

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

*A Mantle of Protection? A Critical Analysis  
of the Personal Safety of District Nurses.*

A thesis presented in partial fulfilment for the degree of  
Master of Arts  
in  
Nursing

at Massey University, Wellington, New Zealand.

**Jillian Ann Wilkinson**

**2001**

## **Abstract**

This qualitative inquiry, informed by Critical Social Theory, explored the personal safety experiences of district nurses in a New Zealand city. While interest in workplace safety in New Zealand has been gaining momentum, there has been no formal research to date regarding the personal safety of district nurses. Studies by Beale, Fletcher, Leather and Cox (1998), Koch and Hudson (2000), and White (1999) have begun to address district nurses' experience and management of violence in the community but do not address the power issues implicit in the existence of the problem. The Critical Social Theory perspective that underpins this study aimed not only to initiate discussion about occupational safety for nurses working in the community, but paid critical attention to the power systems that are perpetuated by ensuring district nurses remain vulnerable and relatively powerless. It also explored the tolerance that nurses demonstrate for an unsafe working environment.

District nurse participants recalled incidents in which they felt their personal safety was compromised. Data was collected from six district nurses using interviews based on the incident(s), in order to explore the ways in which personal safety of district nurses was compromised. Data was also collected from a focus group discussion with the participants. Analysis of the data suggests that nurses have modest expectations for their own safety and even these were circumscribed by institutional practices. The complex power relationships that shape the experience of nursing in a community impinged on the ability of the nurses in this study to confidently and safely fulfil their role. Recommendations emerging from the research are that issues of building security, access to client information, provision of cellphones and regular safety in-service require urgent attention. Attention must also be given to the development of institutional policy that prioritises nurse safety, and has in place post-incident plans and support structures.

## Acknowledgements

Firstly, I would like to thank the district nurses who participated in this project. Their time, thoughts and experiences form the basis of this thesis, and without them, it could not have happened.

I would also like to thank Annette Huntington, my supervisor, for her encouragement, her insight, and her skill at asking impossible questions. In particular, her confidence in my ability to think and write gave me the courage to keep going.

My colleagues who have supported me in such subtle ways, and listened wisely as I discussed some theoretical point - thank you. Whitireia Community Polytechnic Research Committee for not only contributing to the financial cost of the project, but also the ongoing interest and support. Also the Regional Ethics Committee and Massey University Human Ethics Committee for allowing me to undertake this project.

Finally, my husband Graeme who has listened with great patience and tolerated my preoccupation, not only during this project, but also throughout this degree - how can I thank you?



# Table of Contents

<i>Introduction</i>	1
<i>Chapter One</i>	10
<i>Theoretical Background</i>	10
Introduction	10
The Development of Critical Theory	10
Critical Social Theory and Nursing	19
Conclusion	24
<i>Chapter Two</i>	27
<i>Nursing and Occupation Risk of Violence</i>	27
Introduction	27
Defining Violence: Exploring Prevalence	30
The Risk of Violence	38
The Community Experience of Violence	41
Conclusion	55
<i>Chapter Three</i>	57
<i>Methodology</i>	57
Introduction	57
Study Design	60
Participants	60
Data Collection	63
Data Analysis	70
Ethical Issues	71
Adequacy of the Methodology	75
<i>Chapter Four</i>	79
<i>The Vulnerability of Client Contact</i>	79
Introduction	79
The Client Group	80
Preserving Integrity	83
Powerlessness and Vulnerability	88
Conclusion	102

<b>Chapter Five</b>	<b>104</b>
<b>Organisational Issues</b>	<b>104</b>
<b>Introduction</b>	<b>104</b>
<b>Institutional Power defines Nurses Safety</b>	<b>107</b>
Professional Development	107
Staffing	113
After-hours and Weekends	115
Call Out	117
Communication Devices	119
Fleet Cars	124
Building Security	127
<b>Conclusion</b>	<b>129</b>
 <b>Chapter Six</b>	 <b>130</b>
<b>Discussion</b>	<b>130</b>
<b>Introduction</b>	<b>130</b>
<b>Re-interpreting Organisational Structures</b>	<b>132</b>
Resources	132
Professional Development	137
Policy	139
<b>Tolerance for an Unsafe Working Environment</b>	<b>142</b>
<b>Critical Social Theory as Methodology</b>	<b>145</b>
<b>Conclusion</b>	<b>148</b>
 <b>Chapter Seven</b>	 <b>151</b>
<b>Conclusions</b>	<b>151</b>
<b>Creating a Culture of Safety</b>	<b>151</b>
<b>Recommendations</b>	<b>154</b>
Primary Prevention	154
Secondary Prevention	155
Tertiary Prevention	155
<b>Implications for Further Research</b>	<b>156</b>
<b>Implications for the Future</b>	<b>157</b>
 <b>References</b>	 <b>159</b>
 <b>Appendix One</b>	 <b>1</b>
<b>Information Sheet for District Nurse Participants.</b>	<b>173</b>
 <b>Appendix Two</b>	 <b>175</b>
<b>Consent Form for District Nurse Participants.</b>	<b>175</b>

## Introduction

My interest in the personal safety of district nurses has emerged both from my experiences while working as a district nurse and from the experiences of my district-nursing colleagues. The situations that I felt compromised my safety were everyday occurrences that I felt powerless to prevent happening again. I felt that irrespective of how astute I became about looking after myself, the attitudes amongst the staff and the way that the work was organised perpetuated a level of risk that I felt was unnecessary. Pursuing this private disquiet as a research topic was spurred on by a presentation by Mary Sylvester, a midwife, who in the process of her own research had encountered significant personal risk as she collected data from participants in their own homes. For Mary, the everyday circumstance of district nurses visiting clients in their own homes was highlighted as a personal risk, and she suggested that the topic warranted further research.

Another incident that influenced me to pursue this research interest was the Wellington murder of a caregiver in April 1995. The caregiver was employed to care for a brain-damaged man in his own home when he used a kitchen knife to stab her to death. The caregiver was unaware that her client had been aggressive in the past, as her employer had not made this information available to her ("No warning", 1998). While this study addresses the concerns of district nurses and not of caregivers, the circumstances of this caregiver's death resonate with the circumstances district nurses work under, that is working alone in private houses with limited access to information about their clients.

Although now working as a nurse educator, I was convinced that district nurses' were at risk not only because of my own experiences but because whenever I spoke to district nurses about my intentions for the study they would immediately share anecdotes about times when they had felt unsafe. I was anxious to begin collecting this data and so began the process of gaining ethical approval for the study. In the course of gaining the appropriate permission, I encountered an intriguing phrase that was offered as a possible explanation for why nurses had hitherto not experienced significant harm. Alluding to the stereotype of nurses as angels or saints, the phrase referred to an invisible barrier that nurses are imbued with by virtue of their role: '*a mantle of protection*'.

I felt that I wanted to be offered more than an invisible mantle of protection to protect my personal safety if I were to work as a district nurse again. I also felt that it was incumbent on the employer to provide this more tangible resource. Nonetheless, in the course of this study I have come to believe that the 'mantle of protection' is the key protective device that nurses rely on as they go about nursing people in the community. This position is one of default rather than choice, and occurs in the absence of an organisational structure that supports and promotes personal safeguards.

The stereotype of nurses as angels or having saint-like qualities relates to the notion of having 'a calling' to nurse and stems from the religious origins of nursing. Many nurse historians link this calling to heal with what has traditionally been women's work anyway. Moreover as Huntington (1994, p. 21) points out, "the care of the sick and maintenance of health have been women's

work and therefore, along with other women's work, been taken for granted". Or as Kim Hill put it so succinctly on National Radio recently: "nursing is a calling rather than a job. Hey, you're a woman - this is what you do. It's just doing it with a uniform on" (Hill, 2001).

The taken-for-grantedness of women's work as nurturing 'naturally', relying on instinct rather than knowledge, intelligence or judgement ignores the complexity of caregiving and the agency of the nurse (Buresh & Gordon, 2000). While the naturally nurturing notion of agency may have been fitting for the calling, it is no longer fitting for the profession. Such notions serve to undermine and devalue nurses and their work, and lead to nurses not speaking of their work – who wants to hear about it? As women who speak little about their work they also complain little about their work and this is significant when considering personal safety issues for nurses. Hegemonic systems position nurses as women who may complain but can easily be ignored, or at least not taken seriously. Voicing valid concerns about workplace safety can be relegated to minor complaint because at the end of the day, the work still gets done.

Since nursing was first formalised by Florence Nightingale, safety has been a concern connected with nursing. At the beginning of the 20<sup>th</sup> century, nurse safety was managed in separate residences for nurses called nurses' homes. According to Bullough (1990) this separation allowed women to be alone, to relax from the threat of sexual harassment and to feel at home. Bullough (1990) says that women were ordinarily under the jurisdiction of their fathers, brothers, husbands or sons, but if they became nurses they moved beyond the protective

male umbrella rendering them vulnerable to threat of male harassment in the outside world. Bullough (1990) believes that Nightingale addressed the problem of ensuring the safety and respectability of her student nurses by having them live in nurses' homes. There was constant supervision of every aspect of their lives with strict rules that governed behaviour, hours of work, study, recreation, worship and free time.

The Nursing Home tradition was adopted in New Zealand from Britain, eventually becoming defunct by the mid 1980's. By an intriguing coincidence, in at least five Community Health Services that I have either worked in or visited in New Zealand, these same decaying buildings are now used as the work base from which district nursing services operate. A question arises over whether the buildings that were designed to closet nurses away from an unsafe world in off-duty hours, continue to oppress nurses by virtue of their being built for an altogether alternate purpose. Buildings that were once integral parts of the hospital institution now serve to hold district nurses on its periphery. The location of these buildings could be seen as strangely epitomising the marginalisation experienced by district nurses, despite their being the providers of one of the institution's key business areas.

In undertaking this study, I was not content to understand and describe the world of district nurses; I wanted to change it. This led me to explore qualitative critical paradigms and I found myself immersed in the concepts of power and control. I began looking at the world through the lens of Critical Social Theory, which began to influence the way I viewed client-nurse relationships. Even a simple

interaction that I observed as a visitor between a nurse and a family member in hospital prompted me to write an article about the power dynamics inherent in the exchange (Wilkinson, 2001). I wrote about the hospital setting where nurses easily assume a position of privilege over his/her clients because of their greater knowledge about the institution, and the client's condition. However, this thesis is concerned with the shift in power that occurs when a client is discharged home. At home, a client is on his/her own territory and the nurse an invited guest. Here, the *client* is able to assume a position of privilege because of their greater knowledge about the immediate environment, as well as being at liberty to comply with a nurse's request, or not. Consequently, the nurse's safety in some instances may be compromised, if, for example, a client chooses to deadlock the exit doors against the nurse's wishes.

The choice of a Critical Social Theory framework for the study therefore arose out of a desire to do more than merely describe existing safety practices for district nurses, but to suggest and bring about change. The ontological position of Critical Social Theory maintains that history is shaped over time by social, political, cultural, economic, ethnic and gender factors. It provides a means to explore each of these avenues for the power relationships that shape the nurses' subjective experience (Guba & Lincoln, 1994). Such a framework would be useful for uncovering the tolerance nurses demonstrate for an unsafe workplace.

Central to Critical Social Theory is the concept of hegemony, which refers to the ascendancy or domination of one power over another, giving the oppressed people the impression that the dominant force is unassailable (Roberts & Taylor,

1998). Hegemony is a term used throughout this thesis and is most often used in reference to the 'institution'. In sociology, the institution is "a stable cluster of values, norms, statuses, roles and groups that develops around a basic need" (Robertson, 1989, p. 54). It is used in reference to the major institutions of family, education, religion, economics and politics. From a Critical Social Theory point of view, the institution also has a set of values and beliefs and to a certain extent they overlap with the sociological perspective, especially in their tendency to resist change. However in this study, the institution refers to the employing body. More often than not, the nurses in this study personify the institution by using the words "them" or "they". Evidently, the institution is more than a set of institutional practices; it is seen by the nurses as comprising real people who are responsible for the decisions that are made.

The fittingness of what is essentially a *social* theory to nursing is apparent in Critical Social Theory's emphasis on the tripartite notions of enlightenment, empowerment and emancipation. The philosophical assumption is that no aspect of social phenomena can be understood unless it is related to the history and structure in which it is found (Fulton, 1997), and that every form of social order entails some form of domination and power (Browne, 2000). There is an imperative for liberation from these constraints, and with regard to nursing, Critical Social Theory provides a medium to address the socio-political context of nursing practice as it applies to the discipline of nursing and also to consumers of health care.



Having established that I wanted to instigate change in this study, I reviewed the literature about personal safety for nurses working in the community. While interest in workplace safety for nurses in New Zealand is gaining momentum, there has been no formal research about it to date. Studies by Beale, Fletcher, Leather and Cox (1998), and Koch and Hudson (2000) began to address nurses' experience and management of violence in the community but did not address the power issues implicit in the actual existence of the problem. I had clearly identified a need for a New Zealand study - I now needed to decide on a method.

I chose to interview practising district nurses who had experienced unsafe circumstances in the course of their work, as I wanted to access the people who were experts in the area into which I was inquiring. I was aware that my own experiences as a district nurse and my familiarity with the literature about the occupational risk of violence would influence the study. However, this fitted with the epistemological position of Critical Social Theory, which links the researcher and participants interactively, with the values of both inevitably influencing the inquiry (Guba & Lincoln, 1994). My own position is made explicit through a process of writing reflexively. Essentially this means that the researcher articulates her thoughts and beliefs in response to the research process as it unfolds. I have deliberately identified my own feelings and attitudes and considered my participation in the creation and interpretation of the research data. According to Hall and Stevens (1991), making the participation of the researcher in the generation of new knowledge explicit adds to the accuracy and relevance of the results.

While my original interest and motivation for the study has not changed, the objectives for the study have been shaped by the literature about workplace safety. There is overwhelming evidence to suggest that nurses are exposed to violence in the course of their work, and I am interested in knowing why nurses show such tolerance to it. I hope that initiating discussion about safety in the community will encourage district nurses to consider the things that perpetuate their position of vulnerability to potentially violent situations.

The overall aim of this study is to critically analyse the personal safety of district nurses. The objectives are as follows:

- ◆ To initiate discussion about occupational safety for nurses working in the New Zealand community
- ◆ To explore the power systems that are perpetuated by ensuring district nurses remain vulnerable and relatively powerless
- ◆ To explore the tolerance nurses demonstrate for an unsafe working environment
- ◆ To develop recommendations based on the findings of the study that when implemented, will improve the personal safety of district nurses.

Chapter One explores the history and application of Critical Social Theory to nursing research as the framework that underpins the study. Chapter Two reviews the literature as it relates to nurses and occupational risk of violence, defining violence, risk factors for violence in healthcare and nurses in the community. Chapter Three outlines the chosen methodology and the method the study employed, the process of interviewing, the use of qualitative data analysis

software and the process of gaining ethical approval for the study. Chapters Four and Five present analysis of the data from the interviews in the context of a Critical Social Theory perspective. The first of these chapters explores the vulnerability of nurses in relation to direct client contact, while the second explores organisational issues that principally emanate from the institution. Chapter Six is a discussion about the issues that arose from the data, and Chapter Seven contains concluding remarks and recommendations for the future.

# **Chapter One**

## **Theoretical Background**

*"In the broadest terms, critical social science is an attempt to understand in a rationally responsible manner the oppressive features of a society such that this understanding stimulates its audience to transform their society and thereby liberate themselves" (Fay, 1987, p. 4).*

### **Introduction**

This chapter introduces Critical Social Theory and its development, and addresses the central tenets of enlightenment, empowerment and emancipation that have informed this study. The notions of power, oppression and of reflexivity are also discussed. The way nurses have adapted what is essentially a social theory to nursing research and practise is explored. Finally, the way in which Critical Social Theory has been used as the framework for this thesis is explained.

### **The Development of Critical Theory**

While there is no one Critical Social Theory (Stevens, 1989; Manias & Street, 2000), critical social thinking usually refers to a series of ideas that developed out of the critical theory perspectives of the 1920's and the Frankfurt School of philosophers (Max Horkheimer, Theodor Adorno and Herbert Marcuse). Inspired by critical Marxist philosophy and Hegelian dialectics these writers were connected to the Institute of Social Research at the University of Frankfurt. Under the leadership of Horkheimer they were involved in a programme of

interdisciplinary research involving philosophers, sociologists, economists, historians and psychologists (Stevens, 1989). This interdisciplinary approach served to foster a basic belief that no aspect of social phenomena can be understood unless it is related to the history and structure in which it is found (Fulton, 1997). An emancipatory value orientation was central to their analytical style (Stevens, 1989).

These scholars concentrated their efforts on developing a theory to address the unsuccessful integration of capitalism and socialism in Central Europe and questioned why these had failed to address the social unrest evident at that time in Europe. The context of post-war Germany bearing the weight of reparations, unemployment and marked economic depression, shaped their belief that injustice and subjugation shaped the lived world. They felt there was an urgent need for a change in this perception (Kincheloe & McLaren, 1994). "Thus critical social science was born out of a reaction to social need as well as to epistemological dilemmas" (Roberts & Taylor, 1998, p. 124).

As Germany came under Nazi control, Horkheimer, Adorno and Marcuse, who were Jewish, escaped Germany and settled in California. While they accepted the objectivity of positivism as appropriate for the natural sciences, they were shocked by the widely accepted American view that objective facts, techniques and scientific rule-following had *taken over* subjective knowing, critical thinking and reason (Roberts & Taylor, 1998). Their subsequent writing was a reaction against the "taken-for-grantedness of the supremacy of the empirical-analytical paradigm" (Roberts & Taylor, 1998, p. 124). They compared scientific ideology

to the ideology of the aggressors who were sweeping Europe in the name of progress at that time. While Horkheimer and Adorno returned to Germany in the 1950's to reestablish the Institute of Social Research, Marcuse, who remained in the United States, gained popularity and provided the philosophical framework for the student movements of the 1960's (Kincheloe & McLaren, 1994).

By the late 1960's, Critical Social Theory in the Frankfurt School tradition was rejuvenated by a second generation of German theorists, the most prominent and prolific of whom has been Habermas (Stevens, 1989). Grounded in the Enlightenment tradition of reason, language, and rational argument (see Browne, 2000), Habermas described three categories of knowledge or cognitive interests. These are identified as technical, practical and emancipatory interests and are based on "the empirical-analytic sciences, the historically hermeneutic sciences and the critically oriented sciences" (Habermas, 1971, p. 308).

Habermas viewed the knowledge produced by these cognitive interests as collectively essential for the apprehension of social reality. The emancipatory interest added a much-needed dimension of requirement for action to the technical and practical paradigms. This idea reinforced Marx's comment that "heretofore the philosophers have only *interpreted* the world, in various ways; the point, however, is to *change* it" (cited in Fay, 1987, p. 4).

Habermas then did not dismiss as unimportant the positivist and interpretive interests, but rather vehemently rejected the belief of positivism "in itself providing all the answers required by human beings" (Emden, 1991, p. 18). It is

then a synthesis, as Holter (1988, p. 231) described of the three processes of inquiry "in an essential generic perspective comprehensive enough to apprehend the biological, psychological and sociological dimensions of the human being".

As mentioned, rather than representing a unified school of thought, Critical Social Theory encompasses different strands of theory heavily influenced by the Frankfurt School (Browne, 2000). To differentiate his work from other strands, Fay (1987) chose to use the term 'critical social science' rather than 'critical theory', while continuing to highlight the integral social agenda. Fay proposes (cited in Emden, 1991, p. 22) that a Critical Social Theory is one which will "simultaneously *explain* the social world, *criticise* it, and *empower* its audience to overthrow it". He sees this as essentially the same as Habermas' scientific, critical and practical interests.

A concept central to any discussion of Critical Social Theory is that of power disparity arising from an oppressor group over an oppressed group. "In social theory underprivileged groups are commonly described by the concept of *oppressed* groups" (Kuokkanen & Leino-Kelpi, 2000, p. 237) which may include ethnic groups, homosexuals, immigrants, women, nurses (as representatives of a female-dominated group) and patients (Kuokkanen & Leino-Kelpi, 2000).

The educationalist Freire (1972) developed his thesis on oppression from his experience of teaching the illiterate poor in Latin America. His work is discussed here because his notions of power and oppression and their position within a critical framework have relevance to this study. He writes that "any situation in

which A objectively exploits B or hinders his pursuit of self-affirmation as a responsible person is one of oppression. Such a situation in itself constitutes violence" (Freire, 1972, p. 31). Those who oppress and exploit initiate such violence. For the oppressors, the oppressed (thought of as 'things') are conceded only the right to survival; and "this concession only because the existence of the oppressed is necessary to their own existence" (Freire, 1972, p. 34). Such thinking cannot be divorced from the political, which by its nature is concerned with the acquisition of power and authority.

An assumption of Kincheloe and McLaren (1994, p. 140) that is basic to Critical Social Theory is that "certain groups in any society are privileged over others and ... the oppression that characterises contemporary societies is most forcefully reproduced when subordinates accept their social status as natural, necessary, or inevitable". This point too, is central to that of Freire, who defines a 'culture of silence' as the inability to perceive a situation, nor to critique it. On this basis, any education must teach more than how things work, but teach the ability to critically assess a situation with a view toward changing it (Faý, 1987).

