incidents were more common and more serious so the less serious one such as verbal abuse paled into insignificance. Thus, violent incidents might have been under-reported and this might have an impact on the management of the problem.

More importantly, the study provides a further insight into reasons for not reporting violence. Consistent with previous studies, this research indicated these reasons as including: (1) tolerance of aggression, (2) the viewpoint of expected violent behaviours in certain groups of patients (e.g. patients with psychiatric problems, drugs/alcohol used), (3) avoidance and denial of violence, and (4) doubts about the usefulness of reporting aggressive acts (Arnetz 1998; Daffern 2004; Hills 2003; Jones and Lyneham 2001; Lyneham 2001; Yassi 1994; Zernike and Sharpe 1998). In addition to these, this study further indicated that violent incidents which happened in front of a group of ED staff such as in the resuscitation room were often not reported because it was less likely for the individual to perceive he or she was specifically targeted. Aggressive behaviours from demented patients were not usually reported due to the understanding of mental incapacity responsible for their behaviours. This finding is similar to that of a recent study conducted by Pawlin (2008) in which 82% of respondents indicated that identified dementia or brain injury associated with violence behaviour would prevent them from reporting incidents.

Moreover, it is indicated from this study that a heightened level of self-confidence might have made nurses less willing to report their encounter with violent incidents as they might see it as a 'loss of face'. This is in agreement with Ferns' (2005) viewpoint that nurses do not formally report violent incidents to the authorities because they may not want to give the impression that they cannot handle the situation in such an environment.

Informal conflict management

The study has provided an interesting illustration of informal conflict management. Informal conflict management seemed to be more frequently used in the ED for dealing with violent incidents. It was divided into direct and indirect responses.

Direct responses were measures nurses used to manage the violence then and there. These measures were often learned through 'trial and error' and at times were imparted from senior to junior nurses informally. Unfortunately, not all the direct measures in this study provided positive outcomes. Measures of overt demonstration of authority such as giving warnings and reprimands appeared to further inflame the situation. Alternatively, strategies such as empowerment of the patient (e.g. letting the patient make a decision, speaking slowly to the patient) and professional attitude to establish rapport (e.g. showing care and concern by using an empathetic tone, friendly body language, calling the patients by their first name) were more likely to diffuse the situation.

Nurses tended to use direct responses when the patients involved were mentally sound. When they thought that these responses would not work (e.g. as with patients with psychiatric problems or drugs/alcohol intoxication), they commonly adopted the formal mechanisms such as restraint or patients' seclusion.

The study showed that when under stress related to violence, nurses might adopt more extreme direct approaches such as withdrawal of care. It is possible that prolonged and inadequately handled stress associated with violence and the ensuing negativity (i.e. *'nothing could be done'*) might have influenced nurses to resort to these aggressive violence management strategies.

Indirect responses were concerned primarily with how nurses dealt or coped with violence at their personal level. In this study, it appeared that indirect approaches such as avoidance (e.g. *I don't expose myself*, *'...not taking it personally'*), toleration (e.g. *'getting used to it'* or *'immune to it'*), and denial (e.g. *'patient wasn't shouting at me'*) were commonly employed when nurses perceived a sense of lack of control over the situations. Such depersonalisation of violence is consistent with the results of a study conducted by Jahoda and Wanless (2005) where they interviewed thirty-six support staff working with people with disabilities. Approximately a third of the responses given by participants indicated that aggressive individuals' behaviours were not taken personally.

All these approaches (i.e. withdrawal of care and depersonalisation of violence) without adequate attention to personal feelings (e.g. anger) may inevitably lead to a sense of emotional exhaustion and therefore they may be ineffective in the long-term

management of interpersonal conflict. Winstanley and Whittington (2002a) assert that the combination of emotional exhaustion and defective coping strategies under these circumstances promotes poor professional-client interactions. The important point to clarify here is that an increase in emotional exhaustion leads directly to an increase in depersonalisation, which can manifest as a negative behavioural change (e.g. being indifferent, judgemental) toward patients with ensuing or gradual patient aggression toward nurses.

Whittington and Wykes's (1994a) study revealed that nurses working on wards with a high incidence of violence talked and listened to patients less often than their colleagues in non-violent wards. In other words there was an increased emotional distance between nurse and patient. However, it is difficult to establish whether staff behaviours such as talking and listening to patients less were a result of their exposure to patient violence or their behaviours had caused more patient violence. It is highly possible that this is a vicious cycle; higher levels of violence result in less patient interaction and thus cause more violence and less patient interaction.

Value of communication and empathy

The following sections are concerned with the value of intercultural communication between nurse and patient/relative with particular emphasis on empathy or the ability for nurses to understand patients/relatives' concerns and emotions from their perspectives (i.e. put themselves in patients/relatives' shoes). Empathy is the capacity to appreciate another person's experience from that person's frame of reference (Hardee 2003). The study indicates that effective empathetic communication is the key to establishing good rapport. Nurse-patient/relative interaction involves both

verbal and non-verbal communication. Verbal communication is mainly expressed through language. Non-verbal communication is primarily conveyed through behaviours in terms of gesture and tone.

Behaviours relevant to the establishment of rapport

The study demonstrated that nurses were able to use some communication techniques involving empathy to establish rapport with patients/relatives. McQueen (2000) concluded that empathetic behaviours can encourage the development of rapport and a trusting relationship. This research highlights that it is important to establish rapport during the initial interaction with patients/relatives as violence occurs early. From the observations, the following empathetic behaviours were useful: (1) acknowledging the patient's arrival/waiting verbally or non-verbally, (2) using friendly body language, (3) greeting the patients/relatives, (4) calling patients by their first name, (5) thanking the patient after patients answered questions, (6) showing care and concern for patient, and (7) foreseeing patients' needs in advance during the interaction.

Behaviours such as acknowledging a patient's arrival/waiting and greeting patients/relative are not context dependent because these sorts of behaviours are basic and important part of a social interaction (Jensen 1995). Calling patients by their first name is critical. However, it can be argued that some patients may prefer to be called 'Mr' or 'Mrs'. Either way it is important because they appear to remind patients/relative of their humanity which is essential in their interactions with the nurses (Presley and Robinson 2002). Based on Presley and Robinson's (2002)

observation, anonymity is associated with a higher risk for violence. Thanking the patients after they shared their important personal information is useful because such self-disclosure from nurses is able to 'equalise' the patients' sense of discomfort associated with one-way disclosure of their personal information (Marck 1990).