Another of Freire's central concepts is the internalisation of the values, beliefs and worldviews of the oppressors in the minds of the oppressed. The alignment is such that they are unable to see themselves as oppressed. In Fay's (1987) discussion of Freire's work, willing cooperation will occur with the oppressors to maintain those social practices that result in their oppression. Although Freire writes about methodology in education, the use of critical theory to effect change in other settings is still basically educative in character.



More recent discussion based on Fay's work by Manias and Street (2000) suggests that there are four main theoretical areas in modern interpretations of Critical Social Theory:

First, the theory of false consciousness demonstrates the ways in which the self-understandings of a group of people are false or incoherent. Second, the theory of crisis requires an examination of a group's dissatisfaction and the way this crisis threatens the social cohesion of society. Third, the theory of education occurs in which individuals may derive some benefit from knowledge. Fourth, a theory of transformative action details a plan of action for change (Manias & Street, 2000, p. 51)

These theoretical areas align with the essential processes of Critical Social Theory of enlightenment, empowerment and emancipation. Enlightenment correlates with the awareness of false consciousness and of crisis; empowerment with education; and emancipation with the theory of transformative action. The transformation process that critical theory seeks to bring about begins with enlightenment. Those who are oppressed become aware, or are made aware of the influences around them that contribute to their current circumstances. While "enlightenment by itself is not enough for individuals to become liberated" (Manias & Street, 2000, p. 51) enlightenment is knowledge, and knowledge begets power (Freire, 1972). It is this power-knowledge that encourages people to work to improve their situation. And so "emancipation is the goal of empowerment through which new arrangements replace oppressive ones, allowing individuals to relate and act in more satisfying ways" (Manias & Street, 2000, p. 51, citing Fay, 1987).

It is only when the entire structure is intact that a theory can explain, criticise and empower in the way a Critical Social Theory must (Emden, 1991). The feelings of hope and anticipation about the potential of society and groups within it (for example, nursing) provide the basis for Fay's point - "that critical social science provides a secular means to salvation" (Emden, 1991, p. 23). The ultimate goal of this is not to facilitate liberation from evil per se, but from constraining social, political and economic circumstances (Guba & Lincoln, 1994; Roberts & Taylor, 1998; Stevens, 1989).

The concept of power that has been discussed in relation to Critical Social Theory is based on the assumption that "power is possessed, that it flows from ...top to bottom and that it is primarily oppressive in its exercise" (Manias & Street, 2000, p. 53) and this reflects the position I have taken for this study. However, an approach not specific to Critical Social Theory but gaining momentum in qualitative research in general, is for the researcher to make explicit their position of power in the research process. That the values of the researcher inevitably influence a critical inquiry (Guba & Lincoln, 1994) calls for an exploration of that position, and Manias and Street (2000) encourage consideration of the ways in which the researcher's activities perpetuate particular discourses. For example, the researcher may ask "how do our very efforts to liberate perpetuate the relations of dominance?" (p. 55) or "do I bestow power or is it self-bestowed?" The articulation of this positioning is known as reflexivity, and involves rethinking the relationship between empowerer and the oppressed (Manias & Street, 2000).

Wasserfall (1997) suggests that reflexivity is the careful monitoring of one's own subjectivity in an effort to be non-exploitative. MacBeth (2001, p. 36) describes it as "a deconstructive exercise for locating the intersections of author, other, text and world". Essentially this means that the researcher articulates her thoughts and beliefs in response to the research process as it unfolds. For the researcher (analyst) this implies a disciplined articulation of oneself, often autobiographical in nature, explicating the position of the researcher in the world of the research. Analytic rigor is tied to the analyst's reflexive self-conscious engagement with the world and to the technical processes of data collection (Ball, cited by MacBeth, 2001). "Positional reflexivity thus aligns methodological rigor with a critically disciplined subjectivity" (MacBeth, 2001, p. 38).

Along with Heslop (1996), MacBeth refers to 'positional reflexivity' and to 'textual reflexivity'. Positional reflexivity "takes up the analysts' (uncertain) position and positioning in the world he or she studies and is often expressed with a vigilance for unseen, privileged, or worse, exploitative relationships between analyst and the world" (Heslop, 1996, p. 37). Textual reflexivity is the deconstruction of representational language in the text, and realising more fully the linguistic implications of preferred positions.

This leads to the epistemological and ontological positions maintained by Critical Social Theory and adopted for this study because the way in which we attempt to know the world will influence what our world is like. Similarly, how we study something will influence the types of interpretations we get. It is

usually assumed these are independent, however in critical theory, ontology is dependent on epistemology and vice versa.

The position of critical theory that I have taken in this study regarding the nature of being (ontology) is that history is shaped over time by social, political, cultural, economic, ethnic and gender factors that crystallise into a series of structures that are taken as 'real'. "What lies behind the critical model of social science is an ontological picture of humans which portrays them as self-interpreting beings who partially create themselves on the basis of their own interpretations" (Fay, 1987, p. 46).

Epistemologically, the researcher and the participants are assumed to be interactively linked, with the values of both inevitably influencing the inquiry. The methodological implications are for a transactional nature of inquiry that requires a dialogue between the researcher and the participants. It must be dialectical in nature if it is to transform misapprehensions into more informed consciousness. This includes inquiry into how the structures might be changed and comprehending actions required to effect change (Guba & Lincoln, 1994).

The historical background and more recent developments of Critical Social Theory have been examined, and the central tenets of power and reflexivity, and the epistemological and ontological positions have been discussed. The next section will examine how a social theory can be of use to nursing.

## Critical Social Theory and Nursing

Until the early 1980's, Critical Social Theory was virtually absent from the philosophical positions that informed nursing theory and practice (Browne, 2000). The hitherto lack of attention to social, political, economic, and historical conditions that influence consumers and providers of health care instigated a move by nursing scholars to draw upon Critical Social Theory. It provided the theoretical and philosophical basis on which nursing could refocus attention on the context in which health care occurs (Browne, 2000). Additionally, Critical Social Theory was seen as a means of decreasing the apparent theory-practice gap in nursing (Heslop, 1997) by fostering critical reflection of existing structures through the use of action and participatory research designs.

The following section is based on the core tenets of Critical Social Theory and how they may be applied to nursing. The fittingness of a *social* theory to nursing becomes apparent when applied to the concepts Stevens (1989, pp.59-60) derived from the Critical Social Theory literature. They are listed here:

- oppression and domination are embedded in social structuring
- power is not experienced equally across groups in society
- the ideology of the dominant system of ideas is insufficiently challenged
- liberation from such ideology is the goal
- this is achieved by critique of the oppressive ideology using oppositional thinking, reflection, analysis and dialogue
- dialogue is key to raising collective consciousness
- conscientisation is learning to perceive social, political, and economic contradictions

- action based on critical insights, reflection and dialogue, is the meaningful behaviour by those who are oppressed in order to bring about change.

Critical Social Theory "starts out from the premise that certain groups are in a subordinated position" (Kuokkanen & Leino-Kelpi, 2000, p. 239), and in relation to nursing this means nurses, by dint of gender, class, and occupation (Fulton, 1997) and to clients. In this context critical theory emphasises the need for empowerment among nurses, between nurses and clients, and other health professionals. Empowerment is necessary for emancipation from the hierarchical systems and dominating relationships that nurses have historically laboured under. Nurses must be empowered themselves before they can empower others (Fulton, 1997). According to Bent (1993, p. 297):

despite the responsibility that falls to nurses as the predominant mediator of patients' hospital experience, they lack overall administrative power and continue to battle for the right to control the pace and context of their work, to set their own hours, and to structure their own relationships to physicians.

The process then of liberation begins with the ability to apprehend the very existence of these relationships, which may be hindered by the 'culture of silence' described by Freire (1972) that is present in oppressed groups.

The theory of false consciousness described by Manias and Street (2000) demonstrates the ways in which the self-understandings of a group of people are false or incoherent. Browne (2000, p. 48, citing Lather) suggests that false consciousness means "that people are generally unaware of how commonsense

ways of looking at the world are imbued with meanings that sustain their disempowerment and oppressive situations". This is addressed in the literature as 'consciousness raising', which may be described as the critically reflective process that makes visible embedded power/knowledge axes. Cheek and Rudge (1994, p. 62) maintain that it allows "nurses to recognise not only the part that hegemonic discourses play in their oppression, but also the part that they themselves play".

An idea akin to consciousness raising is found in nursing philosophy, with the practice of critical reflection on clinical practice. Benner (1984) has emphasised the link between theory and practice provided by critical reflection and Roberts and Taylor (1998) define this as *praxis* when change in practice is the underlying motivation. Rose and Parker (1994) propose that nursing knowledge is underpinned by the philosophies of both art and science which are integrated in such a way that nursing is greater than their sum. This complex mix of art and science lends itself well to critical thinking and marries with Habermas' three categories of technical, practical and emancipatory cognitive interests. The practical and technical interests align with the art and the science of nursing, while the emancipatory interest is particularly appealing to nurses interested in social justice and critically orientated praxis (Browne, 2000). Heslop (1997, p. 49) points out that "the ontological basis of Critical Social Theory requires an activist conception of the human being, who is capable of self-reflection", reiterating a characteristic that is the essence of critical theory.

Conger and Mezza (1996) integrate critical thinking into the framework of the nursing process by placing emphasis on reflection to inform nursing action.

However there is ongoing debate about the congruency of the nursing process and the concept of critical thinking. Cody (1998), in particular is critical of nurses who have used what is essentially a social theory to embellish nursing practice. He argues that nurses need to stand alongside their clients without suspicion and judgement of their circumstances; he finds the notion of societal norms degrading to human freedom. According to Cody the "apparent inaction of the oppressed is poorly explained (and not at all resolved) by critical theory" (p. 46). Furthermore, everyday life reveals that power commonly prevails and is more complex than the rational explanation offered by the critical theorist. He accepts that this position is "necessary for building a *sociology*, but the same assumptions would put the nurse in an untenable position" (Cody, 1998, p. 45).

My own position is that I find the link between theory and practice provided by critical reflection exciting, especially its capture by nurse researchers who have put it to methodological use, often as consciousness raising (Henderson, 1995). Duchscher (1999) regards critical thinking, although not solely, as providing a framework for the practice of Critical Social Theory. In a critical research setting, praxis involves the collaborative processes that work with research participants to bring about change. Nurse researchers have taken the technical and practical interests (art and science) a step further to include in their research with clients, and with nurses and nursing, an emancipatory dimension.

Stevens (1989) observes that re-framing the focus of the research from individuals and their immediate circumstances to include social, political and economic environments gives the investigation a broader scope and is more



informative about reality. Such research "provides a transforming vision of the future as well as a critically analysed structural picture of the present" (Stevens, 1989, p. 64). The methods used to collect data may not always be obviously different from traditional (qualitative) data collection methods, but the underlying emancipatory intent belies a motivation for change in the way the participants perceive themselves or their situation. Enlightenment paves the way for liberation to other possibilities.

Critical Social Theory epistemology maintains that knowledge as truth is socially constructed and that life is only valuable in its meaning. Such meaning is derived from the lived experiences of persons (Duchscher, 1999), placing value on subjectivity. That Critical Social Theory places value on the subjective knowing of the informant has led Browne (2000, p. 48) to express concern about its compatibility with the notion of false consciousness. She feels that it undermines the "epistemological assumptions about who can contribute knowledge and what counts as legitimate knowledge". If a client's (or nurse's) perception of his/her situation is attributed to false consciousness, does this undermine the legitimacy of his/her contribution? Browne's feeling is that while Critical Social Theory may have applicability to nursing as a whole (its ideological assumptions, biases and blind spots) it may not have individual practice-based applications where subjective, individually based knowledge is valued. My own position on Browne's (2000) critique is that I agree with her concerns and value the contributions of the participants as legitimate. However, I also believe it is possible to integrate Critical Social Theory's perspective and raise consciousness about domination and power in the minds of the participants and readers.

The methodology of any critical inquiry requires a dialogue between the investigator and the subjects of the inquiry. The dialogue must be dialectical if it to transform ignorance to a more informed consciousness (Guba & Lincoln, 1994). Guba & Lincoln address the researcher as the instigator and facilitator of the research and as such propel the study to completion. The inherent danger is in the researcher "understanding a priori what transformations are needed" (p. 113).

Heslop (1997) too, questions the way in which emancipation is used in some research designs. The risk is that a researcher can approach a project with a predetermined attitude, a preset political agenda that has a specific end in mind to bring about a change in the way the participants see themselves, or the way in which they practise. While the research appears to empower the participants, the assumption of the researcher may be that he/she is more ideologically correct. Heslop asks "will change be emancipatory or will it subjugate others?" (p. 52). Heslop (1997) suggests that the practice of reflexive writing may assist with overcoming this possibility.

Finally, the last of Stevens' (1989) concepts is the requirement for action and herein lies the ultimate goal of Critical Social Theory. It is action that brings transformation in the structural conditions that ultimately oppress people.

## **Conclusion**

With change as the underlying motivation for this study of personal safety for district nurses, the epistemological and ontological positions that have been discussed, signal Critical Social Theory as the paradigm of choice. The ontological position maintains that history is shaped over time by social,

political, cultural, economic, ethnic and gender factors and provides a means to explore each of these avenues for the power relationships that shape the nurses' subjective experience. The epistemological position links the researcher and participants interactively, with the values of both inevitably influencing the inquiry. The necessity for dialogue provides the opportunity for transformation of misapprehensions into more informed consciousness, including how the structures might be changed, and an understanding of the actions required to effect change both individually and within the institution (Guba & Lincoln, 1994).

The change mechanism that I envisage occurring through the use of a critical style of research will occur from *within* the individual nurses who participate in the study. As the issue of personal safety is raised in their consciousness, it is hoped that work practises will begin to change until ultimately, policy will change to reflect the new practises. This is a 'bottom up' or inductive approach, which is likely to bring about lasting and effective change in practice and policy.

As a nurse who has worked as a district nurse in the past and been exposed to circumstances in the course of my work that left my personal safety compromised, the thrust of this research is to do more than document existing practices, but to bring about change. A critical approach that values the subjective and looks at how subjective experience is shaped - often invisibly - by power and social relationships (White, 1999) will be useful for addressing the aims of the study. Firstly, it will initiate discussion about occupational safety for district nurses, and then to uncover the social and power relationships that

underlie the tolerance nurses demonstrate for an unsafe work environment. The next chapter examines the literature about nursing and occupational risk of violence from a Critical Social Theory perspective.

## **Chapter Two**

### **Nursing and Occupation Risk of Violence**

#### **Introduction**

The international literature and research relating to violence and aggression in the workplace is extensive. There are studies that quantify violence across all occupations, and others that look more specifically at industry sectors such as the construction industry, taxi drivers, or social workers. There is literature concerning sexual harassment and abuse, domestic violence, battered women syndrome, and violence involving children. More specifically concerning health care settings, research relates mostly to emergency room (Levin, Beauchamp-Hewitt & Misner, 1998; Naish, 1996), psychiatric (Arnetz, Arnetz & Petterson, 1996); Lanza, Kayne, Pattison, Hicks & Islam, 1996), aged care (Chambers, 1998; Gage & Kingdom, 1995; Hagan & Sayers, 1995) or other inpatient contexts (Whittington, Shuttleworth & Hill, 1996), with some studies focussing on the community (Beale, Fletcher, Leather & Cox, 1998; Koch & Hudson, 2000; White, 1999). There are enormous resources concerning violence prevention strategies for health care workers in many settings. There is also a discrete body of literature concerning critical incident stress and burnout in recognition of the nature of the work many health workers are exposed to, as well as other workers such as police, ambulance and fire fighters.

However, of significance to this study is the lack of nursing literature available concerning the incidence of violence in New Zealand health care settings. There has been a 77% increase in violent crime in New Zealand society in the last ten

years ("Shutting the Gate", 2001) so I expected that there would be a parallel increase of violence in health care settings and that such events would be well documented, but this is not the case. Health care incidents are reported in the general media but as E. Mullen (1997) suggests, it is only extreme violence and homicide that is reported this way. These reports bring the problem to the attention of the public but do not accurately reflect the daily problems faced by front-line health care workers (Thomas, 1995). After an extensive search the only New Zealand research I was able to find was a 1992 report about violence of intellectually disabled adults towards staff (Heath-Caldwell & Raill, 1992). There was no other published nursing research that explores any aspect of the problem, although a recent issue of '*Kai Tiaki* Nursing New Zealand' was dedicated to the issue of violence in health care (April, 2001). Workplace safety was a consideration in 1972 however, when MacInnes wrote about safety for district nurses in the New Zealand community. She discussed safety as a broad concept for both clients and nurses, with particular reference to the risk of back injury, traffic accidents and dog bites. MacInnes (1972) stresses the need for in-service and other education that will safeguard against these risks.

I am interested in discovering why there is so little New Zealand literature - either there is not a significant problem or it is not considered important enough to research. In reference to Critical Social Theory, perhaps there is a relationship to the value placed on nurses and their well being, or a perception that they are not significantly at risk by virtue of their well-respected role and 'mantle'.

Both internationally and in New Zealand, legislation is in place that obligates employers to provide safe workplaces, for example, New Zealand's Health & Safety in Employment Amendment Act 1998, Australia's Workplace Health and Safety Act 1995, Britain's Health & Safety at Work Act 1974. In response to several recent New Zealand incidents involving mental health nurses working in the community, a current project of the Occupational Safety & Health (OSH) department is to look at personal safety issues for *mental health* workers (including nurses) in both inpatient and outpatient settings. There are currently no New Zealand OSH projects underway to investigate the safety of *general* district nurses, and this is largely due to the absence of a major incident requiring investigation.

When searching the literature for information about personal safety for nurses, it quickly becomes apparent that the international literature which relates to nurses concerns violence and aggression from clients. Many of the studies use survey methods that quantify the problem and give an indication of prevalence and severity. A limitation of this style of research is that it often explores only one facet of the problem and fails to explore the experience of ongoing exposure to both the nuance of intimidation and *potentially* violent situations. Nor does it assess the impact on nurses of accumulative risk factors such as intimidating clients, organisational structures, and resourcing.

Consequently, conducting a comprehensive literature review about personal safety for district nurses defaults mostly to an exploration of violence in formal health care settings. A review of this literature forms the bulk of this chapter and

has relevance to this study because it illustrates the prevalence of the problem on an international level, outlines what constitutes high-risk situations and/or clients, and establishes what procedures have been instituted elsewhere to mitigate the problem. Due to the absence of literature about the particular problems a community setting presents to nurses only a small number of studies are discussed here but these represent a growing interest in the subject over the last two or three years. Key studies have been conducted by Beale, Fletcher, Leather & Cox (1998) and Koch and Hudson (2000) and begin to address nurses' experience and management of violence in the community. There is a close relationship between these British and Australian studies and the New Zealand setting because of the relative similarity of the organisational structures within which the district nurses work. The current study will contribute to this growing body of knowledge and provide a critical perspective unique to New Zealand.

### **Defining Violence: Exploring Prevalence**

Before exploring the literature about nursing and occupational risk, an attempt must first be made to define what entails violence. The problem of an adequate definition of violence has led to a wide range of definitions being used, leading to difficulties in determining the prevalence of violence. According to Lipscomb & Love (1992) the broader the definition, the more incidents will be captured. Some studies include subjective elements such as the feeling of being threatened, or of assaults directed at staff, at property, self-harm, or verbal abuse while others limit it to physical injury. The significance of a definition has implications for research concerning violence, as inevitably it will effect the quality and quantity of data generated.



system that accepts only signs of overt injury. The inclusion of subjective and objective elements as well as describing the context in which violence occurs contributes to a broader understanding of the extent of the problem. These notions lend themselves to an ontological position consistent with Critical Social Theory that subjective reality is shaped by the context in which it occurs (Guba & Lincoln, 1994). E. Mullen's (1997) description of violence at work, which addresses both behaviours and context, forms the basis for my understanding of violence for use in this study.

Beale, Cox and Leather (1996) report that it is exceedingly difficult to obtain an accurate picture of how widespread and serious the problem of violence at work is in the United Kingdom due to inconsistent and inadequate reporting mechanisms. They are critical of a national reporting system that requires mandatory reporting of violent incidents that are entirely dependent on the physical outcome of the incident and not on its nature. Incidents need only be reported if there is a death, a major injury, an injury resulting in the worker being off work for three consecutive days, or hospitalisation. Incidents involving violence have been relegated to security and criminal matters and have not been regarded as 'accidents' so do not have to be reported under Health and Safety regulation. Verbal abuse, intimidation and threat must be addressed with the same strength of conviction as physical assault (Beale et al., 1998). Otherwise, along with problems of under-reporting, it leads to an inaccurate perception of the extent of the problem (Lipscomb & Love, 1992), thus perpetuating the silence.

Beale, Cox and Leather (1996) recommend that organisations record all potentially dangerous situations that might become violent as well as minor incidents, and suggest this would facilitate more accurate assessment and effective risk management. Reporting systems must eliminate questions that imply blame and be "straightforward to operate, must be known about and accessible to those needing to report and must demonstrate some sort of 'pay-off' to justify the time spent on reporting" (Roberts, 1991, p. 101). That is, evidence of support and system improvement must follow. Beale et al. (1996) encourage openness about problem situations and stress the importance of not condemning those who experience them.