Care need to be taken in establishing rapport because some behaviours are not appropriate in certain contexts. In this study, empathetic behaviours such as using humour and showing humanity were not commonly used by nurses because these appeared to be more context dependent. For example, joking with a distressed patient/relative is not appropriate. Regarding the importance of humour in establishing rapport, Watson, Marshall and Fosbinder (1999) have stressed that a sense of humour from nurses is important to alleviate patients/relatives' anxiety and helps to shape a balanced and effective therapeutic relationship. This is supported by the palliative care patients' responses in Richardson's (2002) phenomenological study, with the view that their psychological well-being was enhanced by humanistic and egalitarian interactions with the nurse.

This study makes apparent the valuable contribution that a minor change in nurses' behaviour with the application of empathetic skills has towards a better nurse-patient/relative interaction. It demonstrated that after the application of empathetic skills, often there was a 'turning point' where nurses were able to avoid or contain violence. At times, such a positive outcome might have resulted from simple verbal (e.g. '*mate*', '*OK*') and non-verbal communication (e.g. a smile and eye contact).

The following sections will concentrate on the important factor affecting the communication between nurse-patient/relative: firstly, expectations; and secondly, the two critical barriers that impede interpersonal communication - ethnocentrism and prejudices.

Expectations

During informal interviews with ED nurses, they regularly mentioned the impact of patients/relatives' expectations on the nurse-patient/relative interactions. In spite of this, there have been very few studies on this issue. This study was only able to shed some light on patients' expectations given the condition that no patient was willing to participate in a formal interview. Only a small amount of data regarding patients/relatives' expectations were gained through the observations of nurse-patient/relative interactions at triage.

Based on field observations, patients/relatives' expectations of nurses were one of the integral factors affecting nurse-patient/relative communication at triage. The study found that there were two significant aspects of patients/relatives' expectations in the ED: waiting times and analgesia. Patients/relatives often requested information on waiting time at triage (e.g. *'How long am I supposed to wait?'*). As mentioned in previous sections, an expectation for shorter waiting time was apparent when patients/relatives noticed that there were only a small number of people in waiting room. In addition to this, the majority of patients/relatives expected a reasonable explanation when the waiting times were beyond their expected time frame. This is congruent with the findings by Watson, Marshall and Fosbinder (1999) where the

majority of the patients in the ED expected to be told about the reason for continued waiting.

In terms of another aspect of expectation (i.e. analgesia), pain is such an unpleasant experience for patients that there is general expectation of prompt action to relieve suffering. Anecdotal evidence also suggests that pain is the most common reason for presentation at an ED. Patients/relatives often requested analgesia at triage soon after their arrival at ED (*'Can you [nurse] stop the pain first?'*). An observational study whose sample consisted of 522 patients with pain and 144 patients without pain revealed that the majority of patients expected most of their pain to be relieved in the ED (Fosnocht, Heaps et al. 2004). It is possible that when the expectations for pain relief are not being fulfilled, the patients may perceive that they are being treated unfairly, which for them may justify their aggressive behaviour.

In the ED setting, having an expectation toward another party is not exclusive to patients/relatives. Nurses in this study expected patients to listen to advice, to cooperate, and to comply with management. This was evident by common comments in the interviews such as *'he/she should listen to me (nurse)'* and *'...he/she should not argue in critical situation'*. The gist of nurses' expectations of patients' behaviours is illuminated by Fry's (2008, p.283) statement that *'within ED, notions of efficiency, timeliness and equity give structure to a system of meaning through which expectations of patient behaviour are cemented and a culture of ED care sustained'*. For the sake of a desirable nurse-patient relationship beneficial for patients, nurses expect patients to relinquish some control or have limited autonomy once they step into the ED. It is arguable whether limitation on a patient's autonomy

in the setting of ED is justifiable. As suggested by Hagerty and Patusky (2003), this sort of nurse-patient interaction negates patients' right of choice and ultimately leads to less desirable care. However, it is undeniable that some restrictions or rules and regulations (e.g. all patients need to be triaged by a nurse before doctor consultation) are necessary for patients/relative to adhere to in order for the ED to function at its best levels.

Another form of expectation that nurses had toward patients was clearly demonstrated in their initial interactions with patients at triage. It was '*what the patient should say in regard to his or her complaint*' that concerned the triage nurses most. It was observed that the most essential aspect of care that nurses expected from patients/relatives on their arrival at triage was a clear statement of the reason for their visits (e.g. '*I have chest pain*'). However, opposite to what nurses expected from initial patient encounter at triage was a demand for investigation or treatment (e.g. '*I need to have an X ray*'). With such a response from patients, it was more likely for triage nurses to take a defensive stance because of a perception that patient was usurping their professional role in triage.

This study observed that when patients acted beyond reasonable expectations (i.e. making a demand such as '*I want to see the doctor ASAP*'), some nurses appeared to react negatively. They reciprocated such frustration with a reaction that was often critical. As such reciprocity may undermine the foundation of the nurse-patient relationship, it is important to recognise patient's needs early and accept their emotions as being natural and reasonable (Adams and Murray 1998). Adams and Murray (1998) maintain that such a view has the advantage of allowing nurses to

avoid being judgemental and subsequently able to handle the difficult patients/relatives' behaviours by using empathetic communication skills.

Ethnocentrism

As with expectations, nurses were possibly unaware of their ethnocentric behaviours. Similar to expectations, ethnocentrism is mainly influenced by the factors inherent in the cultural background, societal norms and life experiences. However, ethnocentrism has a more subjective and personal outlook than expectation as it renders nurses the tendency to view patients' illnesses and relevant issues from their own perspectives. It often entails the concept that one's own judgement is superior to others.

The study indicated that some nurses were ethnocentric when interacting with patients/relatives. Based on field observations, their ethnocentric manners became evident under certain conditions. When patients' actual level of physical pain was out of proportion to nurses' predicted level of pain and expected tolerance to it, nurses appeared to doubt the patients' claim of physical pain. Subsequently, their requests for analgesia were perceived as illegitimate by nurses. Legitimacy of a request will be explained in the following paragraph. Such ethnocentrism could be problematic because the majority of patients who present to the ED have a chief complaint of pain (Tanabe and Buschmann 1999).

In this study, the ethnocentric behaviours of ED nurses manifested themselves when they handled patients'/relatives' requests. They maintained that there were two types

of patients/relatives' requests: legitimate and illegitimate. Nurses often responded to what they regarded as being illegitimate or unreasonable requests with less diplomatic approaches and these sorts of responses were more likely to provoke a frequently violent reaction from patients.

Even though the legitimacy of a request was influenced by factors such as availability of resources and hospital policy, it was largely dependent on nurses' judgement. For example, a nurse's view that pain claimed by the patient was inexplicable or the suspicion that the patient was a 'drug seeker' might have led to a failure to promptly recognise the urgency of the patient's need for analgesia. There had been a failure to evaluate the underlying causes of pain or illness, all of which invariably affected reasonable therapeutic outcomes.

Even when equipped with skills in the recognition of suspicious drug seeking behaviours, ED staff still risk falling to make correct judgements due to preoccupied thoughts directly connected to ethnocentrism (Blank, Mader et al. 2001; Wilsey, Fihman et al. 2004). With the emergence of such an ethnocentric view or behaviour, what significantly concerns the health professionals in the ED is the risk of provoking anger in patients/relatives and, in turn, their irrational behaviours. It is also important to understand that behaviours of drug-seeking patients, for example, will not be changed by denying their requests for analgesia.

From a different perspective of ethnocentrism, nurses' own judgement of the appropriateness of patients' access to emergency services and priorities to prompt care are subject to limited ED resources, timely patient management and a more

equitable distribution of patient care. This research discovered that some nurses in the study often held the view that '*non-emergency cases are supposed to be put on hold unless emergency cases had been dealt with*'. They called this the '*therapeutic wait*'. This was problematic because it tended to evoke discontent in patients/relatives because they felt that their needs and concerns were not being acknowledged.

Grief and Elliott (1994) stated that such ethnocentric judgements regarding the appropriateness of patients' access to the emergency department are frequently made among nurses. Considering lack of generally accepted measurement tools to stratify the appropriateness of patients' attendance at emergency care and nurses' own judgement under the influence of ethnocentrism, ED staff working with limited resources and timely management would need to make concerted efforts to minimise mistakes (Afilalo, Guttman et al. 1995; Pereira, de Silva et al. 2001).

Prejudices

Besides ethnocentrism, prejudice was another factor that jeopardised the communication between nurse and patient/relative. Prejudice in nursing practice has been conceived as an unfavourable opinion or view which blocks nurses' perception of patients/relatives as a person, causes them to lose sight of essential humanity inherent in their profession and denies the basic respect to patients (Grief and Elliott 1994). As indicated in Grief and Elliott's (1994) study, nurses appear to be unaware that they are acting prejudicially. A very similar view was found in this study with the indication that there is a need for ED nurses to be aware of some of their

prejudices. Based on the field observations and existing evidence, it is plausible to state that prejudices can be projected in the behaviours at the time of nurse-patient interaction and they can evoke ripples of negative reactions that are picked up by patients and relatives.

As noted in this study, there was widespread prejudice against certain groups of patients in the ED. Nurses in this study appeared to be more annoyed or frustrated in dealing with patients who presented with psychiatric or addiction problems such as drugs or alcohol. The following statement based on the field observation may be one additional point that should not be ignored: Unfavourable first impressions of these patients had almost formed at the initial encounter, with the consequence that they were labelled '*bad/difficult*'. This sort of prejudice can be ascribed to the difficulty in evaluating such patients' problems and insufficient immediate solutions based on professional expertise (Mavundla 2000).

The diversity of prejudices is seen at different levels of patient care. As demonstrated in this study, patients who were thought to be responsible in part for their conditions (e.g. patients with drug/alcohol intoxication) were discriminated against because nurses believed that '*people should take control and responsibility for their lives*'. There was also an extensive prejudice against patients/relatives who enquired about the waiting time upon their presentation at the triage desk. Such a view was often demonstrated in the way nurses communicated the waiting time. In these circumstances, an ambiguous or pessimistic response (e.g. '*may wait for hours*', '*you are going to have a hell of wait today*') was sometimes given. For the purpose of nursing practice, such a communication approach fails to fully acknowledge the

feelings and needs of patients/relatives and may be detrimental to the further nurse-patient/relative interactions.

Summary

This study has provided a sophisticated and thorough understanding of the cultural aspects of violence in the ED. The cultural meanings of violence suggest it is a complex issue with many paradoxes. It is a person and target specific phenomenon. However, there are lessons to be learned. Although the environment plays an important role in violence, the nurse-patient/relative relationship is a key factor in prevention and management of violence. The establishment of rapport is crucial and needs to occur early.

More importantly, there is often a ‘turning point’ in such interpersonal relationships that provides an opportunity for the nurse to act to avoid violence. The understanding of expectations (i.e. patients/relatives’ and nurses’), and nurses’ awareness of their own prejudices and ethnocentrism are vital in acting on the ‘turning point’ where the risk of violence can be minimised.

In regard to the indicators of violence at triage, the study suggests that they are not simple and straight forward because it involves interactions among various contributing factors such as patient/relative, nurse and situational factors, and the rational analysis of such interactions is practically difficult. In addition, the nature of the ED setting also limits the identification of some indicators, in particular those which are covert (e.g. agitation). However, this study implies that patients/relatives who initiate and who reciprocate the greeting, and those who are cooperative or

willing to cooperate in the nurse-patient interaction are less likely to be involved in violent incidents.

In conclusion, an effective interpersonal empathetic communication has a significant role in reducing violence in the ED. Knowledge of the culturally appropriate formal and informal conflict management strategies is also critical. The next chapter examines the strengths and limitations of the study, followed by appropriate recommendations.