A common thread throughout the international literature in terms of prevalence of violence is that of under-reporting of incidents. This is a widely recognised phenomenon (Lanza & Campbell, 1991; Lipsomb & Love, 1992; Yassi, Tate, Cooper, Jenkins & Trottier, 1998) and presents an avenue worthy of further exploration in terms of the power relationships that perpetuate under-reporting. Reasons may include the variable definition of assault, fear of blame, peer pressure, the opinion that patients are not responsible for their behaviour, filling in forms being too time consuming, the incident not being thought serious enough, coping with aggression being seen as part of the job, staff not wanting to damage their professional reputation and being seen as unable to cope, and the feeling that their managers would not take any helpful action if they did report (Beale et al., 1998; Croker & Cummings, 1995; Lanza & Campbell, 1991). Additional reasons for under-reporting may relate to the coping strategies of

denial, rationalisation and minimisation of the event (Croker & Cummings, 1995; White, 1999).

Many authors suggest that the reason for the low rate of reporting assault may be based on the underlying fear that the nurse would be blamed for precipitating or provoking the assault (Croker & Cummings, 1995; Lipscomb & Love, 1992; Paterson, Leadbetter & Bowie, 1999). This lends weight to the notion that relationships involving power influence the decision to report an incident. Blame for failing to respond to the verbal and non-verbal cues that may preface an event calls into question the nurse's professional ability. Lanza (1992) and Paterson, Leadbetter and Bowie (1999; 2001) found that a pervasive attitude amongst nurses, based around the dominant belief systems of individual professional competence and ability to cope, is that reporting an incident is a tacit admission of performance failure.

Not only are there issues to do with nurses that affect the reported prevalence of violence, but there are also management issues. Lanza & Campbell (1991) comment on the difficulty inherent in the accurate reporting of incidents from an administrator's viewpoint. While they may insist that they want accurate statistics, "this at best puts them in a highly ambivalent position" (Lanza & Campbell, 1991, p. 65). An apparent increase in reported incidents implies that there is 'something wrong' that must be 'fixed' and may also reflect poorly on the management performance in the area in question. Thus the message to report only serious events is reinforced at all levels of the organisation.

In the search for reliable data regarding the experience of nurses and workplace violence in the United Kingdom, Ryan and Poster (1993) surveyed nurses about the frequency of assault-related experiences, and nurses' attitudes and beliefs in relation to work safety and assault ( $n = 554$ ). Of relevance to this study, one hundred and forty-four nurses worked in the community (26%), with the remainder working in hospital settings in mostly general medical/surgical or psychiatric areas. Although well represented here in the data, the level of assault occurring in inpatient settings overwhelmed specific community nurse responses. Rather than obviate the need for community focussed studies, the need is reinforced.

Ryan and Poster (1993) did not offer a definition of assault on which the nurses could base their responses, nor did they discuss any possible definitions. Only 8% of respondents said they had never been assaulted during their career, with the remainder reporting they had been assaulted between one and fifteen times or more. One in four of these incidents had not been formally reported, although this group believed staff should report all injuries. Of the 77% who reported an assault incident, only 34% found the response helpful, which may explain, in part, under-reporting (Roberts, 1991; Yassi et al., 1998). If support has not been demonstrated following a previous incident, then the time and potential risks to oneself may not merit documentation of subsequent events.

Of concern in the study by Ryan and Poster (1993) is that almost two respondents in three (61%) agreed that nurses could expect to be assaulted at some time during their careers. The expectation and tolerance of violence at

work normalises its occurrence, and minimises the seriousness of any events in the eyes of both victim and colleagues (Croker & Cummings, 1995). This may be likened to the theory of false consciousness, whereby the self-understandings of a group of people are described by Fay (1987) as incoherent.

Arnetz et al. (1996) investigated the prevalence of reported violence among Swedish nurses from different work disciplines. A questionnaire was sent to a random sample of nurses who worked in both in- and out-patient settings, including geriatrics and psychiatry ( $n = 2690$ ). Again a definition of violence was not offered and is acknowledged as possibly problematic, although not considered by the authors as statistically significant given the magnitude of the sample. Of nurses who worked in outpatient settings, 16.8% reported exposure to violence in the course of their work on one or more occasions. However "the relative risk for exposure to threats of violence was twenty-four times greater in psychiatry compared to outpatient care" (Arnetz et al., 1996, p. 124). When interpreting these results, it is important to remember that the violence may reflect a response to the realities of the inpatient setting as much, if not more than the clients' disorder (P.E. Mullen, 1997). The specifics of how and when these incidents occurred are beyond the scope of the Arnetz et al. (1996) study and may not reflect at all what occurs in the community with clients whose mental health is stable. Albeit, P.E. Mullen's (1997, p. 7) review of the literature concerning mental disorder and violent behaviour concedes that there is "an association between mental illness, in particular schizophrenia, and having an increased propensity to behave in a violent or threatening manner".

This is a significant point when considering the characteristics of the clients visited by district nurses in this study. As the de-institutionalisation of stable mental health clients continues, so does the frequency with which district nurses encounter these clients in the community. The risk lies not in mental health clients per se but in when or if de-stabilisation of mental health status occurs precipitously, and in the access to these clients' clinical records and psychiatric history.

There are many other studies that explore the prevalence of occupational risk of violence and there are national institutes in most Western countries that research violence in the workplace. These institutes collect data and statistics relating to occupational health and safety. They include the World Health Organisation (WHO), the United States National Institute of Occupational Safety and Health (NIOSH), the National Occupational Health and Safety Commission for Australia (NOHSC), Occupational Safety & Health New Zealand (OSH). There are professional nursing bodies, for example the International Council of Nurses (ICN), the American Nurses Association (ANA) the Royal College of Nursing (RCN), and the New Zealand Nurses Organisation, (NZNO) that research and publish guidelines for their members about violence in society. Such strong worldwide interest and concern about nursing and occupational risk of violence indicates the timeliness for New Zealand to position itself to examine these issues and create pre-emptive strategies that are relevant to the culture and context of its healthcare settings.

Given the lack of definition about what constitutes a violent event, and the complex factors that impinge on a decision to report, the reliability of evidence regarding prevalence is questionable. That is, it is likely that violence towards nurses, including the nuance of intimidation, is more prevalent than studies indicate. With an estimate that nurses report only 20% of violent incidents (ICN, 2001) there is sufficient cause for concern to merit ongoing monitoring by national institutes and professional organisations. Considering the climate that nurses work in, it is useful to consider what factors place a nurse at increased risk of a violent event occurring.

### **The Risk of Violence**

Clearly identified in the healthcare related literature are areas in which staff are more likely to experience violence than others. Psychiatric areas (Arnetz et al., 1996; Lanza et al., 1996), emergency departments (Levin, Beauchamp-Hewitt & Misner, 1998; Naish, 1996) and aged-care (Chambers, 1998; Gage & Kingdom, 1995; Hagan & Sayers, 1995) feature regularly. Whittington, Shuttleworth and Hill (1996) report the rate of assault in emergency and medical/surgical wards to be at least as high as that reported in an earlier study of a psychiatric hospital. They report that "prior to many assaults, delays in receiving treatments were frequent precursors of violence and, in surgical wards, that post-operative confusion was often a feature" (p. 331).

Yassi et al. (1998) found that considerable verbal abuse occurred when a service requested by a client was not provided. E. Mullen (1997) also addresses this issue and stresses that violence must be understood within the broad social

context and that underlying causal factors need to be identified. She suggests that:

cuts in public funding resulting in a reduction in resources for social services place community and health care workers at high risk. Their clients may respond violently to their perception that they are inadequately, unjustly, or unfairly treated, by the very agencies that should provide support and succour (E. Mullen, 1997, p. 29).

As Yassi et al. (1998) point out, this has implications for staffing resources. With fiscal responsibility for maintenance of a service comes accountability to both clients and professionals involved in that service to facilitate a high standard of service delivery by adequately resourcing it. Otherwise, clients are at risk of poor quality care and nurses are at risk of violent encounters with frustrated clients.

Yassi et al. (1998) also examined more specifically the causes of staff abuse in health care facilities. They found primarily that patients who were angry or frustrated by their diagnosis or situation were likely to be abusive. Croker and Cummings (1995) identify confusion, fear, anger and alcohol as precipitating factors. Additionally Hansen (1996) identifies previous history of assault, substance abuse, personality disorder, bipolar affective disorder, and organic brain syndrome, which may account for the frequency of violence in psychiatric institutions. P.E. Mullen (1997, p. 7) found the "chances of confrontation with others are likely to be amplified by the substance abuse to which schizophrenics all too often resort for relief from the negative symptoms of their disease and from their loneliness". Lipsomb & Love (1992) and Lanza et al. (1996) also found that a history of violent assault is the best predictor of future assaults. They



found that threatening language and increased motor activity were important signs of impending assault.

Yassi et al. (1998) and Lanza et al. (1991; 1996) reported that conflict arising from rule enforcement or limit setting accounted for a large proportion of all abuse incidents. Abuse was often "precipitated by physical touching in the course of providing a physical service" (Yassi et al., 1998, p. 490). Croker's & Cummings' (1995) findings were that 91% of assault cases occurred when it was necessary for the nurse to touch the patient's body (Lanza, Kayne, Hicks and Milner, 1991). Of interest is the Lanza et al. (1996) comment that staff victims were generally nurses that the clients liked, and according to Hansen (1996) and Lanza and Campbell (1991) were probably the least experienced. Having a sense that the client likes the nurse is likely to disarm the nurse, and contribute to him/her being ill prepared for a violent event. Inexperience would compound this further.

To summarise this section, incidents of assault or violent behaviour towards nursing staff are more likely to occur in psychiatric areas, emergency departments, aged care, and some medical/surgical wards. A client with any or all of the following is likely to exhibit violent behaviour:

- a previous history of assault
- a psychiatric condition
- a history of alcohol consumption and/or substance abuse
- confusion or fear
- anger and frustration about their diagnosis or condition

- a delay in treatment
- issues with rule-enforcement
- care that requires physical touching
- increased motor activity and/or uses threatening language
- economic disadvantages.

Although this list has been compiled in reference to inpatient settings, in the absence of research about client-specific risk factors in the community, it is of consequence to district nurses who often visit clients who meet these criteria. They may be visiting without being privy to information about the client's mental health history, alcohol or drug use, or history of assault. Due to limited staff resources, client visits may be subject to delay, and the care that is provided is often intimate in nature. Furthermore, if the client is new to the service, it is likely that their diagnosis is recent and they may be harbouring feelings of frustration and anger about their situation. Any combination of these factors places the district nurse in a high-risk situation and she is especially vulnerable because she works alone. Many of these factors could be mitigated by institutional policy that provides adequate resources and support. The following section specifically examines research related to nurses working in a community setting.

### **The Community Experience of Violence**

NIOSH (1997) completed a comprehensive survey of job-related violence that identifies rates of injury and death by industry and occupation, including comparisons over time. This survey reported that workers are most at risk if their job involves routine contact with the public or the exchange of money. They are

also at increased risk in situations such as working alone or in small numbers, working late or very early hours, dealing with violent people or in volatile situations, or work in high crime areas. Clearly district nurses work under these circumstances and the NIOSH survey does identify home health visitors as being at increased risk of nonfatal workplace assaults, as they are providers of services in community-based settings.

A study by Gellner, Landers, O'Rourke and Schlegel (1994) surveyed Community Health Nurses in three home health agencies in the United States to ascertain the real and perceived safety risks to nurses. The nurses identified urban areas, inner-city apartment complexes, visiting during domestic quarreling, and being in neighborhoods where groups or 'gangs' were on the street as high-risk, as well as visiting clients who were not previously known to the nurse. An escort service was available to these nurses, who were more likely to call on this service during the evenings than during the day. However, there was some reluctance to use the service due to the inconvenience, dislike of an escort and the negative perception the client may have about the presence of an escort. Access to cellular phones, personal alarms and increased communication and cooperation with other community resources were viewed as measures that would enhance nurse safety.

Gellner et al. (1994) defined 'safety' as a position of optimal security and a 'high-risk environment' as a situation that placed the nurse in real or perceived danger of bodily harm or loss of property. While the use of a survey limits the depth of data to be collected, what is interesting about this study is the adaptation of the

Neuman Systems Model - a nursing theory for providing patient care - as the theoretical framework:

This model is based on theories of stress adaptation, and views the person as being a multidimensional whole, in constant interaction with the environment. The role of the nurse is seen in terms of degrees of reaction to stressors, and the use of primary, secondary and tertiary [nursing] interventions (Murray, 1999, p.1).

In the context of this model, Gellner et al. (1994) discuss both the internal and external stressors as environmental factors on nurses (rather than clients). They also discuss the adverse affect of stressors on normal 'lines of defense', which are viewed as having the potential to adversely influence the nurses' ability to perform effectively. While Gellner et al. (1994) focus on physical environmental stressors, from a critical perspective these could include those emanating from the institution, and this is of particular interest to the current study. Although Gellner et al. (1994) discuss issues that arise from the organisation, they are not discussed as contributing stressors, when they may in fact be stressors.

Gellner et al. (1994) then group their recommendations for enhancing safety into primary, secondary and tertiary level violence prevention strategies. Primary, or pre-emptive intervention involves nursing practices such as use of guards, cellphones, personal alarms, attending safety inservice and calling in at the end of a shift. Secondary prevention is mandatory use of the above, as well as ongoing safety inservice and support. Tertiary prevention relates to follow-up procedures after incidents have occurred and the overall safety policy by

management. This three-tier approach is useful for grouping the interventions and I have used a similar approach on which to base the conclusions and recommendations of this study.

A study of United Kingdom district nurses (n= 373) by Ballard (1994) surveyed a wide range of health and safety issues in relation to their work in the community. Factors such as work-related illness, injury (including musculo-skeletal), exposure to Hepatitis B, stress, overwork, and physical and verbal assault were covered. Ballard (1994) reports a similar incidence of back and musculo-skeletal injury compared to nurses in general, but work-related stress as being almost eight times higher for district nurses. Reasons for the high incidence of stress were cited as inadequate staffing and insufficient time to get through their work, inadequate support, and lack of staff cover for sickness absence or annual leave. The incidence of physical or verbal assault may also be a contributing factor with 46% experiencing either or both in the previous twelve months. These incidents involved patients or carers, or occurred while travelling. Inner city nurses were most at risk (74%), compared with those practising in suburban (43%) and rural (34%) areas.

One of the key and most recent studies that emerged out of studies like that of Ballard (1994) is a British review commissioned by the National Health Executive in conjunction with the Royal College of Nursing (RCN) on violence to National Health Service (NHS) staff working in the community. It was carried out by the Centre for Organisational Health and Development at the University of Nottingham between February and June 1998. Community based staff,

hospital based staff who make visits in the community, and ambulance staff were interviewed, as well as support staff in a wide range of disciplines, managers, health and safety officers and union representatives. An extensive review of the professional literature and a trawl of the documentation from all NHS trusts was undertaken. The findings from the review indicate that for NHS staff working in the community "the incidence of non-physical violence, such as threats and abuse, is at least as high as for staff in most other locations" (Beale et al., 1998, p. vii).

As a result of the review, the NHS Executive in conjunction with the RCN has written a number of publications offering advice and guidance on preventing violence against staff working in all areas of the NHS. They have implemented a 'Zero Tolerance' campaign which may be summarised as ensuring that staff who spend their lives caring for others are not rewarded with intimidation and violence. Comprehensive management strategies include all NHS staff working in inpatient settings and the community, identifying risks, reducing the risks, encouraging reports of incidents, working with the police, staff training in dealing with aggression and debriefing following an incident. In addition, the NHS Trust's Occupational Health and Safety service responded to staff needs for support and guidance by instituting a 'Violence Hotline'. This provides immediate counselling support for staff following violent encounters in the course of their work.

This review looked at all NHS community settings. A key point that it identifies is the isolation and consequent potential for harm that health workers experience in the community:

The crucial point is that, when staff face aggression in the community, they are often by themselves, remote from their colleagues and the hospital security systems on which other staff can rely. The *potential* for harm, both physical and psychological, is therefore considerably increased (Beale, et al. 1998, p. viii).

The review identified that many trusts had extremely comprehensive emergency action procedures in place to cover every member of staff who makes visits in the community. Other trusts had no procedures worked out because "nothing has ever happened" and teams were expected to "problem solve on the spot" if an unsafe situation arose (Beale et al., 1998, p. 93). Many risks to staff safety were identified such as trace-ability and communication away from base, provision of adequate information, sexual harassment, presence of animals, access to resources and information after hours, and increased vulnerability of staff after hours. These were dealt with by various trusts either extremely well or not at all and were largely dependent on the attitude of the trust to thorough risk assessment procedures.

Beale et al. (1998) considered that an employer attitude that supported the notion that health visitors would not be harmed by any member of the public in the course of their duties was in breach of health and safety legislation. In the United Kingdom under the Management of Health & Safety at Work Regulations 1992

(cited in Beale et al., 1998), employers must assess all risks to the health and safety of their employees, identify precautions needed, appoint competent people to advise on health and safety, and provide information and training to employees. In order to facilitate compliance with this legislation, a guide for NHS managers and staff on reducing the risks from violence and aggression entitled "Safer working in the community" was written by the authors of the review (Leather, Cox, Beale & Fletcher, 1998). "The emphasis in law is placed on prevention, and, as the employer is the generator of the risk, on organisational level interventions" (p. 42). This places the onus of prevention clearly on the employer to address the issues that relate to institutional practices and adequate resourcing of staff.

This is also true for New Zealand under the New Zealand Health and Safety in Employment Amendment Act 1998. It states that "every employer shall take all practicable steps to ensure the safety of employees while at work" (section 6) and that the employer shall take all practicable steps to eliminate significant hazards (section 8) or to minimise them (section 10). Employees are to be informed of all identified hazards and have access to necessary safety equipment and devices (section 12). This strong emphasis on prevention in the Act is held as the employers' responsibility and has relevance to the conditions under which district nurses' work. This includes the base from which they operate, the places they visit in the course of their work and intervening transport.

In contrast to many of the quantitative studies mentioned, Koch & Hudson (2000) used an emancipatory methodology that involved a group of practitioners



taking responsibility for freeing themselves from the constraints of their practice (Roberts & Taylor, 1998). This study marks a shift away from attempts to quantify the problem of workplace violence towards exploring the subjective experience of violence, with a view to challenging the existing structures that allow these situations to continue to arise. Koch & Hudson (2000) used a participatory action research process to develop a model for best practice in the community for the prevention of workplace violence. The study worked with the district nursing service in South Australia and explored stories of violence that had occurred in the community. The definition of violence that met with group consensus was "that violence was whatever the nurse telling the story felt it was" (Koch & Hudson, 2000, p. 5). Koch & Hudson (2000) noted that many incidents discussed had not been officially reported and this was felt to be related to the belief maintained by society that violence is restricted to physical assault. They liken the nuance of intimidation and threat to that of sexual harassment, which traumatises but may or may not physically harm.

Koch & Hudson's (2000) best practice model begins with a 'vigilant triage (or vetting) system that occurs as soon as a new referral is received and visiting agreed to. The first visit includes a comprehensive assessment of potential for violence. Key aspects of self-awareness, self-control, and self-preservation are necessary skills that the nurse must have to carry out this assessment. This largely involves intuition, awareness of personal emotional triggers, the ability to appear calm and in control, and noting and addressing potential hazards and ways to overcome them (namely, to escape). Jacobs (2000, p. 44) supports the importance of intuition by stating that "there may not be any objective findings

of hostile behavior, but someone has a feeling that something is wrong ... it is just as important to listen to intuition ... Gut feelings could be the only safety net to prevent someone from becoming a victim". The notion of intuition in nursing is supported by a relationship to Carper's (1978) pattern of personal knowing which is concerned with the knowledge of self. She suggests that personal knowing has a central and primary place in all knowing and is therefore critical to expert nursing practice.

Based on Bowie's strategies for coping with threatened or actual violence (cited in Koch & Hudson, 2000) when a violent episode occurs, the options available to the nurse are to negotiate her way out, leave, do nothing, seek back up, set up a diversion, use evasive self-defense, restrain the client, or fight the client. As pointed out in the review of the best practice model, these last options may set the unrealistic expectation that staff could be expected to resort to them, rather than exit a potentially violent situation. It is especially important that knowledge of a range of options available to a nurse requires educational preparation before an incident occurs. This is a key aspect of the best practice model and links with Freire's (1972) concept of empowerment through knowledge. Nurses with this knowledge have an increased capacity to remain safe and in control, rather than become the victim in an unfortunate incident. Koch and Hudson (2000), Paterson, Leadbetter and Bowie (2001) and Beale et al. (1998) confirm that after the occurrence of an event, post incident defusing, debriefing and counselling, when delivered promptly, can reduce acute stress levels for victims and witnesses.

Fisher, Bradshaw, Currie, Klotz, Robins, Searl, and Smith (1995) conducted a study about the frequency and severity of violent incidents experienced by remote area nurses in Queensland, Australia. Using a mixed methodology of survey as well as collecting stories of violence, they explored the extent to which experiences with violence are stressors in nurses work experience. By accessing stories of violence from the nurses' experiences, they attempted to address the definition of violence by exploring the context in which it occurred. This study found that remote area nurses experience of violence both in their place of work, and in their private lives was severe and was often handled badly by employers, the community, and by remote area nurses themselves. Of great concern, was the lack of support from colleagues and employees once a violent incident occurred. Fisher et al. (1995) identified a 'context of silence' that ensures consistent under-reporting, and downplaying of the severity of the problem. They suggest that the context of silence that surrounds this issue needs to be overcome so that appropriate policy, post trauma procedures, and preventative education campaigns can be implemented. The 'context of silence' identified in this study differs from Freire's (1972) 'culture of silence' in that these nurses were well able to perceive and critique their situation, but feeling powerless to change it, chose to remain silent.