CHAPTER 7:

CONCLUSION

Introduction

Violence in the emergency department (ED) is a significant and complex problem encountered by nurses across all cultures (Ferns 2007). The impact of violence is widespread. It not only affects nurses who are involved in violent incidents, but also inevitably compromises the nurse-patient/relative relationship and quality of patient care (Whittington and Wkyes 1994a; Fernandes, Bouthillette et al. 1999; Arnetz and Arnetz 2001).

Knowledge about the theories of violence is critical to the development of effective long-term violence management strategies for the ED (Ferns 2007). There are several theories of violence that have attempted to explain the reasons for this phenomenon including biological, social learning and frustration-aggression theories (Walter 1998; Mohr and Mohr 2001). These theories provide a more general explanation of violence which is insufficient to explain the violent behaviour at interactional and intercultural levels (i.e. nurse professional versus patient/relative culture). The understanding of violence is also complicated by the inconsistency in nurses' definition and reporting of the problem. In this study, ethnography has provided a more thorough and sophisticated understanding of the cultural meanings, contexts and management of violence in the ED.

This chapter summarises the major findings of this research and their significance, and evaluates the strengths and limitations of this study. Following these, the implications will be discussed and recommendations made.

Major findings of the study and their significance

The main purpose of this study was to examine and explore the cultural aspects of violence in the ED. The study indicated that the cultural meaning of violence was a complex issue. Violence was not exclusively a discrete phenomenon (i.e. verbal or physical). In reality, there were different levels and types of violent behaviours.

In this study, perception of what constituted a violent act was highly subjective and varied among nurses. It was a person and target-specific phenomenon. Commonly, an aggressive act would be regarded as violence if the: (1) patient was considered responsible for his or her action, or (2) a nurse involved in the violent incident thought that he or she was a target. Individual nurses who experienced violence in the presence of a group of health professionals often perceived that he or she was not a target and did not regard the incident as violent. However, those who were outside the group who witnessed the behaviours would dispute this and regard it as being violent. Such an understanding of cultural meanings of violence is important for the construction of measures looking at reporting violent incidents.

Violence, a complex problem in essence, has a number of paradoxes. For example, violence was seen as both a challenge to handle and a threat to avoid. More importantly, this study pinpointed that there was a duality in the perceived predictability of violence. On one hand, nurses perceived that violence was

unpredictable and inevitable. On the other hand, they talked about triggering factors and warning signs which allowed for violence prediction and management. Rationally, violence may not occur if the cause or trigger is being removed. However, nurses perceived that violence was still unavoidable because they were powerless to remove the causes or triggers of violence. Such powerlessness was strongly associated with attribution of blame. They commonly attributed the blame to an individual (e.g. patient and other colleague) or situations (e.g. long waiting time). Placing blame solely on individuals is likely to pose a risk of ignoring other important factors (e.g. interactional factor) which precipitate violent episodes. In order for them to deal with violence more effectively, it is important that nurses are aware of such paradoxes and the culture of blaming.

The cultural context of violence suggests that environment plays a significant role in violence. Violence in the ED was more likely to occur when the department was busy and chaotic. It is highly probable that when nurses were working beyond their capacity, they were less likely to identify the covert warning signs (e.g. agitation and pacing) and foresaw the needs and fulfilled requests made by patients/relatives. Under such stressful circumstances, nurses were also less likely to practice empathetic communication skills in their interactions with patients/relatives.

This study indicated that violence in the ED happened more frequently for patients/relatives who had drug/alcohol or psychiatric problems. However, such a finding which is in agreement with previous investigations (Brookes and Dunn 1997; Lanza, Kayne et al. 1996) does not mean that drugs/alcohol and psychiatric problems are good sole indicators of violence. This is because nurses in the study often

perceived that patients/relatives with such a problem commonly did not show any warning sign prior to a violent incident. Fortunately, this study had shown that the immediate and direct personal behaviours (e.g. being unfriendly, not appreciative, inattentive and uncooperative) displayed during the initial interactions between nurses and patient/relative were better predictors of violence in the ED.

Nurses in this study commonly perceived that the rejection of requests of patients/relatives had a significant role in violent incidents. Actually, it was not always the rejection *per se* that determined the likelihood of an incident. Instead, it appeared that the manner in which the rejections occurred was more critical. In this light it is important for nurses to use more tactful strategies for rejecting a request, such as providing explanation for the rejection coupled with empathetic communication skills. The strategies for such refusal will be explained in the 'recommendations' section.

Dissatisfaction associated with waiting times was perceived as another crucial trigger for violence. This research suggested some critical points about the problems surrounding this issue. This study showed that the patients' negative responses to waiting time were not exclusively dependent on the actual duration of waiting. Such a finding may suggest that promotion of a positive attitude toward waiting in the ED through effective interpersonal interaction may be more realistic than the actual improvement of waiting time to reduce violence. Dissatisfaction associated with waiting times also derived from conflicting messages patients/relatives received from the waiting time display, which was rarely changed. In the ED setting, at times, it may not be realistic to expect an update of waiting time regularly. Therefore other

means of informing waiting time may be more applicable in the ED, for instance having patients/relatives access their personal waiting time electronically without violating others patients' privacy.

This research indicated that the behaviours of both nurses and patients/relatives played a pivotal part in a violent encounter. Behaviour that occurred had a reciprocal relationship. Negative behaviours from one cultural actor (e.g. nurse) were more likely to trigger a response from another actor (e.g. patient) which was usually also negative. The study demonstrated that empathetic communication which commonly involved rapport establishing techniques (e.g. greeting, calling patient's first name and thanking a patient after he or she answered questions) was the key to ensure a good outcome in the intercultural interactions between nurses and patients/relatives. It is apparent that such empathetic communication is crucial and needs to occur early because a few studies, including this one, have shown that violence in the ED is more likely to occur within the first hour of patient presentation. More importantly, the study indicated that there was a 'turning point'; a crucial moment when empathetic communication could contain or prevent violence.

Nurses' prejudices and ethnocentric perceptions of patients/relatives and their problems were main obstacles impairing such intercultural communication. This study indicated that there had been widespread prejudice against certain groups of patients (e.g. those who had drugs/alcohol or psychiatric problems, or those who asked about waiting time upon their presentation at triage) and nurses were ethnocentric when interacting with patients/relatives under a few circumstances (e.g. when handling the requests made by patients/relatives, in particular requests

involving opioid analgesics or making personal judgement about the appropriateness of patients' usage of emergency services). In order for them to deal with difficult interactions and circumstances more effectively, it is important that nurses are aware of such prejudices and ethnocentrism.

Strengths and limitations of the study

Strengths

The major strength of this study was the adoption of the ethnographic approach to document the complexity of violence in the ED. The approach which was based on a naturalistic inquiry and multiple data collection strategies proved to be particularly valuable in studying the cultural aspects of violence in the ED. This is because it enabled a provision of a more holistic explanation of the various contributory factors of violence. The prolonged field observations were also able to give a more authentic account of violence in the ED setting.

In addition, although the researcher was an emergency nurse, there was a certain degree of 'outsider' or 'etic' view in the observations because the researcher did not work in the setting where the data were collected. Baillie (1995) and Kanuha (2000) argued that being seen as 'an insider' may make it difficult for the researcher to ask apparently naïve questions, which may limit the depth of understanding of such a social phenomenon such as violence. In contrast to the disadvantage of being an insider, the outsider is able to observe with an open mind and have less biases inherited from social tensions that affect the interpretation of the cultural scene.

The non-participatory role underlying the field observations in this study had two main advantages for the researcher. Baillie (1995) described the absence of guilt toward the co-worker in a busy situation for such a role. The problems of such role conflict would have been more obvious if the researcher was part of the group. Awareness of the drawback of role conflict enabled the researcher to be more careful about the effect of the so called 'disturbance' created in the natural scene and took some precautionary measures in terms of the interpretation of the interactions.

Furthermore, such a non-interactive observation was less likely to influence participants in the study because it allowed the researcher to gather material with little exchange with the nurses in the study. Werner and Schoepfle (1987) suggest that participant observation (i.e. interactive observation) is often problematic because the gaining of information often depends on the intentions and motivations of participants. This sort of observation can be compromised as participants can control the access of the researcher to the people and events.

The creation of the revised version of the observation guide (Appendix 9), which was more appropriate and concrete after the initial observations, demonstrated that while a structured approach to data collection was required this did not preclude the flexibility of modifying the data collection tool as required. It indicated that the researcher was willing to adapt the data collection tool for what was being considered as most useful within the cultural scene. This was important as it allowed the researcher to continue searching for concepts and categories that appeared meaningful to the investigation of cultural aspects of violence in the ED.

Limitations

In view of the difficulty associated with ethical approval, there were two major limitations in conducting this study. In the process of getting approval, it was proposed that patients involved in violent incidents would be contacted for telephone instead of face-to-face interviews. It was argued that patients involved in violent incidents could potentially endanger the safety of the researcher and bias might arise in interviews due to emotional instability of the patients involved. In this study, the use of this approach might have decreased the chance or caused the inability to recruit patients. Therefore, views from the patients' perspectives were limited and this may have proved a barrier to effective management of violence in the ED. It is clear that the risks and benefits need to be balanced against each other in this type of research and ideally, focus groups which are potentially less threatening may need to be considered to ensure optimal input from patients.

In terms of the issue of consent involved in observing nurses and patients, it was suggested by the University of Adelaide Ethics Committee that individual written consents had been obtained from all participants. The research proposal was resubmitted and approved with reference to the National Health and Medical Research Council (NHMRC) (Anonymous 2003b, p.E130) guideline which states:

‘...obtaining consent would interfere with the strength of the “naturalist” approach of ethnography. Seeking consent from participants in the situations where they are aware of observation for research purpose may lead to behavioural changes that would invalidate the study and ...it is ethically acceptable to conduct certain types of research without obtaining consent from participants in some circumstances, for example...observational research in public places...’.

It is clear that, in a public place such as the ED waiting room, patients are already aware of ongoing observation in the form of security cameras and the triage nurse. Therefore, making observations without consent in ED research would not be regarded as significantly unacceptable practice.

In this study, during the field observations nurses were informed verbally and patients were given information sheet (Appendix 3) to inform them about the study when they presented to the ED. Even though written consents were not required for this study, oral and implied consent might have interfered with the ‘naturalist’ approach of ethnography and subsequently might have led to behavioural changes that could affect the interpretation of findings.

Recommendations

After careful consideration of the major findings, strengths and weaknesses of this study, the following sections will focus on recommendations for violence management and prevention which involve practice, education and research.

Recommendations for practice

Recommendations for practice mainly focus on interactional and structural issues. Interactional issues target the micro level of violence management and prevention: the communication between nurses and patients/relatives.

Empathetic communication skills which are of particular importance in the ED setting include acknowledging patients’ arrival/waiting or emotions/concerns (e.g.

‘How are you feeling today?’), calling patients by their first name, thanking patients after they answer questions, and asking patients/relatives about their expectations (e.g. ‘What can we do for you today?’). It is crucial for nurses to become adept at such communication techniques. Another critical point to take in relation to communication from this study is the recognition of ‘turning point’ and knowing that something can be done to improve the strained relationships between nurses and patients/relatives. This research reveals that starting with empathetic communication is most appropriate, but it is the recognition of the ‘turning point’ where nurses can act to contain or prevent violence that is crucial.

In addition, this study pinpoints the focus of communication that needs careful consideration and attention: handling of waiting times and requests made by patients/relatives. The study implies that communication of waiting times needs to be prompt, accurate and unbiased. When providing a rationale for further waiting, nurses need to consider that patients/relatives cannot see behind the closed door.

Given that demands and denials are irrefutable in the ED and many violent incidents occur as a consequence of such denial, it is crucial that less provocative methods of communication are used. The steps of less provocative communication skill are illustrated below: (1) Acknowledging/validating the request made by patient/relative: Do not directly or abruptly ask why they make such a request as it may be provocative. (2) Providing alternatives or explanations for the rejection.

Structural issues impact on the macro level of violence management and prevention: situations (e.g. lack of prior interaction before the incident), organisation (e.g. nurses' role) and environment (e.g. privacy) in the ED.