Fisher et al. (1995) suggest that the nurses reinforce the way in which silence surrounds the issue of violence against health professionals in these remote communities. They feel they may lose their jobs, or be blamed by their community or their employer for the violent event. They may understandably be

reticent in raising community awareness of the amount of violence occurring, or in drawing attention to themselves and/or their job conditions. The nurses may also choose to downplay the level of violence that exists, in particular in Aboriginal communities to 'protect' the communities themselves from a society which has often failed to understand the complexity of cultural relationships and the influence of colonisation on Aboriginal people. Resigning from the job may be viewed as a more attractive alternative, further reinforcing the 'context of silence' (Fisher et al., 1995). While this study took place in the Australian outback, and the context was rural, the culture of silence about violence appears to be a common theme throughout the international literature. A Critical Social Theory perspective could further impugn the structures that perpetuate that silence.

In another South Australian study by White (1999) the nature of four community nurses' concerns about aggression from clients was explored. This study used a feminist methodology examining gender issues and in particular the relationship between women as nurses and men as perpetrators of violence. The nurses revealed twenty-one situations of verbal abuse, threats, sexual harassment, and non-verbal intimidation. There were no physical assaults or injuries. White (1999) confirms that aggression from clients is as much or more of a concern for community nurses as it is for nurses working in other settings.

Nurses in White's (1999) study described feeling vulnerable to violence due to working in isolation from colleagues, working in client-controlled, unfamiliar and constantly changing workplaces, with lack of immediate help. Experienced

nurses had developed a wide range of strategies and responses to prevent and manage violent situations, but less experienced nurses lacked training and confidence. White (1999) concluded that the expectation that nurses and female carers will put themselves at risk to care for such clients needs to be further challenged.

What seems clear from these community studies is that district nurses are exposed to violence in the course of their work. Due to the isolated nature of their work, the potential for harm is greater than in other settings. The need for education in the management of violent situations has been identified, as have been comprehensive management policy and procedures such as Koch and Hudson's (2000) model for best practice in the community. Violent encounters are stressful and as previously mentioned in other healthcare settings are under-reported (Fisher et al., 1995). As White (1999) points out the expectation that nurses put themselves at risk to provide care under these circumstances needs to be further challenged, particularly when relatively straightforward strategies requiring minimal investment could considerably reduce their risk. Many organisations have written resource packages in an effort to mitigate the problem of violence in the community and some institutions have implemented changes. These are briefly presented in the following section.

The ICN as the professional nursing body representing nurses throughout the world acknowledges violence as a significant occupational hazard for nurses. They have compiled a number of resource kits for use by health service providers and nurses to manage and prevent violence in their institutions (ICN, 2001). This

is one of many documents that have been produced for use by organisations to help with policy development (ANA, 1994; Coffey & Hanley, 2000; Elliot, 1997; Jacobs, 2000; Leather et al., 1998; NIOSH, 1997; O'Connor, 2001; OSHA, 1998; Suzy Lampugh Trust, n.d; WorkCover, 1998).

With such a wealth of resources available, many health providers have developed their own policy for their area. It is important to note that a comprehensive policy approach that addresses both the education needs of the staff as well as security is necessary (Coffey & Hanley, 2000). The focus must be on anticipating and planning for violent events rather than to responding to them only as they unfold. Employers must develop an infrastructure for critical decision making that incorporates an immediate response as well as long-term planning. This is in addition to addressing physical security needs, formal plans for investigations, descriptions of threat management teams and procedures for their implementation.

NIOSH (1997) urges good visibility and external lighting to be incorporated into environmental design considerations. Areas requiring careful assessment are access to and egress from the workplace, the number of entrances and exits, the ease with which non-employees can gain access to work areas because doors are unlocked, and the number of areas where potential attackers can hide. These issues have implications for the design of buildings and parking areas, landscaping, the placement of waste disposal areas, and storage facilities that workers must use during a work shift. Nurses homes which are used as district nursing bases, often fail to meet these recommendations. This is perhaps due to

the original building specifications no longer suiting the purpose for which they are now used, and adaptations necessary for promoting safety have not occurred.

Numerous security devices may reduce the risk for assaults against workers and facilitate the identification and apprehension of perpetrators. These include closed-circuit cameras, alarms, two-way mirrors, card-key access systems, panic-bar doors locked from the outside only, and trouble lights or geographic locating devices in mobile workplaces (NIOSH, 1997).

In addition to providing a building that is safe to access, safety procedures must include practices that enhance safety on home visits. There are implications for the way in which nurses practise and for institutional practice and resourcing. Some health providers hire minders or security guards to escort nurses on home visits during dark winter nights ("Escorts offer security", 1996; Rickford, 1995; Ungvarski, 1996) and provide staff with cell-phones and personal alarms (Beale et al., 1998; Duffan, 2000). Other practices consist of the nurse leaving a list of intended visits at base, informing colleagues of the general area to be visited, and reporting back to base at the end of the day especially if s/he lives alone (Smith, 1988; Beale et al., 1998). Clients' notes should be computer flagged to indicate past history of violence (Lipscomb & Love, 1992; Beale et al., 1998). For those clients whose behaviour or circumstances continue to place the visiting nurse at risk, the service of home-care is withdrawn and an alternative arrangement is made (Ungvarski, 1996). The policy of an institution needs to reflect the community it serves and be responsive and flexible to the needs of clients as well as the nurses.



## **Conclusion**

The literature discussed has established that occupational risk of violence is exceptionally high in health care settings. Potential for non-fatal assault or abuse as a health care worker in the community is significant due to the characteristics of the clients visited and the isolation in which nurses work. The United Kingdom, Australia and the United States are involved in comprehensive research to define the extent of the problem, and describe the effects on staff well being. There is a health and safety legislative imperative to construct strategies that identify hazardous situations, minimise, and where possible eliminate them. The drive from professional nursing groups has also contributed to this body of knowledge.

The need for workplace analysis, policy and procedure, and above all, resources that are context specific to the community in which the health service is provided is becoming increasingly apparent. While many health services enthusiastically promote staff safety, there are others which do not consider violence and aggression to be serious issues for community staff (Beale et al., 1998). Failure to have a policy in place that addresses personal safety for employees is in breach of health and safety legislation.

While interest in workplace safety for nurses in New Zealand is gaining momentum, there has been no formal research concerning it to date. By using methodologies that explore rather than quantify violence, the studies by Beale et al. (1998), Koch and Hudson (2000), Fisher et al. (1995) and White (1999) have begun to address nurses' experience and management of violence in the



community. However they do not address the power issues implicit in the fact that the problem exists. The Critical Social Theory perspective that underpins the current study aims not only to initiate discussion about occupational safety for nurses working in a New Zealand community, but to pay critical attention to the power systems that are perpetuated by ensuring district nurses remain vulnerable and relatively powerless. It also explores the tolerance nurses demonstrate for an unsafe working environment. The emphasis in this research, then, is to do more than document existing practices, but to bring about change. The following chapter details the guiding methodology used throughout this study, including approval processes, data collection and analysis.

# **Chapter Three**

## **Methodology**

### **Introduction**

This qualitative study is informed by Critical Social Theory. Critical Social Theory stresses the significance of power as a concept, with power relations being understood in terms of domination and subordination. It challenges and critiques assumptions about conditions that structure people's actions, as systems of power have the potential to distort consciousness (Heslop, 1997). Just as there is no single Critical Social Theory (Kincheloe & McLaren, 2000; Stevens, 1989) there is no single prescriptive Critical Social Theory study design or method that must be followed (Berman, Ford-Gilboe & Campbell, 1998; Roberts & Taylor, 1998). The distinction between methods and methodology is described by Berman et al. (1998) as seriously misunderstood and they note important distinctions between the terms. 'Methodology' refers to a set of principles for conducting research, whereas 'methods' refers to the ways in which data are collected.

Qualitative methodologies were originally derived from disciplines such as sociology, anthropology and philosophy, and "nursing borrowed from these methodologies to conduct research. As the discipline matured, methodology based on nursing ontology emerged" (Lobiondo-Wood & Haber, 1998, p. 234). Descriptive methodology attempts to explore the relative nature of knowledge,

which is seen to be unique and context dependent. Broad distinctions within qualitative methodologies can be made into interpretive ideologies and critical ideologies. Interpretive frameworks concern the generation of meaning, while critical research aims to bring about change (Roberts & Taylor, 1998). The aim of critical inquiry is "the critique and transformation of the social, political, cultural, economic, ethnic and gender structures that constrain and exploit humankind" (Guba & Lincoln, 1994, p. 113). A critical approach values the subjective and it looks at how subjective experience is shaped - often invisibly - by power and social relationships (White, 1999).

The method (or way in which data were collected) utilised common qualitative methods that have been employed in both interpretive and critical research for many years. The challenge, according to Berman et al. (1998, p. 4) is to use the chosen method "in a manner that is consistent with the paradigmatic methodological assumptions". Given the methodological assumptions of Critical Social Theory, I therefore chose to carry out individual interviews in addition to one focus group to collect the data for this study.

These methods for data collection are consistent or congruent with Critical Social Theory because they "are based on the assumption that real and trustworthy knowledge is found by paying attention to what people say and do in specific circumstances" (Roberts & Taylor, 1998, p. 170). Participant interviews were used that focussed on a particular event or events which the nurse came prepared ready to discuss. This gave structure to the dialogue and from a Critical Social Theory perspective produced a measure of control for the participant over the

content of the interview. They provided a direct way of accessing the nurses' area of expertise and experience.

In contrast to the many quantitative studies cited in the previous chapter, for these nurses, sharing the details of specific events was a means of giving voice to issues of concern with a view to 'something being done about them'. In this context the interviews did more than debrief (although I believe that did occur during some interviews) they were a means to bring about change. A strong expectation among the participants was that this research would become a legitimate and timely vehicle for voicing their concerns on which management would be obliged to act. One could say that the very act of participation in the study was a political one in terms of the impetus for change. The focus of Critical Social Theory is "transformation and change, working from the bottom up rather than the top down" (Grbich, 1999, p. 126). One of the study's purposes was to facilitate consciousness raising about safety issues at a 'grass-roots' level. Not only was this achieved for those participating in the study but also for other staff for whom an awareness of the progress of the study appears to have led to a greater awareness of safety issues.

Bringing the nurses who participated in individual interviews together in a focus group achieved two things: it validated the preliminary data analysis that had been done on the interviews, and it allowed nurses to meet collectively as a group with common concerns. According to Stevens (1989, p. 66) "group discussions...are not only a means of getting more diversified information, but they also assist participants to overcome structural isolation and understand their

individual oppressions, fears and constraints as *collective phenomena* that have social, political and economic origins". Meeting in this way confirmed for each nurse that their concerns about the hegemony of the systems and conditions they were working with were not isolated, but were felt by the others in the group. In terms of Critical Social Theory, the notion of empowerment was evident at this focus group as awareness of the impact of collective phenomena motivated the group towards improving current practices.

## **Study Design**

### ***Participants***

District nurses working in two Hospital and Health Services (HHS) were approached as possible participants for the study. From these, six self-selected district nurses participated in the study. Denzin & Lincoln (2000, p. 370) state that "many post-positivist, constructionist and critical theory qualitative researchers employ theoretical or purposive, and not random sampling models. They seek out groups, settings and individuals where and for whom, the processes being studied are most likely to occur". Six nurses was considered the minimum number of participants needed to successfully complete the study. More nurses would have been welcome, but only six expressed an interest to participate. Foley (1998,) says that small numbers are acceptable in qualitative research provided the sample is 'information rich', which indeed it was. The interviews took place between June and December 2000. Accessing two institutions made it possible to avoid singling out either institution about their provision of a safe working environment, and to keep the participant group confidential.

Following appropriate access and ethical approval (detailed further under ethical issues), a presentation was made at the district nurses' general staff meeting at each Community Health Service (CHS) to explain the purpose of the study in July, 2000. Nurses who met the inclusion criteria were invited to participate.

The criteria were:

- ◆ currently working as a district nurse, providing care to clients in the community
- ◆ registered nurses
- ◆ had worked as a district nurse for at least 12 months
- ◆ part time or full time, and
- ◆ were able to describe a time when they felt their personal safety was compromised in the course of their district nursing work.

These criteria ensured that the participants were experienced in community health and were not new to the existing procedures and practices of the institution. Information sheets (Appendix One) were made available for district nurses to read at their leisure and consider whether or not they would like to participate in the study. A stamped and addressed envelope was attached to each Information Sheet for interested participants to tear off and post their contact details to me.

During the presentations the nurses appeared receptive to the study and afterwards there was a period of twenty to thirty minutes of general sharing and discussion. Some nurses shared anecdotes about when they had felt unsafe and then rationalised why they shouldn't feel that way. I noted that some nurses believed that feeling unsafe was a personal issue that they needed to come to terms with. The stories told were about being afraid at night, or going into houses

they were uncertain of, or approaching the CHS base after hours, or concerned particular patients. Rather than consider this to be a normal response to an abnormal situation, or to consider possible institutional or procedural resolutions that would enhance personal safety, these nurses appeared to blame themselves for feeling insecure. Anecdotal discussion such as this reinforced my decision to use Critical Social Theory because of its emphasis on liberation from constraints and particularly those that emerge from the institution. It confirmed my belief that the study was indeed necessary and timely.

The literature reports that nurses have a tendency to minimise events as a means of coping with them (Croker & Cummings, 1995; White, 1999). They may consider incidents too small to report by comparing them to a standard of physical assault. This may have had a bearing on how valuable a nurse felt her contribution to the research might be and affected her decision to participate. Alternatively she may have felt the research would impact on her credibility. A problem that is well supported by the international literature is the problem of under-reporting of incidents (Lanza & Campbell, 1991; Lipsomb & Love, 1992; Yassi, Tate, Cooper, Jenkins & Trottier, 1998). One of the reasons suggested for this is the notion that the nurse is to blame for allowing herself to be placed in an unsafe or dangerous situation. The implied suggestion is that if the nurse were more skilled at observation, at defusing, or at predicting the future, the situation need never have arisen. While this can only be seen as blaming the victim, it nonetheless may have contributed to a reluctance to be seen to participate as an interviewee, or more publicly in the focus group. To help protect the identity of

the participants from their colleagues, contact was made to their private residence either by post or by telephone, rather than by leaving messages at work.

After each presentation, more examples of incidents were shared with me in a more personal, conversational way as I was standing about in the CHS corridors and offices. Although many nurses had incidents to share, the nurses who eventually became participants were known to me either as previous colleagues or as past students. This illustrates the importance of the pre-existing relationship and rapport that was supportive of the research process.

### ***Data Collection***

Participation in the study was two-fold. Firstly, a private interview was arranged for which the nurses were asked to consider a time when they felt that their work circumstances had compromised their personal safety. Prior to the interview they were asked to write down details about an event that I would use as a basis for the interview. Secondly, they would be invited to join all the study's participants in a focus group meeting to share their comments and feedback about the preliminary findings of all the interviews.

On receipt of the contact details of a nurse, a telephone call was made and an appointment arranged for an interview at a mutually agreeable time and place. Interviews occurred in the participants' homes on four occasions, one on Community Health Service premises and one in my own home. Each interview lasted between forty-five and ninety minutes, was audio-taped and later transcribed verbatim by either a research assistant or myself. Each transcript was then sent by post to the participants.



Interviews were conducted at a place that was nominated by the participant in order to minimise the inconvenience of time and travel. These decisions seemed to be based on consideration of current caseload and although the management of each institution had given permission for interviews to occur during paid work time, on hospital premises, all but one nurse arranged for the interview to occur in her own time. This may have been because there was less risk of interruption, they could feel more relaxed and speak honestly, or because approval in terms of resourcing for the study was not perceived to be a genuine offer. That is, there was no resource made available to provide clinical cover while the nurse attended the interview with me.

I had assumed that the interviews would go much as they have been described in the literature. However, I soon discovered that interviews do not necessarily go according to plan and the contexts of these venues were not unproblematic. One CHS interview room was located in an old Nurses' Home and the only available electrical power point for the tape-recorder had a timing device that turned any appliance off every two minutes. Consequently, for the duration of the interview, my hand was poised over the button to ensure an adequate recording.

The interview that occurred in my home - an environment that I had assumed I would have ultimate control over was fraught with interruptions. My printer had jammed as I was printing out the consent form and my husband arrived home in the middle of the interview to fix it (he also decided to stay for lunch while he was at home). My usually well-behaved dog insisted on repeatedly going outside, barking and then tapping at the door to come back inside. The men who cut our

lawns arrived unannounced and proceeded to use both weed-eater and lawn mower - sounds to which the audio-tape bears testimony! These factors were significant distractions for both the participants and myself and in all probability did impact the quality of the data due to our disrupted concentration. Nonetheless, the data from these interviews does meet Foley's (1998) criterion of 'information rich' and I was satisfied with both tape quality and information gained.

The interviews deviated from what might be considered a 'normal' interview by being based on an event or vignette that I had asked the nurses to write down first. I felt this would focus the interview around specific situations and I expected the process of writing about the event to prepare the nurse for some critical reflection around some of the issues that contributed to the event's occurrence. I also felt this was a reasonable request and anticipated little difficulty enlisting the nurses in this process because the notion of communicating an event by writing is a familiar concept to the majority of New Zealand nurses.

This assumption was based on the extensive use of exemplars in clinical career pathways where they are used as a means of demonstrating that a nurse is capable of delivering care at a sufficiently high standard to merit career advancement. On reflection however, the context in which exemplars are normally used is to illustrate exemplary practice, and in reality I was asking the participants to exemplify admonitory practice or circumstances. The participants therefore may have been confused about my intent and this may explain their

approach to preparation for the interview. Although asked to come with a written vignette, each nurse came with a rough list of the points they wanted to discuss - many with an event that illustrated each point. There were other general safety concerns that the nurses wanted to discuss and these too comprise a significant portion of the data.

Had the nurses conformed to my request to write down a single event, the data would look quite different and may not have included all the points the nurses wanted to make. It illustrates that while a researcher can construct data collection strategies, the power lies with the participant who shares what she wants to share, leaving the researcher somewhat powerless over what is contributed.

The interviews were conversational in nature, beginning with a general invitation to talk a little about themselves and their nursing experience and then to share the issues or events they had come prepared to discuss. These interviews differed from genuine conversations in that the intent of data collection was made explicit from the outset. For the most part, in each interview, the nurse 'drove' the interview, being intent on covering all the points she wanted to mention. The questions I asked were for clarification, to prompt, or to introduce a related idea or aspect that had been raised in other interviews.

The literature describes different kinds of interviews, usually dividing them into structured, semi-structured and unstructured patterns (Lobiondo-Wood & Haber, 1998). However my interviews differed from a standard textbook category because there was no formalised, pre-decided agenda set by myself

(unstructured), but the content was structured by the events the nurses came with. The clean, straightforward process described by Lobiondo-Wood and Haber (1998) and others (Roberts & Taylor, 1998; Wilson, 1987) does not address the realities and power relationships inherent in the process. In this study, the nurse doing the talking held considerable power by deciding prior to the interview what would be discussed, rather than deciding in an ad hoc fashion during the interview.

Interviews occurred over a six month period, often with one or two intervening months, and aspects from previous interviews were inquired about in subsequent interviews. My previous position as a district nurse, my position as a researcher and as an interviewer meant that my understanding and knowledge of the types of difficulties encountered snowballed. Consequently, I introduced ideas I had gleaned from other interviews and my own experience to draw further comment. I have mentioned the power the nurses' held by coming prepared with an event(s) to discuss, but I feel that to a degree the nurses were powerless against my growing enquiry into aspects they would have had no way of anticipating.

Interviewing is not, therefore, unproblematic in terms of power sharing. The participants' power lay in their capacity to edit or withhold substantive commentary or information, and my power lay in my ability to create a climate which facilitated disclosure of often intimate details of events. Opie (1999) suggests that within this climate participants can say 'too much'. Returning the transcripts was a useful way of attempting to equalise a complex power relationship as each nurse had full editing and deletion rights over her interview.

Four of the six transcripts were returned with minor alterations only needing to be made to grammar and occasionally, sense. Having the transcripts checked in this way also served the following purposes: to validate the data as a true and accurate representation of the interview; and to preserve the integrity of each nurse by offering her final control over what would be included as data for analysis. This allowed the nurses who returned their transcript to have a measure of control over the final appearance of what they may have shared 'in the moment'. It was important that this checked transcript be acceptable to them both as data for me to work with and for inclusion in the final report. This was important to one participant who expressed relief that she would have an opportunity to check the transcript and correct and/or add to it. She had participated in a study once before and something she had said had "been taken totally out of context" and used in a way that she had never intended. She had not been offered the opportunity to correct her comments and was relieved that she would be in this study.

Following preliminary analysis of the interviews, the participants were invited to meet with me to discuss the findings in a focus group. Waldegrave (1999, p. 230) describes a focus group as "an intensive group discussion 'focussed' around particular issues". The strength of this data collection technique is the relative freedom with which the group can discuss and reflect on problems, prompting and bouncing ideas off one another (Waldegrave, 1999). Focus groups seem to work best with small numbers where people share some common interest or characteristic (MacDougall & Fudge, 2001).

A meeting was held with lunch provided and four of the six participants were able to come; two were unable to attend because of work commitments. Three of the four attended not only during lunchtime but also on a rostered day off. I felt this level of commitment to the research reflected the importance and potential they felt the study held for bringing about change.

Each participant received a two-page summary of the findings and this was used as the basis for further discussion. There was little need to prompt the discussion and conversation flowed quite freely, lasting for about one hour. Individual stories from the interviews were not discussed, but new stories and instances were.

The discussion was recorded on audio-tape, transcribed verbatim and returned to the participants for checking as with the individual interviews. Both the focus group discussion based on the preliminary analysis and the transcription check were intended to minimise any inadvertent imposition of meaning from my own interpretation at this stage of the study. Strategies in the research design allowed me to get 'close to' the nurses' perspectives and minimise power in a potentially authoritative relationship (Heslop, 1997). However, as the researcher responsible for analysis of the data, there is an element of interpretation that I have imposed by virtue of the Critical Social Theory approach I have chosen to use. The focus group facilitated a measure of participatory dialogue but was essentially an honest attempt to ensure the interview data accurately conveyed the nurses concerns.

## ***Data Analysis***

Analysis of the data in this study was facilitated by the use of a qualitative data analysis software programme called "NUD\*IST Vivo" (*NVivo*). This programme was valuable for coding and categorising transcript data obtained from interviews and focus groups and helped with the identification and exploration of complex relationships and patterns within the data.

Computer tools have assisted qualitative research for over a decade. NUD\*IST was among the first programmes widely accepted as assisting many of the tasks of researchers. Researchers with this sort of 'Non-numerical, Unstructured Data' require ways of 'Indexing, Searching and Theorising' - hence the acronym NUD\*IST. QSR NUD\*IST Vivo (*NVivo*) was released on to the market in May 1999 and has been used in this study because of its ability to handle rich text documents - a feature not available in its predecessors (QSR, n.d.).

For the most part, the document browser and coding were the main functions I used in *NVivo* to aid data analysis. Initially, I created free nodes for all of the key points raised and then arranged the free nodes under parent-sibling nodes. I could then readily browse a node by selecting it so that all the text relevant to that node appeared, referenced to interview and paragraph. Quotes from the interviews were then copied and pasted directly into my analysis chapters. Asensio (n.d.) discusses the importance of new technology like *NVivo* fitting with and not intruding on the research perspective and approach. My experience was that it enhanced my ability to keep track of ideas within the data and allowed me to focus on the Critical Social Theory perspective I was using, rather

than be distracted with data management problems.

While *NVivo* is capable of far more complex tasks than I have described, I felt it adequately served my purpose. At one point I discovered I could do a single item count and decided to count the number of times the word 'dog' was mentioned in the data. On reflection, as I realised this was not contributing to a Critical Social Theory viewpoint I abandoned single item counts as a diversion, reasoning that the ability to perform a function does not necessarily warrant its performance.

Sandelowski (1994) discusses the use of quotes from the transcript of participant interviews and their presentation in the final research report. She says that "researchers should select an approach to quoting that is both faithful to what the person speaking wanted to convey and to their own ideas concerning what the quote represents or means" (Sandelowski, 1994, p. 481). She is especially critical of researchers who present a quote without guidance to the reader about what they ought to see. Consequently, participant quotes in this thesis have been selected to illustrate the essence of an idea that a nurse wanted to convey with a commentary about what is pertinent to the argument under development. Because the participants comprise a small and fairly homogenous group, in the interests of confidentiality they are referred to as 'nurse'.

## **Ethical Issues**

Ethical approval for the study was sought and granted from the Massey University Human Ethics Committee (MUHEC) and the Regional Ethics Committee. The Regional Ethics Committee (attached to the local Hospital)



approves all research that relates to health, consumers of health and health workers in the area. Consequently the district nurses that this study was seeking to access, although not considered a vulnerable group (Roberts & Taylor, 1998) required this committee's approval prior to commencement of the study.

Each committee required evidence of permission from the Management of each hospital that the study proposed to access. This involved speaking with the Director of Nursing at each institution under whose jurisdiction nursing research falls. Following their approval, I contacted the direct manager of the service, who contacted the Service Manager of each service, who then granted final approval for access to staff and any potential resources (such as a room in which to conduct interviews).

It was only when final ethical approval had been granted that the study could be presented to the district nurses about whom the study was conducted and without whom the study could not progress. In essence, I had written a proposal that was considered to be ethically sound by my supervisor, the department, two ethics committees, two Directors of Nursing and the service managers of two institutions and negotiated access before any consultation had occurred with the very people whom the study concerned. I found this to be in conflict with the empowerment model my research was based upon. That such power structures are in place suggests that the power of veto about whether the study would proceed or not lay with those structures. While later on the nurses could decide *how* the study would proceed, it was not their decision *if* it could proceed in the

first instance. Had the study been vetoed at that early stage, the district nurses may never have known that a researcher was interested in their personal safety.

Guba and Lincoln (1994, p. 105) argue that "questions of method are secondary to questions of paradigm". However the progress of the study up to this point was not defined by the worldview of the investigator (myself) but of the established structures through which all student research must go. This process of institutional review and the requirements of writing a proposal have raised interesting questions. They have enabled the critique of a process that is enlightening in terms of the power of the institution to prevent access to the very people whom I hope to assist in improving their working environment.

The minutiae of gaining access approval from managers implies they have the power to screen which research activities occur. This may be a convenient position to hold should a proposal be tabled that directly relates to their own job performance measures. My normative position on Ethics Committees was they are there to protect individuals and at face value they serve this function very well. The point my study has raised is that the institutional processes have been set up to protect the nurses as if they are vulnerable, when they are not. Fortunately, because the research was able to proceed and because of the chosen design, the impact of these issues on the research was negligible.

Ethical implications of the study include discussion about possible coercion to participate. As 'free agents' the nurses had individual choice about participating in the study. Specifically this means that a decision to participate in the study had

no bearing whatsoever on their relationship to me - I currently work outside of district or community nursing. Because of my past relationship as a colleague, particular care was taken to ensure that the nurses were not pressured by me to participate and the Information Sheet (Appendix One) offered about the study was an invitation only to participate. The initial meeting to present the proposed study to each of the Community Health Services did not involve active recruitment.

Once a participant group was established, however, great care and attention was paid to my relationship with each of the nurses. Every effort was made to ensure that the research was a relatively minor inconvenience in terms of time and travel and they were well informed about the progress of the study. Providing lunch for the focus group was one way of attending to this relationship.

Prior to each interview starting, a Consent Form (Appendix Two) was presented and explained to each participant for signing. Emphasis was placed on each nurse's right to withdraw and to choose not to participate in the focus group. The participants' loss of anonymity to other participants at the focus group was stressed and is made explicit in both information sheet and consent form. Audio-tapes and transcripts of the interviews were retained by me in a locked filing cabinet at the request of the participants. Computer files containing data were password protected on my home computer. The typist who assisted with audio-tape transcribing signed a confidentiality agreement.

It was anticipated that the interview process might bring up memories for the participants that were unpleasant or even traumatic. The literature reports a distinct reluctance of nurses to share stories about violent interaction possibly because of their personal nature or because of the unpleasant memories they evoke. Stories of overt violence were not shared although there were stories of implied violence or potential for violence. Ongoing low-level stressful encounters such as these can contribute to overall stress in similar ways to a major incident. While counselor assistance was not necessary, the dual role of nurse and researcher was evident as the discussion resulted in an element of defusing during the actual interviews. This was especially true for one participant who expressed considerable anger at the end of the interview about her perception of how management dealt with her concerns about staff safety. It was necessary to spend some time allowing her to articulate those feelings and thus provide an opportunity to defuse before she returned to her work.

### **Adequacy of the Methodology**

Kincheloe & McLaren (2000) are critical of research that is obsessed with issues of technique, procedure and correct method and is forgetful of the "humanistic purpose of the research act" (p. 282). 'Proper' method however, must be seen to be adequate for the purpose of the research as a means to verify the adequacy of the research findings (Kincheloe & McLaren, 2000). Just as there is no one way of doing qualitative research, there is no one accepted test of rigour in qualitative research (Roberts & Taylor, 1998) but whatever criteria are used must be appropriate to the research process.

According to Roberts and Taylor (1998) 'rigour' in qualitative research refers to the judgement and conduct used to ensure that the steps in the research process have been "set out clearly and undertaken with scrupulous attention to detail" (p. 172). Methodological attention must also be given to the philosophical perspective utilised in the study. The process must be transparent to be determined a trustworthy process and nursing researchers have established four categories for determining rigour in qualitative research. They are credibility, fittingness, auditability and confirmability (Sandelowski, 1986)

Credibility refers to both participants and readers of the research recognising the lived experiences described in the research as being similar to their own. In this study, this was achieved when the individual and focus group transcripts were checked and at the focus group itself. Fittingness refers to the extent the findings fit into other contexts outside the study's setting. Outside readership will be achieved on publication of this report. Auditability is the evidence of a decision trail that documents the methods and processes used in the research. This thesis provides the majority of such a decision trail, with audiotapes, transcripts and coding available for further scrutiny. Confirmability is the criterion that is met when all the others have been achieved.

More specific to the Critical Social Theory perspective maintained in this study is Berman et al.'s (1998, p. 4) outline of the core methodologic characteristics which in their view are common to all critical approaches. They are listed here because they are appropriate to this study's methodology.

Kincheloe and McLaren (2000) who describe research in the critical tradition as taking:

the form of self-conscious criticism - self conscious in the sense that researchers try to become aware of the ideological imperatives and epistemological presuppositions that inform their research as well as their own subjective, and normative reference claims (p. 292).

Both data and analysis are placed within the context of prior nursing scholarship in order to illustrate the ways that power structures have influenced nursing practice and nurse safety. District nurses were invited to participate in this study because of their expertise and experience in the community. Their views and ideas were respected throughout the individual interviews and focus group meeting.

Finally, dissemination of the research findings will occur through presentation to the Community Health Services involved in the study, presentation at the annual New Zealand District Nurse conference in 2002, and publications in interested nursing journals as future opportunities arise. The next two chapters present the findings from my analysis of the data. The first addresses the events that relate directly to clients, and the second, organisational issues.

## **Chapter Four**

### **The Vulnerability of Client Contact**

#### **Introduction**

The next two chapters present the findings from my analysis of the data obtained from interviews and the focus group conducted with the six district nurses. The first chapter deals with events that relate directly to clients. The second of these chapters explores issues of concern about work practices that the nurses wished to discuss.

This data analysis chapter explores events involving clients that illustrate compromised personal safety for the nurse involved. In the first section I describe the clients about whom the nurses spoke. The second section explores the strategies the nurses used to mediate events to preserve the safety and integrity of both client and nurse. Thirdly, I explore the effects of powerlessness and vulnerability generated from both the events themselves and attempts at mediation. The literature that relates to and supports the data is integrated into the discussion along with the Critical Social Theory concepts that have informed my analyses. The questions posed to the data were "who and what have district nurses allowed to define their practice?" and "what power structures are perpetuated that ensure district nurses remain vulnerable and relatively powerless?"

The way I have chosen to represent the nurses in the text is to write direct quotes from the transcript in *italics*. The quotes are often integrated into the sentence structure to provide an uninterrupted flow for the reader. An often-used convention in the presentation of qualitative data is to supply each quote with a reference to the transcript - in the interests of readability I have chosen not to do this. Rather a numeral (<sup>1-6</sup>) in superscript appears before each quote indicating to the reader which nurse is speaking. An <sup>f</sup> in superscript indicates a quote from the focus group. The numbers can be traced back to each transcript should verification of a quote be required.

### **The Client Group**

The nurses came to their interviews prepared to discuss specific situations where they had felt their own personal safety was compromised. To create an understanding of the type of clients the nurses felt unsafe with, the clients they described in these events are presented here.

The nurses described a wide range of clients. They included women, a young man, family members, and the elderly. Some clients were without a phone, and some spoke English as a second language. Many lived alone and appeared to be lonely. As one nurse said <sup>5</sup>*he liked my visits because he didn't see too many people*. The majority of events related to men, some of whom had continence problems.

Male clients with a psychiatric history featured prominently, with instability of mental health status and unpredictability being of particular concern. One nurse described a group of people with <sup>2</sup>*diabetes with unstable mental conditions*. She



felt that clients with both these conditions had contributed to her most unsafe experiences. Most clients were being visited by the district nursing service to provide care related to diabetes or for wound care (often for a pilonidal sinus) or both. One incident occurred inside a psychiatric institution where the district nurse visited to provide wound care, despite the on-site presence of registered comprehensive nurses.

Another nurse related a series of events about an aggressive psycho-geriatric woman who lived alone and had severe dementia, insulin dependent diabetes and multiple bilateral leg ulcers. Also described was a nineteen-year-old man with a stab wound, an intravenous drug abuser with a phlebotic abscess, and a tetraplegic member of a gang needing wound and bowel care at least three times a week. As clients usually live in a family or neighbourhood context there was comment made by one nurse that <sup>2</sup>*sometimes you might be seeing a client who is fine, but it is the family who you're concerned about ... who pose that risk to us, that threat.*

While no one described overt violence one nurse was aware of recent or impending violence occurring between the house occupants. <sup>3</sup>*You felt it when you went into the house that things were really, really tense and aggressive.* Verbal abuse was mentioned three times with one nurse reporting that <sup>3</sup>*he could get really, really verbally nasty if you didn't do exactly what he wanted.* Other verbal abuse came from a <sup>6</sup>psycho-geriatric client, and from relatives asking <sup>3</sup>*and who the f\*\*\* does she think she is?"*

Five situations related to the nurse feeling unsafe because of the male clients' inference that a sexual encounter with the nurse would be desirable. Such innuendo occurred when it was necessary for the nurse to touch the client and the client was partially undressed in order for wound care to occur to the peri-anal area, or to apply a uridome. When describing an incident one nurse said <sup>5</sup>*he was partially stripped off, and was dangling, swinging his penis around - obviously for me to take note, and he was laughing*. The findings of several studies report that personal touching is associated with a high-risk of assault (Crocker & Cummings, 1995 and Lanza, Kayne, Hicks and Milner, 1991; Yassi et al., 1998) and these situations are identified by the nurses as having the potential for that to occur. These situations also highlight the power differential between nurse and client whereby the client holds the greater balance of power by virtue of being in their own environment. This position of power is the reverse of many inpatient settings and highlights the isolation and vulnerability district nurses work in.

Another part of experiences to do with clients were events that related to animals owned either by the client or by neighbours. Dogs were encountered at clients' houses, on the driveway approach to the house, sometimes belonging to neighbours, and were particularly troublesome at night when more appeared to roam free. A general observation by one nurse about the size and nature of dogs encountered was there <sup>1</sup>*tends to be more guard type dogs around*. Some areas of the city were felt to be worse than others with the comment that <sup>6</sup>*there are a lot of dogs that are unregistered and wander around the streets of \_\_\_\_*. All the nurses mentioned dogs; some more than others.

Not all events related directly to clients. Many involved getting lost, being alone in the dark in an unfamiliar neighbourhood, no-one knowing or having responsibility for the nurses' whereabouts, having to carry drugs in a marked car, lack of basic resources such as cellphones and working from an ill-secured base at night. These issues are addressed in detail in Chapter Five: 'Organisational Issues'.

### **Preserving Integrity**

The strategies used to preserve the integrity of both client and nurse when the nurse felt unsafe can be grouped into two categories: resolving the immediate danger; and preventing the situation arising in the future. Removing oneself from an unsafe situation was reported as the wisest (and only) immediate choice and was neatly summarised by a nurse with the saying <sup>4</sup>*if in doubt, get out!* When sexually propositioned by a client with the client suggesting <sup>5</sup>*"oh, we could go and lie down"*, the nurse said that she *quickly changed the subject and then cleared out of the scene*. No other immediate strategies such as de-escalation or setting up a diversion were talked about, although a desire for education about possible strategies was expressed at the focus group.

Removing oneself from the situation is one of the low-level strategies suggested by Bowie (cited in Koch & Hudson, 2000) for coping with threatened or actual violence. Provided the nurse can successfully negotiate her way out, this is the safest immediate action. As Koch and Hudson (2000) point out, having a range of options available to a nurse requires educational preparation before an incident occurs. Other than this low-level strategy of removing oneself from the situation,

the nurses in this study, perhaps reflecting a lack of educational preparation in this area, did not demonstrate other options.

Nurses felt they were pragmatic about their own safety and claimed not to be troubled by a client's care being compromised by their exit. However, only two events describe times when patient care was not delivered due to the nurse's anxiety about her safety (one involved a dog, and another involved a mentally unstable client who failed to notice missed visits). Otherwise, the necessary care was delivered, the nurse made a hasty retreat, and a plan was later put in place to improve the nurse's safety in future. The plans most often utilised made use of the existing resource and provided a modicum of safety. They did not provide long term solutions to recurring problems. Such plans might involve briefing another nurse on the situation and one nurse planned for another nurse to *contact me if I'm not out in five minutes*. Another option is arranging for two nurses to visit. Arrangements were occasionally made with the Mental Health nurses to coincide visit times with the District Nurses. However, as one nurse pointed out, there are *times when it would be useful to go to places together as a double, but you don't always know that until afterwards*.

It is for this reason that Koch & Hudson's (2000) best practice model contains a triage system where new referrals are first vetted for possible threat to visiting nurses. The client's GP is contacted, as well as other community agencies, and the referral source such as friends or neighbours. While this has privacy issues for the client, this must be balanced against the right of the nurse to a safe

workplace. Beale et al. (1998) also recommend contacting the hospital ward if appropriate - a regular practice utilised by the nurses in this study.

Sometimes a frank discussion with the client was all that was needed to establish the client limits the nurse needed for her safety. The following incident describes the way one nurse set limits.

*<sup>3</sup>I could see that someone was shooting up in the kitchen... so I said to her that I will be coming daily and I expect you to be ready for me at a certain time and I would like to have an area that is set aside for me to be working with you. In other words I just wanted to be sure that I was not privy to anything [else] that was going on in the house....*

In addition to limit setting, another strategy nurses were obliged to employ was to address the immediate reason for referral (such as wound care) and avoid delving into other potentially provocative issues. For example, the intravenous drug abuse was not addressed by the district nurse. She said *<sup>3</sup>I did not want to get involved with anything but to deal with her dressing.* Sometimes the fear of reprisal for involvement was sufficient incentive to remain task focussed. As this nurse explained *<sup>3</sup>I tried not to get involved when his partner and he had physical fights. He wouldn't be able to hit her but he would get somebody in the gang to give her a good hiding.* The inference being that if he could arrange for his partner to be beaten up, he could make the same arrangement for the nurse.

Many of these 'other' issues were left to other agencies such as the detoxification unit, in the hope that they could make a difference. Liaison with other agencies was not always fruitful.

*JW: Was there much communication between those other services and yourself?*

*Nurse: <sup>3</sup>No, none at all.*

Clearly this nurse was in a vulnerable position as a witness to illegal activity. She had positioned herself as responsible for providing essential nursing care and not for addressing a drug and physical abuse problem. This may have been a management strategy whereby denial becomes a form of personal protection, or more simply, a resourcing issue in terms of both time and skill. However there are ethical and legal aspects to a nurse being witness to illegal activity. The 'silent position' that nurses take can leave others who are more vulnerable than themselves at great risk. In these instances, the client's baby and the other client's girlfriend may have been at risk and no other appropriate agency informed. Either way, this nurse is rendered both vulnerable and powerless by institutional practices. She is resourced to manage a routine visit and is without the skill to delve into issues for which she is not resourced anyway. Situations such as these reflect the increased complexity of needs in society, but also the omission of change from conventional district nurse practice to account for those changes. Thus, an outmoded historical context continues to shape district nursing practice, for reasons relating to both the culture of nursing and to economics.

Another simple strategy was the "no action option" (Koch & Hudson, 2000). This involved remaining focussed on the task at hand and taking no notice of what the client was doing. One nurse described <sup>5</sup>*matter-of-fact sharing of information about how to care for the uridome and things to look for, rather than zeroing in on his size of his penis or anything like that. It's just "this is how the*

*uridome goes on; we have a measure...*" While the no action option may resolve the immediate situation, unless a strategy is put in place for future visits, the situation is likely to arise again.

Strategies for dealing with dogs were inventive and often quite successful. *"If two of us were going at any one time, then one would wait at the end of the drive, and jump into the other car and away we'd go. You know, only sort of fifty to a hundred feet, but at least you weren't stuck up a driveway with someone's great Rottweiler foaming at you.* An alternative was parking on the driveway to the house and tooting the car horn until someone arrived to restrain the dog (not so useful at night). New to district nursing, one nurse was advised to wear Doc Martens to kick the dogs should she need to.