Situations

Nurses in this study frequently stated that they '*just walked into a situation*' and they had very little knowledge about the patients. Provision of patients' psychological and emotional status in the triage note may be a plausible solution to such a problem. However, this is a controversial solution for the ED. On one hand, such information is likely to be abused (e.g. labelling of patient) by nurses and therefore it is unethical. On the other hand, triage nurses' roles should not be confined to physical assessment. Assessment of psychological or emotional well being of patients is also crucial. However, it could be argued that the provision of patients' psychological well being may not be sufficient due to staff lacking the time to read the notes. Thus, other ways to improve verbal communication among nurses may need to be put in place as a more satisfactory solution to this problem.

In the attempt to plan for a more effective violence management and prevention program for the ED, it is critical to take findings from this study into consideration. As indicated in this study, the incidence of violence in the ED peaked between 1500 and 2400 hours. Therefore, measures used to manage these incidents (e.g. communication of accurate and prompt waiting time) need to be available at these times.

Organisation

This study also indicated that there was a lack of recognition of communication role by the triage nurses in the ED. This is a very important issue because most triage nurses' time is spent in communication and previous studies have shown that communication improves patients/relatives' satisfaction in the ED. Allocation of a nurse whose sole role is to communicate could be useful strategy for the ED. Such a nurse can communicate waiting time and handle requests more efficiently and effectively because he or she does not need to juggle triage and other tasks concurrently. This would be beneficial in particular when the department is busy.

Environment

This study showed that the lack of privacy at the waiting and triage area might have contributed to some of the violent incidents which occurred at these locations. Thus, nurses should be encouraged to more commonly use their own clinical judgement in selecting the most suitable location to triage patients based on their assessment of patients' awareness. For instance, some patients are likely to be self-conscious may need a private room or cubicle for triage.

Recommendations for education

This section is primarily concerned with recommendations for violence management and prevention from the perspective of nurses' and patients/relatives' education. Even though awareness and acquisition of interpersonal skills in dealing with violence should be instilled at an early stage (i.e. basic undergraduate nursing

training), continuous violence education at a later stage is crucial (e.g. in-service training). In particular, nurses need to feel confident in applying the violence handling strategies. Frequent discussions of problems associated with violence and giving examples of successfully managed violent episodes as well as role playing of violence handling strategies could be used to achieve this.

It is also important for nurses to acknowledge the importance of cultural meanings and contexts of violence which are pertinent to the ED setting, and their personal expectations, prejudices and ethnocentric thinking when interacting with patients/relatives. Nurses need to appreciate that patients' characteristics alone cannot account for all difficult encounters, nor should these be regarded as the sole cause of violence (Adams and Murray 1998) because:

a complex interplay between the patient's medical condition and the patient's affective interpretation of it, pain and discomfort, other emotional components, social factors, the nature of the ED setting, and interpersonal dynamics between patient and care giver create the difficult patient or more appropriately the difficult interaction (Adams and Murray 1998, p.690).

This investigation indicated that there was a gap between triage nurses' roles and patients' expectations about triage. It is therefore important to educate patients/relatives about what triage nurses do in their professional capacity. By doing this, patients/relatives may be able to appreciate triage nurses' unique and complicated roles and have confidence in the decisions that triage nurses make.

Recommendations for research

This section makes recommendations on violence management and prevention from the research perspective. The investigation of violence has been expanded beyond research which focuses on prevalence, nature and characteristics of violence. Studies that concentrate on these aspects are important to provide the basic knowledge about violence in the ED. However, future studies need to be able to give new insights into violence in the ED. In terms of this, further research that focuses on the cultural aspects of violence, which look into its meanings, contexts and management, may ensure a more satisfactory solution for this problem.

The inability to recruit patients in this study for various reasons, in particular the reluctance of patients to participate in telephone, have highlighted the difficulty, sensitivity and the need to investigate this phenomenon by using a different approach. For example, a combination of field observations and on-the-spot interviews could provide a possible solution from the methodological point of view. Alternatively, a focus group discussion may be an option, as it is less threatening for patients to give their views.

Summary

This study has contributed to an in-depth and rich understanding of cultural aspects of violence in the ED. As demonstrated in preceding chapters, ethnography is able to reveal the dynamic interactions involving various contributing factors (i.e. nurse, patient/relative, and environment/situation) associated with violence.

While it is undeniable that situational (e.g. long waiting time) and environmental factors (e.g. busyness) are important violence contributory factors, the human (i.e. nurse and patient/relative) factors have a more profound influence. This is because situational and environmental factors are subject to human manipulation. For instance, the use of empathetic communication can make a long waiting time more tolerable. More importantly, from the nurses' point of view, it is crucial to acknowledge that expectations, ethnocentrism and prejudices are the fundamental human factors that affect the quality of nurse-patient/relative interactions.

Finally, this study has been able to provide some insight to the cultural meanings and contexts of violence which are of particular importance to the ED. More significantly, this study suggests that there are possible solutions for such a problem. For example, the discovery of the 'turning point' may signify the possibility of immediate and effective violence management and prevention at the individual staff level.

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APPENDICES

Appendix 1: Violent incident questionnaire

Date/Time:

Location:

Name of staff member:

(No information that could identify a particular individual will be in the results or made public.)

Please select whichever is/are appropriate:

1. What was the nature of the violence? (Select more than one if desired)

Verbal

Physical

Threats/intimidating

Others (please specify) _____

2. Details of incident

3. Who is/are involved in the incident? (Select more than one if desired)

Patient

Relative/s

Friend/s

Others (please specify) _____

4. Type of referral to the emergency department

Self-referral

Local general practitioner

Referred by another hospital or institution

Others (please specify) _____

5. Violent incident happened within how many hour/s of presentation to ED?

At presentation

Less than 1 hour

1 to 2 hours

2 to 6 hours

6-10 hours

More than 10 hours

6. Did the patient/relative/friend/other involved display any warning signs prior to the incident? (Select more than one if desired)

Non verbal signs (please specify) _____

Verbal signs (please specify) _____

Other (please specify) _____

No warning signs (please comment) _____

7. Did you suffer any physical injury as a result of this violence episode?

- None
- Minor (redness/ bruises)
- Moderate (abrasion and need first aid)
- Severe (need suturing or hospitalisation)

8. What do you think are the contributing factor/s for this violent episode? Please specify (Select more than one if desired)