*<sup>3</sup>She said "you need Doc Martens and you need to dress down".*

*"What do I need Doc Martens for?"*

*"To kick all the dogs."*

However, if dogs are roaming around a house and the nurse is unable to make a fast entry, that visit may be aborted as described in this situation. *"I had no phone to ring the patient to say "can you meet me in the driveway?" So I didn't visit them. I came back to base, rang them up and arranged to visit them another day.*

Beale et al. (1998) suggest telephoning in advance to ask for dogs to be contained prior to the visit. However this nurse did not have a cellphone with her (this is discussed further in the next chapter). Beale et al. (1998) and Koch and Hudson (2000) recommend that the presence of animals should be included in any initial assessment and where they continue to create problems, home visits

should be withdrawn. Some practitioners carry sonic alarms to repel dogs and this is recommended by Beale et al. (1998) as good practice.

The presence of animals is a problem that district nurses deal with on a daily basis, and all of the nurses in this study talked about the threat dogs pose to their safety. The problem is so pervasive that it has almost become a matter of jest and is therefore not addressed by management as a serious issue. This is reflected in the fact that only one of the two institutions in this study has a policy about dog management.

*JW: a lot of people have mentioned dogs and I don't know that  
\_\_\_\_\_ have a policy on dogs.*

*Nurse: <sup>6</sup>I don't think I've come across one.*

For nurses to feel confident about their decision to withdraw or delay visits because of the presence of dogs, they need a policy document that makes that provision, and the support of management. Nurses are not necessarily scared of dogs; rather they are prudently wary. *<sup>1</sup>I'm not scared of dogs. But I just don't like them when they leap all over you, and they're rather large.*

### **Powerlessness and Vulnerability**

It is difficult to remain dispassionate about events that impinge on one's personal safety. For the nurses in this study and in my own experience the tendency is for the feelings associated with an event to remain in one's memory for some time. When similar situations continue to occur in one's practice, such feelings are reinforced (Paterson, Leadbetter & Bowie, 2001), along with a growing sense of



powerlessness to stop future incidents from occurring. The following section describes the reaction the nurses had to the events they discussed.

The nurses used a range of words to describe how they felt about dealing with these events and situations. Schmidt (1996) alludes to the idea that some nurses enjoy the challenge and adrenaline rush that accompanies negotiating unsafe circumstances, however the nurses in this study all chose words that have negative connotations. For example, (very) uncomfortable, vulnerable, scared, frightened, uneasy, cautious, nervous, un-nerved, hard, unpleasant, absolutely dreadful, active dread and feelings of self-doubt described as <sup>4</sup>*going batty* or that <sup>4</sup>*I'm a woos*. Physical effects were noticed such as shaking: <sup>3</sup>*I virtually felt myself shaking with the reaction of the whole thing*; and feelings of stress that took, as one nurse said a <sup>6</sup>*while to wind down* from following a shift. One nurse commented on the spiritual aspects of a sense of oppression that tended to stay with her until such time as she could debrief with a colleague. These words embody a position of self-doubt, that somehow the nurses are at fault for the situation arising. Another nurse spoke of how she felt when a client began talking about sexual encounters he had fantasized about with others and with her.

<sup>5</sup>*When he was talking about the young girls it was sort of like it was a little bit removed. But once he started talking about me, specifically, that's when I started to feel this isn't quite right ... I don't need to be here at this point. He made me feel really vulnerable ... that I was in a position of no control sort of ... but you know if he decided to do anything with me, or at me, or to me, um, I don't know what I would have done really, to be perfectly honest.*

That the nurse was without strategies to deal with this incident illustrates the absence of professional development in this area. She clearly felt powerless and vulnerable without some knowledge of how to deal with him at the time. The situation was managed by the provision of Specialist nursing care via other district nurses who were visiting regularly for wound care, and this deliberately broke the continuity of care and relationship with the specialist nurse.

Despite being familiar with the literature that places blame on the nurse for untoward events, it was not until I had a conversation with a colleague that I realised that I had positioned myself in a place where I wondered which nurse behaviours were contributing to this problem. On reflection and as my own knowledge about mental health issues has developed, it has occurred to me that as this client was fixated on this particular nurse and not others, that he was perhaps thought disordered. Deluded patients with an erotic fixation on clinicians can present a threat of violence (American Psychiatric Association, 1995) and I now wonder if this nurse was at greater risk from this client than either of us thought at the time. While her intuition told her this was important enough to be included in a research report, it may not have occurred to her at the time to make a formal mental health assessment in an area outside her expertise. Her colleagues may not have regarded such an assessment seriously anyway because it is outside of her regular job description. This has led me to consider whether general district nurses in the area should engage in formally assessing the mental health status of clients they are concerned about and report those changes. While not all district nurses have comprehensive registration (i.e have general registration but not psychiatric registration) many nurses do, and a basic mental

health assessment is a skill that should form a part of any nurses repertoire, irrespective of registration.

In terms of documenting her unease, this nurse did not record any of her concerns either in the client notes or in an incident form.

*J.W: What sort of documenting did you do around this?*

*Nurse: <sup>5</sup>I actually didn't do a lot. I didn't write anything about what occurred. I didn't write anything about that.*

*J.W: ...there wasn't any specific incident...?*

*Nurse: <sup>5</sup>No there wasn't and that's probably why I didn't. If he'd actually done anything I probably would have written it down. I 'd like to think that I'd written it down.*

*J.W: And for what purpose would you have written it down?*

*Nurse: <sup>5</sup>As a cover for me.*

*J.W: A cover for you? Maybe if someone else went to the house?*

*Nurse: <sup>5</sup>Oh yes. 'Cos I've only been going. That would need to be included.*

The statement "if he'd actually done anything" is linked to the concept of violence that this nurse held that *physical* harm must occur for an incident to have really happened. As discussed in the literature, this contributes to under-reporting (Lanza & Campbell, 1991; Lipsomb & Love, 1992; Yassi, Tate, Cooper, Jenkins & Trottier, 1998) and is the reason why "what occurred" was not documented. An interesting point that this section of dialogue illustrates is the change in the nurse's thinking about how documentation can protect the safety of

others. It is an example of the consciousness-raising that can occur in the course of an interview that may have a long-term impact on practice.

Despite the negative feelings and experiences, nurses demonstrate great tolerance for an unsafe working environment by repeatedly returning to the client, or other clients with similar circumstances. One nurse observed that nurses seem to <sup>2</sup>*just carry on* providing patient care despite a sense of defeat about promises of action to remedy a recurring problem that <sup>2</sup>*never came to anything*. One nurse complained that despite reporting concerns <sup>3</sup>*nothing happens, I mean you've still got to go to these houses*, and another said <sup>1</sup>*the main issue, something that bugs me, that things are put in place, but nobody ever asks further down the line, is this meeting your needs?* This contributes to feelings of being under-valued, as if the nurse is expendable. As one nurse said <sup>2</sup>*I think if you can put good systems and structures in place... that would make you feel valued*. These nurses feel under-valued, relatively powerless and have limited agency in terms of being able to bring about the changes and improvements they envisage.

There is an expectation that the occasional unsafe event 'goes with the territory' as expressed by this comment; <sup>2</sup>*I partially think it goes with the job, it's my choice to do this job*. The feeling that aggression against nurses is an accepted and expected part of the job is reported by Croker and Cummings (1995) and Jones and Lyneham (2000) and contributes to the problem of underreporting. If this nurse feels that aggression and threat is a normal part of the job and to be expected and tolerated, then it is reasonable to expect that clients and possibly management will feel similarly. The impact on systems and structures to improve

safety will therefore be minimal, and clients will continue to be abusive (Croker & Cummings, 1995).

'Just carrying on' links with altruistic ideals, but unselfish concern for the welfare of others places the nurse at risk. One nurse said, <sup>2</sup>*there are times when I still push beyond what I would perhaps feel is ideal, entirely safe, just because I feel that the need is there, and there is no one else to do it.* This nurse adds at the end of her comment: *and the expectation is there*; which belies an undercurrent of little choice about proceeding with a visit because of the ramifications of aborting. After all, what could possibly happen to a nurse when she is only doing her job?

The ramifications of an aborted visit are that the nurse or another nurse has to go back to make the visit. This has implications for workload as well as collegial relationships. If another nurse does not view the client as threatening, there is potential for that nurse to resent having to make a visit that the first nurse could easily have completed if she wasn't scared. One can understand the influence of the unspoken expectation that this nurse referred to, especially when the department does not have a policy about such matters. A policy would support and legitimise the nurse's decision to leave as well as generate discussion amongst the staff about perceived risk. <sup>2</sup>*There's no, we don't have a protocol or a policy that says, don't go to anyone if you feel unsafe, it's never been spelt out.*

There may be a direct relationship to patient outcome if the visit is terminated, as this nurse reports: <sup>2</sup>*I've been in situations where I've felt I didn't really have a*

*choice to repeatedly go into a home of someone who was quite unstable mentally and potentially violent and needed insulin.* The direct consequence of failing to visit this client to administer insulin may have been a hyperglycaemic coma and even death. The expectation therefore becomes the expectation to maintain the patient in the community and avoid hospital admission or institutionalisation for the patient. A question arises as to whose interests are being served by the perpetuation of such a situation and at whose cost. If client and nurse safety is the primary concern here, then re-institutionalisation may be the best option. However, if fiscal considerations are the primary concern then the less expensive option is to provide care in the community. This stance disempowers the nurse by obligating her to continue in an unsafe environment where she is especially vulnerable as a practitioner on her own.

Aside from patient care implications, some visits continued because of perceived peer pressure. This nurse said: <sup>2</sup>*it's a peer pressure thing again, to think oh well, the other nurses have been going in here.* When one nurse feels uncomfortable about visiting but another nurse does not, the pressure to proceed is reinforced. As she said: <sup>4</sup>*I felt uncomfortable with this person, one of the other girls didn't.*

When I first presented the study to all the district nurses, an element of peer pressure was evident in the anecdotes shared. Some nurses rationalised why they shouldn't feel unsafe because other nurses felt all right about the visit, implying they were just being overly sensitive. Elliot (1999, ¶16) says "violence is an individual perceptual experience that is defined by culture and environment.

What one person perceives to be violent may not be to others, and what one perceives as violence in one setting may not be in another".

Nurses expressed strong feelings of dread about having to visit people with whom they felt unsafe. The apprehension seems to be unrelated to the task involved (even manual bowel evacuations) and directly related to the circumstances under which the care must be given. This nurse said: *[it's] <sup>3</sup>not the physical work so much. It's the whole spiritual aspect.* This comes with obvious holistic care limitations (discussed earlier in this chapter) as the nurse provides the care that she has to and withdraws as soon as possible.

Several nurses blamed themselves for over-reacting or reading the situation incorrectly. Speaking of herself in relation to an incident with a patient who deadlocked the doors behind her a nurse said: *<sup>4</sup>you've got a fertile imagination woman, you're just being, you know, over the top.* Koch and Hudson (2000) are very clear that deadlocks represent a threat to a nurse as they make escape impossible should a difficult situation arise and validate this nurse's anxiety about her safety while in this situation.

There is also the suggestion that colleagues will blame the nurse for getting into an unsafe situation by failing to read the warning signs. One nurse suggested that *<sup>2</sup>perhaps there's the expectation that you'll make wiser judgements.* The literature discusses the propensity for nurses to blame themselves for allowing a situation to arise (Jones & Lyneham, 2000) and Johnstone (in Harulow, 2000) likens such behaviour to that of victims of domestic violence. The position that

this study, and especially the Australian studies (Fisher et al., 1995; Koch & Hudson, 2000; White, 1999) have taken regarding what constitutes risk is that if the nurse perceives herself to be at risk, she is at risk. To a certain extent this position re-affirms the nurse and empowers her to act rather than tolerate the risk. Each nurse in the study had considerable district nursing experience and as such draws on knowledge derived from past experience and intuition. Koch and Hudson (2000) include intuition in their best practice model and Jacobs (2000) suggests it may be the only safety net to prevent someone becoming a victim.

Although there appear to be many subtle reasons for continuing with a visit despite a nurse's uneasiness, the feeling of having no choice about visiting a client was balanced against a clear self-directive that a nurse was simply not going back to that client, house or similar situation again. This nurse said that: *"If at any time I'm uncomfortable I'm out of there - and that's all there is to it. My personal safety is really important to me. I feel I have the right to refuse to go to places where I feel unsafe, and to a certain extent, I would exercise that right."*

Even so, this nurse moderates her clear assertion that she would not proceed with a visit with her qualification "to a certain extent".

Although many nurses expressed a reluctance to visit a client because of certain identified risk factors, all clients received nursing care, albeit with some haste. In this study one client had her dressing deferred because of the presence of her neighbour's Bull Mastiff bitch and puppies in her driveway, preventing the nurse's visit, and another visit was missed in the hope the patient would not notice. What the nurses found to be intensely frustrating was the thwarting of their attempts to make it safer next time.



The frustration is exemplified in the nurses' interaction with Mental Health Services. As general district nurses, the nurses in this study provide general nursing care. As more mental health clients are de-institutionalised and begin living in the community (Jones & Lyneham, 2000), general district nurses are visiting many more clients with mental health issues for general needs such as wound care or diabetes intervention. These clients are usually under the care of Mental Health Services and are visited by mental health nurses, attend outpatient clinics, or are managed by their General Practitioner. Referral for nursing management of a physical need is usually made by one of these agencies.

The frustration arises not out of having to deal with these clients, but with what is felt to be inadequate information about the clients' psychiatric diagnosis, history and current mental health status. There appears to be a reluctance to share information between Mental Health Services and Community Health Services and this leaves the nurse feeling unsafe. This is despite a 'Shared Care' philosophy designed to ensure information is shared appropriately.

*<sup>2</sup>One of the things that frustrates me, is that we're getting referrals through that specifically outlines the medical conditions, like with congestive heart failure, CORD, wound, left, lower... very specific. Then there would be something tacked on the bottom that would say 'psych history'. Just like that, not even the whole word, 'psych history', or you'll look at the drugs someone's on and pick up that they're on lithium or something like that. And it was an issue to me that we're not given more information to give us clues as to our safety.*

Leaving a nurse to have to infer that a client has a mental health issue from the drugs prescribed requires vigilance and experience on the part of the nurse who makes the initial visit. A less experienced or over-worked nurse could easily overlook the significance of a lithium prescription. A statement about the client's current mental health status seems mandatory when one considers the wide range of mood states a bi-polar disorder can create. As this nurse says, the kind of information that is useful <sup>3</sup>*doesn't have to be biased, it just needs to be factual. [For example] "This patient tends to display dis-inhibited behaviour at times. Just be aware and perhaps it would be good to be with another nurse".*

Even when an understanding between the Mental Health Service and the Community Health Service had been reached to have both services visit simultaneously, district nurses remained frustrated. A time would be arranged for the visit but the district nurse would go in alone because the mental health nurse sometimes failed to arrive. <sup>2</sup>*I did feel much better with the psych nurse there, but they weren't reliable in turning up on time, and when they said they would, and you couldn't wait for half an hour, because that would put all your other clients out.* Occasionally the client took umbrage because the mental health nurse was present, leading to increased aggression. Consequently they would be asked to remain outside - a practice that calls into question the value of the arrangement at all.

Another district nurse was required to visit her client to provide wound care while he was an in-patient in an acute psychiatric ward because of deterioration

in his mental health status. The following relates to what happened when she visited:

*<sup>4</sup>I did his wound dressing and we got along fine...and I thought I'd better talk to his nurse, and I went into the office and I said to this guy that was in there, I said about the patient.*

*And he said "oh you've come to do him? and he said "right we'll go in there now shall we?"*

*I said "pardon?"*

*He said "well you need me there"*

*And I said "but some nurse showed me in there and just let me"*

*And he sort of looked at me.*

*And I thought, oh was I supposed to have someone with me? I didn't know.*

This nurse had been shown to the room with a high acuity client and left unaccompanied throughout the wound care procedure. While this portrays a somewhat blasé attitude to risk assessment and safety in general, what really concerned her was the ongoing need for district nursing visits following discharge. When she attempted to get more information about discharge planning:

*<sup>4</sup>he said, "Oh no he's going to have lots of support"*

*And I said "well what sort of support?"*

*He said, "oh just support"*

*You know I thought "what about his medication?"*

*"Oh well..."*

*He was very airy-fairy and vague.*

This conversation left the nurse feeling powerless and vulnerable as she contemplated the possibility that she would have to visit this client at home alone, albeit with a reduced acuity. Considering the experience she had in the ward she had little to reassure her that the assessment of the client's improvement and changed acuity would be competently carried out. In the absence of any support that has substance, her reliance would be on the mantle of protection to protect her on future visits. The assumption is that because she is a nurse, further support for her safety, even in these dubious circumstances, would be unnecessary.

This example of psychiatric (comprehensive) registered nurses refusing to undertake nursing care of a wound because it is outside their current area of expertise is comparable to district nurses refusing to undertake mental health assessments on clients they are concerned about. Both groups of nurses have, at the very least, beginning practitioner skills in these areas but are constrained and controlled by practices that nurses - not the institution - have put on themselves.

The nurses sought a rational explanation for why mental health information was deficient. One nurse suggested that <sup>2</sup>*it was just a reflection of the whole way mental health philosophy is, in that, they very much don't want their clients to be labeled, and it's very hard to get specific information.* Beale et al. (1998) found that district nurses experienced this problem in the UK. They reported that "some mental health practitioners were reluctant to pass on to other practitioners information that they felt might prejudice their attitude to the patients" (p. 60). This attitude contravenes the "Guidelines for Clinical Risk Assessment and

Management in Mental Health Services" (Ministry of Health, 1998) which stresses that "it is vital that information on risk is communicated to others involved with the care of the individual"(p. 10).

Perhaps a philosophy that limits information sharing to avoid labeling is valid for the lay community, but as health professionals, district nurses are not part of the lay community. While the intention to protect mental health clients is laudable, the fact that it places nurses at potential risk is irresponsible. As Beale et al. (1998) report, incomplete or incorrect information can lead to the nurse having wrong expectations, resulting in her being unprepared for problems which should have been foreseen.

This attitude also ignores the experience, expertise and education that district nurses possess and creates further divisions between the two (allied) professions. This nurse said: <sup>2</sup>*I do feel a little bit professionally insulted that you only get half the story when really we're potentially at risk going into homes when we don't know the facts.* Another nurse felt patronised by this attitude. She said: <sup>4</sup>*but we're only little wee district nurses.*

These events epitomise the nature of interaction between district and psychiatric and mental health nurses. They contribute to the antipathy between the professions and do little to promote client well being, let alone nurse safety. It appears to be an example of hegemony whereby one group's interests are served over the interests of another. If knowledge is power, then these examples demonstrate that power is held by whomever is party to select information. As

far as the district nurses are concerned, their agency is curtailed and they are once again frustrated by a system that does not meet their needs.

## **Conclusion**

Why do nurses demonstrate such tolerance for an unsafe working environment? There is a reliance by both nurses and management on a mantle of protection that is promulgated by the belief that no harm will come to nurses who are essentially doing good. It also appears that there is a complex interplay of relationships between clients, nurses, colleagues and management, each bringing their own subtle influence to the work context. In many ways nurses collaborate in their own oppression by accepting unsafe conditions as part of the job, blaming themselves for over-reacting, under-reporting and exerting peer pressure on their colleagues.

Systems of power are perpetuated by ensuring district nurses remain vulnerable and relatively powerless. External influences have been created by the religious origins and historical precedents of altruism in nursing where nurses 'just carry on' with the job because the expectation is there that they must do so. The expectation comes not only from colleagues but also from society's expectation that nurses as women will get on with what is essentially women's work anyway. Economic influences perpetuate nurses' powerlessness by the consistent under-resourcing of the service despite a wider political agenda that has promised increased community spending to justify the downgrading of in-patient hospital services.

Internal to the organisation are structures that impact enormously on a nurse's ability to safely carry out her work. They constrain the way in which the work must be carried out, ultimately defining the way in which a nurse can practise. Thus the detail of how the work is organised defines nursing practice rather than nurses defining the organisation.

This chapter has outlined situations directly involving clients that were deemed by the nurse involved to be unsafe. The ways in which the nurse preserved her integrity, protecting her immediate and future safety were explored, in addition to the powerlessness and vulnerability nurses experience when placed in those situations. The next 'Organisational Issues' chapter explores issues of safety that emanate not from clients, but from the employing institution.

## **Chapter Five**

### **Organisational Issues**

#### **Introduction**

While these two analysis chapters separate the issues into events that relate directly to clients, and those that relate to the organisation, in reality, the issues are inter-related. The nurses came to the interviews knowing I was interested in specific instances of client interaction that they felt were unsafe. The data present overwhelming evidence that for the nurses involved in this study, client incidents cannot be divorced from the politics of the systems that created the incident in the first place. Consequently, all of the nurses talked about organisational issues, some coming to the interview with a list of organisational points to raise.

The nurses see their role as providing and coordinating client care. The role of management is to facilitate that role. In the context of this study, the role of management in providing a safe working environment in order for nurses to provide and coordinate care comes under scrutiny. Although I had anticipated some management issues would arise from this study, my expectation that the client-community would be fraught with danger (a notion derived from the literature) has been overridden by the idea that the institution itself presents almost greater hazards.



Every day that a nurse presents for work she must first negotiate with the workplace her client visit load - and this is largely determined by the staffing resource available. She collects all of the information necessary for delivering the care (including equipment), client address, time of visit, length of visit, potential hazards, liaison with other agencies involved with the client etc. She then gets in a work provided marked car, wearing a work provided uniform and drives around her 'area' (collection of suburbs) to make her client visits. She may or may not be wearing a pager; three of the twelve or so nurses will have a cellphone. This system works well provided everything goes according to plan - and for the most part it does go to plan and this is especially true for daylight hours.

So why do incidents occur that nurses feel are unsafe? As discussed in the previous chapter there are some clients whose behaviour puts the nurse at risk and this may be related to their social circumstances, their physical condition and/or their current mental health status. The issue that is raised by the data is the level to which the nurses are equipped to deal with events relating to clients, both expected and unexpected. In the past, nurses may have been able to rely solely on their position in the community as district nurse, enjoying the status and protection that role offered. That perception of nurses is now outdated and as they are health professionals dealing with sick and often stressed clients they are at risk because a mantle of protection now affords little security.

Being realistically and adequately equipped refers to both the skill set available to the nurse *and* the physical resources available. Both are within the domain of

the employing institution. There is an obligation under the Health and Safety in Employment Amendment Act (1998) to ensure adequate resources are provided. Having the backing of the institution for a reasonable car, basic communication, education and support frees the nurse to attend to her clients with the attention they deserve.

The following sections outline the various institutional practices that shape district nurse practice. Clearly, the nurses in this study would like to be resourced sufficiently to do their job well. However, the complex interplay of values and attitudes constitutes an organisational culture made explicit through procedure and practices, which ultimately impinges on the nurses' ability to confidently and safely fulfil their role. The following quote encapsulates this sentiment:

*<sup>2</sup>I think if you can put good systems and structures in place, and have a culture of safety, a culture of safety among the nurses, and a culture of safety among the management who look after, who manage the nurses in the community. Because, that would make you feel valued. And also if you felt you had the permission to make a call, and be a bit over protective of yourself and not be, not end up being criticised but perhaps not - not that I think it would happen - but I suppose that's something. It's a peer pressure thing again, to think "oh well the other nurses have been going in here". Perhaps if you felt you had the right to just not go to something.*

## **Institutional Power defines Nurses Safety**

### ***Professional Development***

Human Resource managers will tell you that the most important resource a company has is its staff. This comment from a nurse reflects that sentiment: *<sup>4</sup>But then I think, there's only me, ... you know, the only person that's going to look after me, is me, really.* She acknowledges that even if a nurse had every resource available her, the most reliable safety net is herself. She relies on her own skill set of experience, intuition and common sense, and has a vested interest in using those skills to enhance her safety as no other person does. It is for this reason that the primary resource of staffing should be invested in - to enhance and develop those skills.

However it appears that personal safety is not a topic that is addressed by either Community Health Service even as part of orientation to the position. This nurse, who has been a district nurse for approximately three years, said:

*<sup>6</sup>I think I've been more proactive in talking about it since I've been here a bit longer. But even when I first started as district nurse I was quite nervous about some of the safety issues and I would often talk with my colleagues and find out how they had handled it.*

This implies that when she started as a district nurse, no one approached her formally about safety as part of her induction to the service. Of her own volition she went to her colleagues to find out how they handled it. The issue was addressed in an *ad hoc*, informal fashion with people sharing their experiences when asked.

This raises issues related to the way in which new staff are introduced to Community Health Services and this was discussed at the focus group. It was felt that there needed to be a specific induction process for Community Health Services rather than the existing generic orientation to the hospital as a whole.

*‘We are orientated to \_\_\_\_\_ Hospital specifically which I think is an absolute waste of time. We have got to be orientated to a whole lot of things to do with the community, including defensive driving and things like that.*

This comment reflects a lack of consultation between district nurses and the institution in planning an induction programme. The institution believes it provides a worthwhile three-day introduction to the service as a whole, but why be orientated to the hospital when these nurses work in the community? Consequently this nurse has determined that the orientation is a "waste of time" and her recommendation is that it should relate specifically to their job by including activities such as defensive driving. A consultative process would ensure that the needs of the nurses are met rather than just those of the institution.

Another issue raised at the focus group that could be included in the induction programme was self-defense. The nurses identified formal education or in-service about the principles of calming and restraint (sometimes referred to in the literature as control and restraint) as potentially valuable. Although the nurses talked about calming and restraint it was acknowledged at the focus group that: *‘perhaps it wouldn't be useful to us if we were in a situation on our own.* As Beale et al., (1998) suggest, verbal de-escalation skills may be more appropriate for use in the community. Unless a client is committed under the Mental Health

Amendment Act (1999), for a nurse to physically restrain him/her is to commit assault (Wright, 1999). Also, attempting to restrain a client who intends to inflict harm on themselves or another would be extremely unwise given the isolation with which district nurses work. Restraint should only be attempted where there is adequate back-up from other health professionals or police. Restraining the client or fighting the client are the highest level options mentioned by Bowie (in Koch & Hudson, 2000) and should not be used in preference to exiting a potentially violent situation. The key to Koch and Hudson's (2000) best practice model is having a range of options available to a nurse, which requires educational preparation before an incident occurs. However a caution that White (1999) offers about training programmes as the *sole* response to violence against nurses is that they can unintentionally reinforce the problem by implicitly blaming the nurses by implying that aggression is due to a lack of skills on the part of the staff.

Breakaway techniques rather than self-defense skills are now considered to be useful for evasive action only if a nurse is actually under assault. Self-defense training incorporates what are probably legitimate responses to assault but may not be professionally acceptable responses if the client is actually harmed (Wright, 1999). According to Beale et al., (1998, p. 121) "breakaway techniques should be taught as being a last resort only and with thorough discussion of when it is and is not appropriate or safe to use them". In their view basic 'self-defense' courses were *something that should be done every year like CPR [cardio-pulmonary resuscitation]*. They felt that refresher courses were as important as

annual CPR refresher courses and would be of benefit to newer staff. Beale et al. (1998) also suggest annual (breakaway) refresher training.

The nurses commented that while some had attended self-defense courses run by their institution some years previously, these courses were no longer offered. Only one nurse had recently attended a two-day Critical Incident course outside of the institution as part of her professional development. Opportunity for skill development in this area needs to be available for all staff and not just one or two who express an interest. The nurses were also interested in staff development concerning managing unwanted sexual advances. This seems appropriate given the intimate nature of many nursing procedures and the isolation that they occur in. That is, not only in the privacy of a clients home, but often in a bedroom, with the client on the bed, or shut in with the client in the bathroom. However, staff development is usually constrained by staffing resource issues and cost factors, reflecting the value that is placed on nurses' safety. Consequently, institutional power can define nursing safety by acting as a gatekeeper to professional development in this area. This is a reflection of the low priority of policy and training agendas within organisations (Paterson, Leadbetter, & McComish, 1997).

Paying for clinical supervision for district nurses was also discussed at the focus group. It was seen as an important way for nurses to stay healthy by having someone impartial to talk to. The nurses felt it was unfair that other health professionals with similarly stressful jobs had paid access to clinical supervision and they did not.

*<sup>f</sup>It seems terribly unfair that the OT's have it, the physios have it, the social workers have it. The Oncology nurses can choose [a supervisor] and get reimbursed. And we don't have it. It's the only way we can be healthy I think.*

The nurses appeared to focus on the benefit to themselves from clinical supervision in terms of providing an appropriate way to vent about the stressors in their job. However Jones (2001) suggests that it can offer more than support for the nurse. It also develops knowledge and competence, encourages taking responsibility for one's own practice and enhances consumer protection and safety.

Although not necessarily the case, clinical supervision and conflict resolution between staff were referred to as more or less the same thing at the focus group:

*<sup>f</sup>so clinical supervision I think is another important issue, conflict resolution.*

Consequently the management supervision role became confused with the clinical supervision role. The focus group discussion initially suggested that the Clinical Nurse Specialist was the best potential in-house provider of clinical supervision and/or conflict resolution. However this was rejected when the point was raised that he/she was involved in staff appraisals. This was viewed as a direct conflict of interest and no nurse should 'bare her soul' to the person who decides on her next pay rise!

*JW: <sup>f</sup>That Clinical Nurse Specialist is she actually involved in your appraisal?*

*Nurse: Very much so.*

*J.W: So you're looking at not necessarily involving her in a conflict resolution?*

*Nurse: I think that can create a conflict.*

To highlight this point, an example of how this conflict resulted in an abuse of power was cited at the focus group. A colleague had sought clinical supervision from the Clinical Nurse Specialist and the session had then been documented on her appraisal. This nurse said that: *“sometimes people have taken issues to the Clinical Nurse Specialist and then people have their appraisal looked up that they didn't deal with a situation very well.”* Fulton and Oliver (2001) and Jones (2001) agree that ideally the supervisor should be someone outside of the organisation and that clinical supervision should not be confused with management supervision. This confusion of roles does not appear to be confined to the nurses but also to the Clinical Nurse Specialist who allowed this situation to arise, and to management who do not fund external clinical supervision.

It does appear inequitable that other nurses (in addition to the other health professionals named) such as hospice nurses and mental health nurses who deal with not dissimilar clients are provided with clinical supervision. District nurses are at least as involved as hospice nurses in the provision of terminal care and as already mentioned are increasingly involved with clients who have mental health issues. Huntington (in press) states that “assisting people through complex and traumatic events is considered an inevitable part of nursing practice and it seems there is an assumption that nurses should be able to cope emotionally with these events”.

Often the only support available is the informality of a chat in the lunchroom with colleagues who may have some understanding of the experience (Huntington, 2000). However, the nurses at the focus group described a move



away from discussing work during break times in an effort to relax and forget about work. <sup>5</sup>*The lunch room is totally free from work while we're having lunch. And we try not to talk about work.* While nurses who do acknowledge their need for clinical supervision are at liberty to pay for it themselves, that the institution "fails to recognise that much of their work could result in serious negative effects on them as people could be considered a form of oppression" (Huntington, in press).

### ***Staffing***

Staffing resources are provided by the institution and the recruitment and retention of nurses at the Community Health Services are ongoing problems. Consequently, inadequate staffing constrains the way in which the work must be carried out and ultimately defines the way in which a nurse can practise. All the nurses in this study spoke repeatedly of high workloads both individually and at the focus group.

<sup>6</sup>*We're running on a bare minimum of staffing levels and resources really. The time lag between a staff member leaving and being replaced can sometimes be up to three months, which also gets very tiring on the full time staff working extra weekends and afternoon duties to fill the gaps.*

This comment refers to the extended time lag between new staff appointments and the impact on the full time staff who have to fill in gaps on the roster and take a higher case load. While inadequate staffing is an oft-heard complaint in relation to nursing, those discussions are usually in reference to *patient* safety. However, this study is primarily concerned with *nurse* safety and aside from the unwanted stress, short staffing has direct implications for nurse safety. Being unduly pressed for time leads to nursing practice that includes hasty visits to

clients, incomplete client assessment documentation and poor attention to personal safety issues (particularly at night). It is understandable that there may be especially busy times when such things occur, but when there is no respite or catch-up time due to chronic staffing shortage the effect is to curtail nursing practice and ultimately affect nurse safety.

If the resource were available, having nurses travel in pairs would, on the surface, be the most effective way to deal with many safety issues. However, the nurses do not see it that way.

*<sup>2</sup>I don't necessarily think that a solution is to go in pairs everywhere, that's probably a little bit of overkill. But there are times where perhaps we should have a second nurse we are able to call without having to access a great hierarchy of having it okayed. Perhaps at night, or to be able to call or a colleague, and say "look, I just don't feel happy, will you come with me?" Possibly if there was an issue, we could be told we could do that anyway, but at night there isn't really any provision for that, there's one nurse on call for your area.*

There are two issues here: one is about travelling in pairs; the other is about gaining authorisation for a second nurse to be paid to be on call at night. Always travelling in pairs is not necessary, but it may be highly desirable when a high-risk visit is identified, or if the nurse simply feels 'unhappy.' Having to "access a great hierarchy" to gain authorisation for a second nurse is an example of a system that ensures nurses remain vulnerable and relatively powerless. During the night, time is of the essence (particularly if you are on duty again at 8am) and the delay inherent in gaining permission is a strong disincentive to seek it.

Consequently, the nurse 'chooses' to go alone into what she knows may be a high-risk situation. This nurse has defined a personal safety need, but finds her assessment of the risk circumscribed by institutional procedure. The institution can legitimately be held unaccountable for the 'choice' the nurse makes, but has nonetheless created a 'no-win' situation for her.

During the day, having a second nurse present is not feasible anyway when as this nurse says: *<sup>2</sup>the [client] workloads pretty much matches exactly the nursing hours you've got, there's no room for the luxuries.* The issues inherent in this comment are firstly that the time visiting clients leaves little or no time for documentation and liaison with other health professionals - essential aspects of safe working practice. Secondly, this nurse considers having two nurses for a visit that has been identified as high-risk a luxury, or an indulgence rather than a necessity. The nurse's use of the word 'luxury' belies a sense that a second nurse would need to be 'allowed' by management to attend, as if to indulge the nurse's insecurities, as one would a child's.

### ***After-hours and Weekends***

The frequency of compromised visits seems to be more prevalent during the evenings, at night on-call, or in the weekends. Reasons for this relate to there being fewer staff, high use of part time or casual staff, high workloads, visiting unfamiliar clients in unfamiliar areas, and new referrals. In reference to high-risk encounters this nurse explains that: *<sup>1</sup>its usually when you're doing an afternoon duty, you're not covering your own area... you're covering a whole area for all the other nurses. So a lot of it will be, either less familiar, or totally unfamiliar territory, and you don't know the people you're going to, the circumstances*

*they're living in.* Paterson, Leadbetter and McComish (1997, p. 59) discuss how changes in client behaviour may only be recognised "where staff have a knowledge of the individual's normal behaviour in that setting". Clearly, nurses who are unfamiliar with the client are not able to recognise changes that may lead to aggression and this accounts for the increase in frequency of incidents in this study both after-hours and at weekends.

Further to this concern was that new staff or casual staff were placed in situations with clients for which they were unprepared. For example, this nurse expressed concern about the possibility of afternoon staff having to visit one of her clients who has an unstable psychiatric disorder requiring regular admissions: *"but if it was a new girl and she was working an afternoon and got suddenly called to go and see him for whatever reason, she may not actually have the notes in the car with her. So she would go in cold turkey and it might... it could be different then.* Policy could dictate that no visits are made to clients without the notes, but when nurses are already overworked, returning to base to get the clients notes is not always realistic. The consequence of this occurring is that the nurse is unwittingly placed in a high-risk situation with no back up or support available to her after hours except an on-call, non-clinical manager.

New referrals are an inevitable part of district nurse work and although hospitals in this area endeavour not to discharge patients with complex needs on Fridays, it often seems to happen. While that carries workload implications, of greater significance in terms of safety is the haste with which referrals are written and the sketchy details about the client that are provided. One nurse said about a

weekend referral she received that *'there was basically not a lot of information on the referral except "sustained stab wound to the back. Please visit and assess"'*. Even the address the client will be staying at can be inaccurate, exposing the nurse to a household who were not expecting her. Facsimile transmission of referrals can lead to this happening, as numbers on the patient information sticker do not always transmit clearly.

*'The referrals come through with those little labels on them, and by the time they've gone through the fax, often they are very difficult to read. The naught's with the bar through them, and the eight, can often look exactly the same, and I'd just made a mistake with the number of the house, through reading the sticky labels. And not helped of course by trying to read it in poor light, or referring back to it in the poor light of the car.'*

Thus the evolution of practices within the institution, such as hasty, sketchy faxed referrals, perpetuate poor communication between services, when excellence in communication is the desired standard for protection of the nurse making the home visits.

### ***Call Out***

The contract the Community Health Services have with the Ministry of Health is to provide twenty-four hour cover to community clients. This means that outside the hours of 8 a.m. to 4.30 p.m. the nurse working from 1 p.m. to 10 p.m. is on call for the area. A client places a call to the hospital operator who pages the nurse on call. The nurse then phones the client and a decision is made about whether the problem can wait until morning or if a visit is required straight away. The client's name and address are noted and the nurse makes a visit. She may or

may not be familiar with the client, their condition or the address. She reports to no one that she is making the visit, or that she has safely returned. No one is accountable for her whereabouts, and if she lives alone she would not be missed until she failed to present for work the next day at 1 p.m. As this nurse said: *'The fact is that because I live on my own, if I didn't get home for one reason or another, no one would know until I didn't turn up to work the next afternoon.'*

Although traceability away from base is discussed by Beale et al. (1998), after-hours on-call traceability is not reported in the international literature. Because of the nature of the service contract, this particular problem of after-hours on-call traceability is possibly a problem that is unique not only to New Zealand, but to the city in which the study occurred. As Beale et al. (1998) point out, it is therefore up to the individual managers and practitioners to apply the principles of safety management to their particular situation. At present there is an option to phone a security guard about the nature and length of an intended night visit, but there is no obligation on the nurse to do this.

*J.W: From what I have heard about it, it is optional. It's up to the nurse to instigate by ringing the security guard.*

*Nurse 6: I think if something like that is set up it should probably be a compulsory thing that everybody should start to practise rather than optional. So that it becomes a flow...*

The onus is on the institution to have a policy that clearly addresses this issue and to place priority on it as a safety requirement. As long as procedures are optional, nurses choose to 'go it alone' by minimising the perceived risk to

themselves. The institution cannot be held accountable for her choice but neither have they created a culture of safety where checking in is not an option but a personal safeguard.

### ***Communication Devices***

The use of paging devices has improved district nurse communication dramatically in recent years but they have limitations, as this nurse points out: <sup>2</sup>*obviously you can't page out on those* so they are therefore not useful as a safety device. A nurse receives a page from either other staff or clients, asks to borrow the telephone at the house she is visiting and deals with whatever business is at hand. To work it relies on the majority of clients having a telephone and the call the nurse makes must not attract a charge (e.g. to a cellphone or a toll call). Sometimes it means discussing another client's condition within the hearing of the client who is currently being visited. Thus it can be difficult to maintain client confidentiality.

While paging devices are useful from an institutional perspective for contacting a nurse about her work, they have minimal capacity to enhance nursing practice and safety. The advantage of nurses wearing and responding to a paging device is to the institution and not to nurses specifically - unless it is to cancel a client visit.

The cellphone or mobile phone has further improved the ability of district nurses to communicate and assist in both preventative and reactive strategies for reducing risks to their safety (Beale et al., 1998). It allows a nurse to discuss matters confidentially from her car, gives the flexibility to return calls at



convenient times, phone a client to explain a delay or request directions to the house, or contain a dog. In addition to the convenience, a simple call has the capacity to forestall any perception that the nurse is providing poor service by her unexpected lateness and minimise any possible feelings of frustration the client may have. This can contribute to the safety of nurses who may potentially be at risk of violence from frustrated clients (E. Mullen, 1997). Cellphones also allow nurses to easily contact colleagues to request assistance or advice, or to offer help. Beale et al. (1998), Ballard (1994) and Rickford (1994) report that the productivity benefits and patient care improvements alone outweigh the cost of cellphones. The other primary advantage in terms of safety is the speed with which an emergency call can be placed. Without exception among the nurses, a cellphone was deemed to be an essential equipment item offering two-way personal communication and significant safety advantages.

Because there are not enough cellphones for all staff to use, the current arrangement is that during the week, 8-4.30 p.m. the Specialist nurses carry the cellphones and one is then passed to the nurse working 1 to 10 p.m. Of interest is that the 'specialist' nurses are awarded the prestige of having a cellphone to themselves. The afternoon nurse then keeps the phone overnight while she is on call. The phone has to be returned to the base by 8 a.m. for use during the next day. At weekends the three phones are available for (usually) five staff to use.

*<sup>4</sup>I think one of the biggest concerns is that we don't have cellphones as a regular thing - that would help. Because you really notice it on the weekends, when you've got such easy communication with people, and on the afternoons you have the cell phone.*



The ability to readily contact casual staff and provide advice and support was seen as important, especially as these nurses were relieving some of the short staffing burden. As this nurse explained cellphones are also useful <sup>3</sup>*for supporting the staff at the weekends - especially with the casualisation now.*

Cellphones provide the means to check on the whereabouts of colleagues, especially at the end of the day when someone may not have returned to base yet. A nurse who fails to respond to calls can be assumed to be in trouble and measures taken to locate her. This facility is not available for non-specialist nurses <sup>6</sup>*during the weekdays: we don't have cellphones to have someone check up on you.* Beale et al. (1998) report that it is essential for employers to ensure that staff have safely finished their work at the end of the day if they are to fulfill their responsibility for safety of staff while at work. At present this responsibility is not assumed by anyone in particular but may occur on an ad hoc basis if someone has the time or inclination.

Cellphones were seen to be such important safety devices that some nurses carried their own personal phone to use for emergencies.

<sup>5</sup>*I have my personal cellphone on me.*

<sup>2</sup>*I've got my own cellphone.*

These nurses were not prepared to use their personal cellphone to conduct district nursing business at their own expense however. Beale et al. (1998) and Shacklady (cited in Beale et al., 1998) also report in their studies that some practitioners had bought their own cellphone but only for use in an emergency.