- Patient factors (please specify) _____
- Staff factors (please specify) _____
- Situational factors (please specify) _____
- Others (please specify) _____

9. What action/s have you taken in regard to this violence episode? (Select more than one if desired)

- Completed an incident report form
- Reported to a superior
- Not reported
- Police report made
- Reported to security
- Others (please specify) _____

10. What action/s do you think need to be taken as a result of this violence? (Select more than one if desired)

- Counselling for staff
- Counselling for patient involved
- Increase man-power
- Support from colleagues
- Support from superior/management
- Others (please specify) _____

Appendix 2: Ethics approval letter



ROYAL ADELAIDE HOSPITAL
North Terrace
Adelaide
South Australia 5000

RESEARCH ETHICS COMMITTEE
Level 3, Hanson Institute
Telephone: (08) 8222 4139
Fax: (08) 8222 3035
email: tpietra@mail.rah.sa.gov.au

10 December 2003

Dr J Lau
DEPARTMENT OF CLINICAL NURSING
ROYAL ADELAIDE HOSPITAL

Dear Dr Lau,

**Re: "Exploring the indicators of violence at triage in the Emergency
Department: an ethnographic descriptive study."
RAH PROTOCOL NO: 031119.**

I am writing to advise that ethical approval has been given to the above project.

Research Ethics Committee deliberations are guided by the Declaration of Helsinki and NH&MRC National Statement on Ethical Conduct in Research Involving Humans. Copies of these can be forwarded at your request.

Adequate record-keeping is important and you should retain at least the completed consent forms which relate to this project and a list of all those participating in the project, to enable contact with them if necessary, in the future. The Committee will seek a progress report on this project at regular intervals and would like a brief report upon its conclusion.

Yours sincerely,

Dr M James
CHAIRMAN
RESEARCH ETHICS COMMITTEE

Appendix 3: Information sheet

The following study has been reviewed and approved by the University of Adelaide Human Research Ethics Committee:

Project title: Violence in the Emergency Department: An ethnographic study

The purpose of the study is to explore the cultural aspects of violence in the Emergency Department (ED). We strongly believe that knowing the nurse's and patient's perceptions, feelings and attitudes about the experience in the emergency department will be very helpful in terms of predicting violence and subsequently in the preventing of violence. The ultimate goals are helping the Emergency Department to provide a better quality service to the public and promoting a safer working environment for the health care workers.

You are free to choose not to participate or to withdraw from the study at any time without any consequence to your career, now or in the future.

Confidentiality and anonymity will be maintained at all times throughout the study. The participant and institution involved will not be identified. The study will be published without any identifiable information source. The raw data collected throughout the study will be stored in a locked cupboard for seven years at The Discipline of Nursing, University of Adelaide.

If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the project co-ordinator:

Name:

Telephone:

If you wish to discuss with an independent person matters related to

- making a complaint, or
- raising concerns on the conduct of the project, or
- the University policy on research involving human subjects, or
- your rights as a participant

contact the Human Research Ethics Committee's Secretary on phone (08) 8303 6028

If further information is required, please do not hesitate to contact:

Jacqui Lau Bee Chuo
The Discipline of Nursing
Faculty of Health Science
The University of Adelaide

Tel: 61-8-83036292

Email: bee.lau@adelaide.edu.au

Thank you for your participation.

Appendix 4: Poster for the study



Currently we are conducting research to investigate difficult nurse-patient interactions (physical, verbal, emotional) in the Emergency department. If you experience such interaction, please...

Make your views heard

Researcher: Jacqui Lau
The University of Adelaide
Department of clinical nursing

Contact: 08-83036292

Appendix 5: Consent form

Research title: Violence in the Emergency department (ED): An ethnographic study

1. I, _____ (Please print name)
agree to participate in the above named project. I give permission to be interviewed and for those interviews to be taped recorded.
2. I acknowledge that I have read the attached Information sheet and my consent is given freely.
3. Although I understand that the purpose of this research project is to improve the quality of patient care and staff safety, it has also been explained to me that involvement may not be of any direct benefit to me.
4. I agree that the information may be published, provided my name and any information may lead to the identity of myself or any other person or institution will remain confidential.
5. I understand that I am free to withdraw from the project at any time and that this will not affect my career, now or in the future.
6. I am aware that I should retain a copy of this Consent Form, when completed, and the attached Information Sheet.

Signature _____ Date: _____

Appendix 6: Refusal form for telephone contact

Research title: Violence in the Emergency department (ED): An ethnographic study

I, _____ (Please print name)
attended the Emergency department on _____ do not agree to participate in
the above named research. I do not give permission to be contacted for telephone
interview.

I acknowledge that I have read the attached information sheet and my refusal is
given freely.

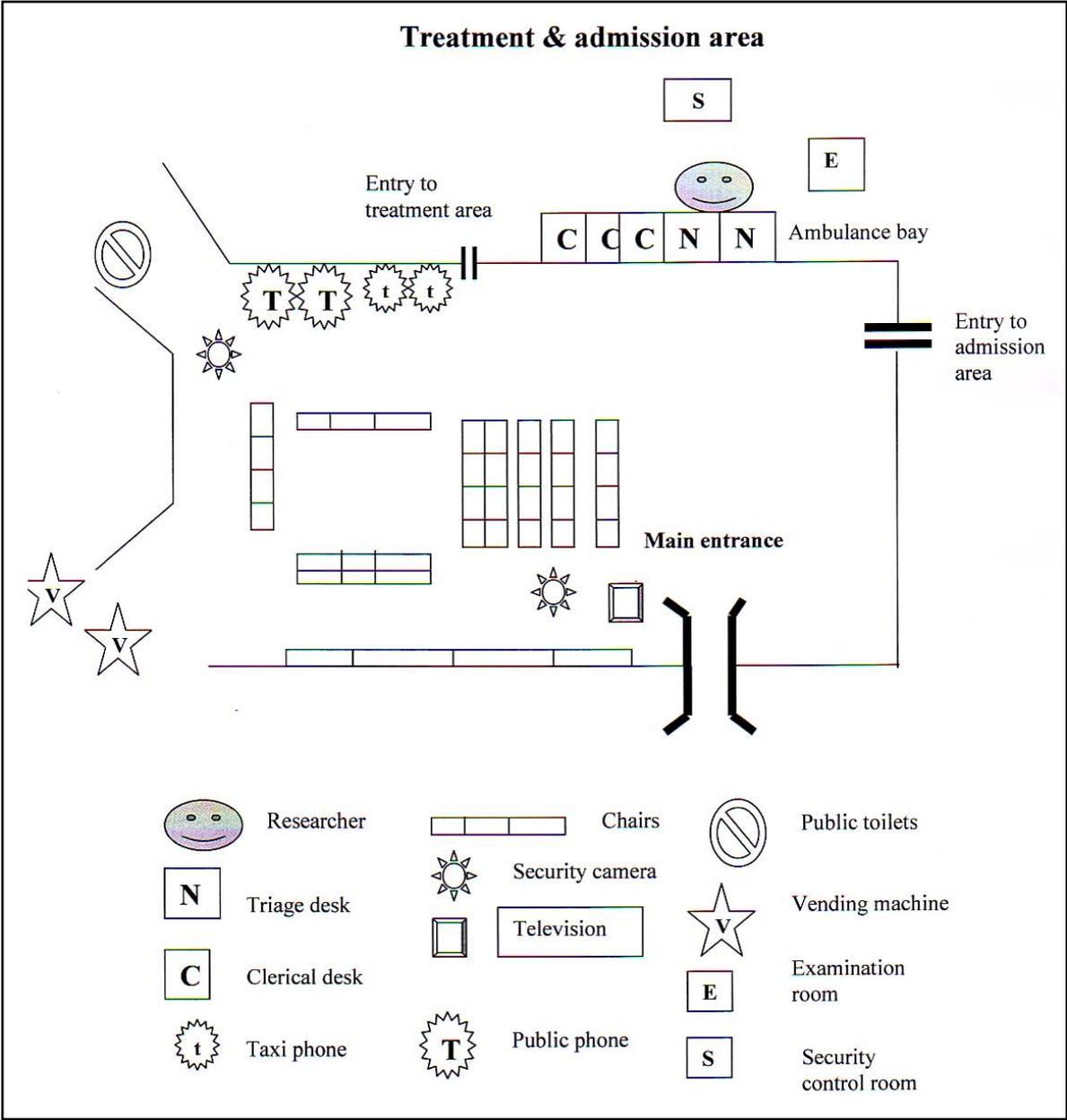
I understand that I am free not to participate in the project and that this will not
affect my treatment, now or in the future.

Signature

Date:

Please submit this form to the nurses in the ED within THREE days

Appendix 7: Layout of the cultural scene



Appendix 8: Guide for observations

Patient/relatives' behaviours

Drugs/alcohol used _____
 (Smell of substance/alcohol on breath __; Poor physical coordination __; Red watery eyes __; Tremors __; Other/s __)
 Psychiatric symptoms _____
 (Hysteria __; Delusion __; Hallucination __; Other/s __)
 Confused _____
 (Not orientated to time, person and place __; Other/s __)
 Pain _____
 (Verbalisation __; Grimaces __; Other/s __)
 Appeared anxious _____
 (Increase pace of speech __; Rapid breathing __; Other/s __)
 Appeared agitated/frustrated _____
 (Restlessness __; Squinting of eyes __; Staring __; Rapid breathing __; Other/s)
 Reluctant to co-operate _____
 Demand to be seen by doctor first _____
 Verbalised inability to wait due to other commitment _____
 Verbally abusive (Increase tone and volume of speech __; Shouting __; Other/s __)
 Others _____

Nurses' behaviours

Cheerful, calm and confidence (appeared relaxed) _____
 Reassurance given _____
 Empathetic _____
 Respect and truthful _____
 Immediate action taken _____
 Giving education about presenting symptoms/problems _____
 Give information about triage category _____
 Communicate waiting time _____
 Choice of reassessment mentioned _____
 Others _____

Situational factors

Overcrowding _____
 Long-waiting time _____
 Changing of doctors _____
 Poor staffing levels _____
 Others _____

Appendix 9: Revised observation guide

Variables		Patients/relatives' behaviours	Triage nurses' behaviours
POSITIVE			
	Greeting		
	'Ok', 'Alright', 'Yep/yes'		
	'Mate'		
	Nodded head		
	Eye contact		
	'Thank you'		
	'Sorry'		
	Smile		
	Posture		
	Ending		
	Short waiting time		
	Others		
NEGATIVE			
	Alcohol/drugs		
	Mental health problems		
	Crying/sobbing/emotional		
	Pain		
	Long waiting time		
	Denial of requests		
	Others		

Appendix 10: Semi-structured interview questions for nurses

Demographic data

Sex:

Age:

Years of experience in ED:

Qualification:

Destination/position:

Questions:

- Tell me about the violent experience you have reported recently?
- How did it make you feel?
- What do you think your interactions with the patient had any influence on the incident?
- What do you think might have contributed to the incident?
- Has anything changed after this incident?

Post-interview reflection:

Appendix 11: Telephone interview procedures and questions for patients

Pre-interview data

Sex:

Age:

Patient:

Frequency of visit to ED for the last 6 months (for patient):

During interview

Date of interview:

Time start:

Time end:

After introducing/greeting, explain the purpose of study as:

I am a student at The University of Adelaide. I am doing a study about violence in the ED. I strongly believe that knowing patients' perceptions, feelings and attitudes about the experiences in the ED as well as their expectations and needs will be very helpful in terms of predicting violence and subsequently in the prevention of violence. The ultimate goals are helping the ED to provide a better quality service to the public and promoting a safer working environment for the health care workers.

The information will be published but your name and any information, which may lead to the identification of you or any other person or institution will remain confidential.

You are free to withdraw from this study at any stage without any consequences. The tape will be returned to you if you wish or destroyed.

Do you agree to participate in this study, to be interviewed and for those interviews to be taped recorded?

Do you have any question before we begin?

Questions for patient during the telephone interview:

- Tell me about your experience in the ED?
- How did you feel about...?
- What do you think about your interactions / dealings with the staff in the ED?
- What do you think might have contributed to the experience?
- Has anything changed after this incident? (If patient acknowledge an unhappy incident in question one)

Post-interview

Reflection on the interview