Problems with using cellphones that were mentioned included the intrusion of a call during client interaction (although this could be overcome with silent ringing and a message service) and pockets of poor cell phone coverage in some of the least desirable areas that nurses visited. As this nurse said: <sup>2</sup>*there are parts of the area I work in where [telephone company] phones don't work* and these areas are notoriously undesirable areas. Perhaps mapping the coverage area may not have been a priority for a non-clinical manager when the contract with the telephone company was commenced. Beale et al. (1998) report adequate coverage as a problem too. This nurse was impressed that her immediate management was endeavouring to address the cellphone coverage problems but felt that the organisation as a whole was not overly concerned about nurse safety.

<sup>2</sup>*I mean our immediate area and our immediate team leader is concerned enough to be trying to address the issue of phones and things, but further up the line its, its you know, the money's just not pouring down for nurse safety shall we say.*

This nurse acknowledged that the institution as a whole did not appear to have a commitment to nurse safety and that this was evident in the way money for resources was allocated. It is not surprising that many of her other comments during the interview related to feeling under-valued by her employer.

Another use for cellphones that enhanced nurse safety was the ability to phone a client ahead of time or even from outside the house and ask them to restrain a dog. As this nurse said: <sup>6</sup>*sometimes you have a phone, so that gives you an opportunity to ring a patient and say "I'm outside and your dogs are on the loose, can you tie them up?"* However, contacting clients by phone is often

affected by the client's economic status because *the client will have like a prepaid phone, which means they may have a phone number, but if it's run out of money they cannot be contacted.* Increasingly, people no longer have a landline telephone connection and they rely on their prepaid cellphone for making and receiving calls. Unless the cellphone has a positive balance, incoming and outgoing calls cannot be made.

A comment at the focus group suggests a gender issue might be a possible reason nurses have limited access to such basic devices.

*We don't have cellphones we only have a page, you can't ring them up and I think that's appalling...I think that's a real issue, because guys get all the new technological advances ahead of us and treat them as toys.*

Her feeling appears to be that (male) staff in management roles within the hospital, sitting at desks with desk phones, working 9 till 5 p.m., also have cellphones. Her feeling was that there would be little debate about cell phone use in clinical practice if these men were visiting clients in the community. The many nurses who carry their own cellphones are evidence of the way in which cellphone use can enhance district nurse practice and safety. At present the lack of cellphones restricts the ability of nurses to safely and efficiently manage their workload. As with the Beale et al. (1998) study, the provision of cellphones is a hot issue but they have clear safety advantages in terms of pre-empting problems and in accessing help in an emergency.

## **Fleet Cars**

The nurses were unhappy about the level of consultation that occurred around the choice of fleet vehicle the hospital would buy.

*<sup>6</sup>But we have read in the 'Evening Post' about the [brand of car] being poorly rated amongst all the little hatchback cars. One of our nurses had written to [the CEO] and asked about when they were due for renewal and why the decision to choose these particular cars and why weren't we, the drivers consulted in this, and that we weren't happy with driving them if they were the poorest standard. We got a reply back from that saying that they had consulted, and yet none of us remember having that consultation, so it was management that they consulted, not the actual district nurses and that they weren't prepared to renew it until 2002.*

It appears that an attempt at consultation was made, but that the nurses themselves were not consulted. This illustrates the value that is put on the nurses' opinions despite their obvious vested interest as the drivers of the cars. The focus group generated considerable discussion about the choice of fleet vehicle and that cost was the primary consideration when the decision was made. The comment was that *<sup>f</sup>apparently they got told they could get two \_\_\_\_\_ for the price of a [different car brand].*

There were other reasons for being unhappy with the fleet and these related to safety too. There is no air conditioning in these cars. A nurse at the focus group said that: *<sup>f</sup>you just felt grotty. By about 2 o'clock you just felt seedy and unwell. Its not just a lack of fluids - that's one of the problems, also the fact that the heat was just unbearable...they're also quite small those cars and so you've got a lot*

of glass. There was poor back support: <sup>6</sup>*when you're spending quite a lot of time driving around your lower back gets quite sore, and no keyless entry. When it may not be appropriate to seek refuge in a client's house, the nurse's car is the only safe place available. This nurse describes trying to hastily get into the car.*

*<sup>6</sup>The other thing about the cars is you're out in the street at nighttime (and during the day), someone's approaching you, you feel uncomfortable, you're just feeling unsafe for whatever reason. You've got a gut feeling that I just want to get in my car quite fast right now and you're fiddling around to get the key in the lock. Whereas I've felt that all of our cars should have a bleep unlock so that you can get into your car pretty fast. Because that is your haven, that is where you are safe - in your car. You can leave, exit fast.*

Beale et al. (1998, p. 39) stress the "importance of keeping transport in good working order and having a central locking system". A car with keyless locking is made available for use at night but is not favoured by the nurses because it involves moving equipment from their own car to the night car and back again. The inconvenience is a disincentive to busy nurses and once again the institution is not held accountable for nurses failing to make use of the car with the safety features. It is an example of the stopgap measures that are used to only partially address the safety of nurses while at work and incorrectly assumes that nurses will never need keyless entry during daylight hours.

What nurses are not in agreement over is whether cars should be marked or unmarked. Marked cars were felt to be at risk of break-in from people who were drug-seeking. This had happened during the night to one nurse when her hospital

car was parked in her driveway at home. Marked cars were seen to breach privacy when visiting clients as neighbours could see that a district nurse was calling as in this example: *I've had some patients say to me "can you park down the road because I don't want my neighbours to know that you're visiting". She said they're very nosy and I don't want them to know. I said that was fine.*

On the other hand there are advantages for the nurse's safety for neighbours to notice a district nurse car in the street. Another advantage of *a marked car is because the traffic is, particularly at the weekend, absolutely chronic and people see our marking on the car and let us in.* Other uses for marked cars as well as uniforms were described as useful for confused patients to help orientate them:

*For a patient that's confused, and a little bit disorientated, I think the uniform and the car helps them. They might not remember that that is you. They see the uniform and the badge and the car parked out on the street - it sort of helps doesn't it?*

While agreement was not reached over whether a car should be marked or not, there was consensus that the cars that nurses drive are an important piece of safety equipment. They provide a means of hasty retreat and should meet at least modest standards for safety in the event of a crash. Given the time that a district nurse spends in her car, they are a virtual office and should be awarded the same ergonomic and environmental consideration that a computer desk and chair are given.

## **Building Security**

*<sup>6</sup>There is something else that I want to talk about and that's the base that we work from. It's OK if you are here when there's everybody else here. But if you are here at the end of the day doing your work and everyone else's gone home (which quite often there is somebody who stays back finishing off a busy days work) you can feel quite unsafe in this building on your own. Especially at night; there's several doors to come in here... We've got the door down the end here, which is secured with a bolt and a chain, which could be snipped quite easily. We've got a fire exit door, which doesn't close properly. We're on the second floor and you do, you just feel very eerie in a big building on your own at night... We don't know who has got keys to this building, we don't know how many people have keys to our building. And when you are out visiting on the evening you don't know who's coming in from the building, who's still in the building, you have no idea of that.*

Two nurses talked specifically about the building the district nurses use as a base. Their concerns were about after-hours use of the building, specifically how the building was secured, who had access and keys to it and who was responsible for monitoring it. *<sup>2</sup>Like other places where people ... have to deactivate an alarm and ring security and say look, this is me, and I expect to be here for 15 minutes, and if you're there longer, the people monitoring the alarm ring up and say, look, you know, you're still there.* There was no alarm in one of the buildings and the hospital orderlies from the adjacent hospital (a five-minute walk) were expected to leave their hospital duties and escort a district nurse in the building

when requested. This was not perceived as a viable solution to security issues as more often than not, the nurse's request for help was not immediately answered:

<sup>2</sup>*usually you leave a message on an answer phone.*

Should a nurse need to access the building during the night to collect equipment for a call out, she could enter the building alone. Or as one nurse said she had to:

<sup>6</sup>*ring the orderlies and ask for them to meet me here at a set time ... but it did still mean waiting ten minutes for them to arrive because they were tied up doing something else. So that meant that the patient didn't get seen for [ages]... so it wasn't an effective solution at all.*

Her reaction was <sup>6</sup>*you need to come to the base to get the car keys or the equipment or something like that. That's the worst. I just hate it, absolutely hate it.* This nurse asked <sup>6</sup>*do we have to have a catastrophe before something gets done? I was thinking that last week when I was doing afternoons, I was feeling very nervous about being in the building on my own.*

This nurse is subordinate to a system that creates her work environment and she is rendered relatively powerless to improve that environment. She clearly feels vulnerable which will impact on her ability to meet her work responsibilities. Her frustration with the makeshift solutions that have been instituted is evident, as she does not see them as providing practical, long-term answers to what simply amounts to an ill-secured building.



## Conclusion

If we believe that everything is interconnected and nothing stands in isolation, then all of these apparently unrelated issues of professional development, staffing resource, hours of work, cars, buildings and cellphones relate in such a way that they do connect and impact on nursing safety in the community. Taken in isolation, they appear trivial and can be conveniently dismissed by an institution as insignificant and then ignored. From a Critical Social Theory perspective, this places the nurses in a position of powerlessness as they strive to bring about change but find that <sup>2</sup>*when they [issues] have been addressed, there have been options suggested, but never came to anything really, because, as nurses we carry on, for whatever reasons we do that.*

Beale et al. (1998) considered that an employer attitude that supported the notion that health visitors would not be harmed in the course of their duties was in breach of health and safety legislation. A reliance on a mantle of protection for nurses is no longer appropriate and the institution clearly has a duty of care to ensure that everything that is 'reasonably practicable' must be done to safeguard the health, safety and welfare of people at work (Safety Advice, 2000). The measures that the nurses in this study have identified are reasonably practicable and are capable of being implemented with minimal expenditure. A properly consultative process would demonstrate an institutional commitment to the value of nursing knowledge and expertise. If these measures are not possible, then these institutions need to seriously question their ability to safely conduct the business they are contracted to provide. These issues are explored further in the next discussion chapter.

# Chapter Six

## Discussion

### Introduction

This study has critically analysed the experiences of district nurses who felt that their personal safety was compromised in the course of their work. Along with specific incidents related to client interaction, many issues were raised about the way in which the institution contributes to compromised personal safety. This chapter discusses the institution's role in resourcing, professional development, and policies. Also discussed is the tolerance district nurses demonstrate for an unsafe working environment. My experience of using Critical Social Theory as the theoretical framework for the study, as well as writing reflexively, is explored.

Based on E. Mullen's (1997) description of objective and subjective behaviours that constitute violence at work, and the assumption that violence is whatever the nurse telling the story feels it is (Koch & Hudson, 2000) there is clear evidence that the nurses involved in this study are exposed to violence in the course of their work. While they were not exposed to high-risk violent encounters, the nature of their work exposes them to *potentially* high-risk encounters with minimal resources in place to anticipate that risk, or manage harm should it occur. Although there were no instances of overt violence, it is possible that "an actual low incidence of violence may reflect a high level of vigilance and expertise of staff in preventing violence rather than an inherently low risk"

(Beale et al., 1998, p. 115). There is a two-fold risk: risk associated with client behaviour and risk associated with the organisational structure. Incidents arising from client behaviour cannot be divorced from the politics of the systems that created the incidents in the first place.

From a Critical Social Theory perspective, hegemonic practices are enforced when an institution assumes the right to define what violence or risk entails. This is an important point because the definition then influences mitigation policies. By accepting only overt signs of injury, nurses who feel that they are at risk, but are without physical injury, feel that their concerns are trivial, that aggression is part of the job, and they may be seen as not coping. Consequently, there is a tendency for nurses not to report, and to minimise the seriousness of events that do occur. However, if a shift in control occurred, and the responsibility for defining violence rested with the nurses who experience it, their concerns could then be addressed as legitimate and appropriate intervention put in place.

For the most part, the expectations that nurses have for their personal safety while at work are modest to say the least. In general they expect the base from which they work to be secure, the cars they drive to be of reasonable standard, communication devices to be available to all staff, communication within the institution to be dependable, and for institutional policy including professional development to support their safety as its highest priority. Although these factors can do little to stop a client who is intent on being violent, nurses view them as essential for ameliorating the potential for harm given the isolation in which they work.

## **Re-interpreting Organisational Structures**

There are three areas for discussion in the next section that relate to the organisational structures which impact on nursing and which ensure that district nurses remain relatively vulnerable and powerless. They are: the resources that are available to the institutions - and therefore the nurses - via the service contract; the institutions' commitment to professional development; and the institutional policies that support district nurse safety. Following these sections is an exploration of the tolerance nurses demonstrate for an unsafe working environment.

### ***Resources***

The contract for services agreed to by the institution determines how clients are accepted into the service, which clients are accepted, and the fee for providing that service (price per visit) with limited input for these decisions coming from the nurses providing the care. Services for ACC and Palliative Care are sub-contracted to Community Health Services from those organisations. Resources are then allocated for staffing and equipment by management, which has apparently little or no acknowledgement of the special safety needs nurses have when working in isolation in the community. The terms of the contract then cap the resources available for provision of a Community Health Service to the community.

When an institution accepts the level of funding offered for the provision of a service it is accepting both the benefit and risk that comes with that contract. One such risk is that it may be unable to safely provide the service given the money allocated to resource it. If this is true then these institutions need to seriously

question their ability to safely conduct the business they are contracted to provide. That is, if for the most part they can safely resource district nursing visits during daylight hours when the perceived risk to nurse well-being is reduced, they should withdraw from providing a service during the night when risk is higher and the associated costs of making nurses safe are higher. Of course this assumes that the demand for nighttime service would not increase, bearing in mind ever-shorter hospital stays and the increasing acuity (complexity) of clients at home. It would require an institutional commitment to prioritising nurse safety and have the added benefit of meeting their obligations under health and safety legislation.

Community nurses face particular problems because they work alone and enter patients' homes. Whittington (1997), in his discussion about violence in the community, points to lower levels of aggression in the community than in the hospital setting. However, community-based staff are at risk of a more severe injury if an incident does occur because they are out of the relatively secure and controlled environments of a hospital. It is evident that nationwide, more and more emphasis is being placed on home care rather than on institutional care. While this movement is not just fiscally driven, given that people desire to be at home and are able to recover more quickly and comfortably in their own surroundings (Gellner, et al., 1994), the increased requirement for community health services generates increasing pressure to provide that care. District nurses advocate community care but see their services being severely stretched. As Beale et al. (1998 p. 118) point out, "the government has a responsibility to

health practitioners not to demand and publicise a level of service which it is not prepared to resource adequately".

The way in which nurses are able to deliver nursing care is contingent on the resources available to them. Resources are not merely the physical equipment but are also the intangibles of skill, support and organisational backing. It is the responsibility of the institution as the employer to adequately resource nurses and when it fails to meet this, both nurses' safety and nurse practice are curtailed. Nurses are left to make 'choices' about how they will manage a potentially unsafe situation when in reality the decision to take the safest option is so fraught with barriers that it is easier to accept the risk and get the job done. Such safety options include requesting permission for a second nurse to visit a high-risk client after-hours, arranging to meet an orderly to access the building after-hours, and notifying a security guard of time and place of visit during call-out. Options like these could be readily streamlined and measures put in place that facilitate nurse safety rather than impede it. Building security and procedures for logging call-outs with a security guard appear to be long overdue. If nurse safety is genuinely valued, the onus is clearly on the institution to address such basic safeguards before a serious incident occurs.

Central to all community nursing practice is communication. Nurses are involved in communicating with others at many different levels. They communicate with management, nursing colleagues and nursing specialists, allied health professionals, general practitioners, consultants and associated medical staff, pharmacists, hospitals, ACC, private providers of home support, rest homes,

hospices, clients, families, and neighbours. In terms of acknowledging the complexity and skill required to manage the communications, there is no funding allocated for the time devoted to it - with the exception of ACC-related calls. The funding is tagged to the task associated with it and is therefore valued by the institution as having greater importance. Not only are the many telephone conversations a nurse has with another agency not funded but also those calls used to make contact with a client or their family. A district nurse who telephones an oncology client, for example, post-chemotherapy, is able to claim for her time provided she actually makes a home visit. Otherwise, her communication is viewed as 'Telenursing' and is not funded according to the contract. Such structures impact significantly on the way in which nurses carry out their work and ultimately define the way in which a nurse can practise. Thus the detail of how the work is organised defines nursing practice rather than nurses defining the organisation.

In light of these funding arrangements, it is little wonder that there has been reluctance to provide each staff member with a cellphone. Surely this represents a cost to the service with little hope of reimbursement? In considering the unsafe experiences of district nurses in this study that were client-related, many involved communication difficulties. While some telephone calls could be made from the landline at the office, many other situations may have been averted if the nurse had access to a cellphone. The direct benefits appear to be in both preventative and reactive strategies for reducing risks to safety (Beale et al., 1998). Preventative strategies include the ability to call ahead to clients about unforeseen delay and facilitate communicating with and tracing nurses when they

are away from base. Reactive strategies include the ability to readily place an emergency call if necessary. The justification for district nurses needing cellphones is already established - what Community Health Services need to consider is which electronic features (message service, text-messaging etc) would best meet their needs.

Additionally, due consideration should be given to following the lead of other providers of community health services elsewhere in New Zealand, which have addressed the information requirements of district nurses with state-of-the-art portable computer technology. Aside from potentially revolutionising district nurse practice, technology such as a portable computer with e-mail and internet access would all but eliminate the problems that district nurses experience concerning incomplete and inadequate client referrals, and even access to psychiatric records.

District nurse safety is regularly compromised by the restriction of information to psychiatric records and this perpetuates the powerlessness and vulnerability that nurses experience when involved with clients who have a history of mental ill-health. While it is considered in New Zealand that "the great majority of mentally ill people present no greater danger to others than the general population ... there is a moderately increased risk of violent or fear-inducing behaviour among those who have mental illness" (Ministry of Health, 1998, p. 14). For this reason and to ensure the safety of all health professionals involved in caring for mentally ill persons, the "Guidelines for Clinical Risk Assessment and Management in Mental Health Services" (Ministry of Health, 1998, p. 10)



specifically state that "sufficient, accurate and timely information is [made] available to others concerned in the care of the individual to enable appropriate provision of care and minimisation of risk". While direct electronic access to this information is conceivably many years away, in the meantime if 'shared care' is to be an equitable reality, both Mental Health Services and Community Health Services need to foster relationships and information sharing between each other. Having access to a client's history and psychiatric record is vital to making safe choices about the best way to approach a client, and diminishes the vulnerability of district nurses who are visiting.

### ***Professional Development***

Being adequately equipped to deal with both expected and unexpected events requires both the physical resources and the skill set belonging to the nurse. White (1999) reported that experienced nurses have developed a wide range of strategies and responses to manage violent situations and as Beale et al. (1998) suggest, it is these behaviours that perhaps pre-empt many situations from arising. The expectation that expert nursing care will always be so neatly pre-emptive must be balanced against the resources, skills and information the nurse has at her disposal. In this study, many or all of these factors are circumscribed by practices imposed by the institution.

The primary resource of staffing requires enhancement to develop the skills and strategies. There were clear needs identified from analysis of the data concerning professional development; specifically, those that would provide a range of strategies for verbal de-escalation and breakaway techniques. Koch and Hudson's (2000) best practice model also includes comprehensive skill development in

self-awareness, self-control and self-preservation. Some refresher courses or in-service regarding mental health assessments would be a welcome and timely addition to the skill set of general district nurses.

Recognition of the special safety needs of nurses working in the community has occurred in the past in one of the institutions in this study by providing an annual self-defense course, but this has long been discontinued. However, that same institution is now offering a one-day Critical Incident Prevention workshop for nurses in their employment with particular reference to the in-patient setting. This workshop has been adapted from a five-day workshop originally offered to nurses working in Mental Health areas. While considerably shorter than the original course, it does represent a growing acknowledgement of the safety needs of nurses, but does not yet recognise the specific needs of nurses working in the community. While the workshop was open to all nurses (maximum of twelve), including district nurses, an adaptation of the material to meet the unique needs of the community would be preferable to a generic course.

From a Critical Social Theory perspective, having knowledge about how to deal with a threat empowers the nurse to do something about a situation rather than become a victim. Thus, knowledge empowers the nurse to use strategies that offer her protection from abusive clients. Given the emphasis and prolific literature available about management of violence in healthcare settings, the fact that the employers of the nurses in this study do not offer ongoing education in this area leaves them open to criticism.

Another issue associated with professional development was that of clinical supervision. This was identified by the district nurses as essential to help them stay healthy and to maintain their own safety. According to Huntington (in press), "the issue of how we expect nurses to continue to care for others when they are not provided with the structures to care for themselves ... needs addressing". These nurses recognised the necessity for clinical supervision, but had hitherto been unsuccessful in demanding the service.

### *Policy*

An issue of striking significance in this study is the absence of institutional policy and procedure regarding personal safety for district nurses. It is possible that these policies do exist, but the actual existence is immaterial when the district nurses themselves have specifically stated that they are unaware of any.

The responsibility for safe management of potential risk factors in the community is a joint responsibility of the employing institution and the nurses themselves. An integrated organisational approach should encompass prevention and preparation before incidents occur, timely reaction when incidents happen, and learning after incidents have occurred (Beale et al., 1998). Policy legitimises a nurse's decisions as well as providing evidence that the institution will support a decision that the nurse makes provided that decision is consistent with the policy. Written procedures provide sequential steps towards pre-determined strategies and enable a nurse to appropriately and safely escalate/de-escalate a problem. Employers are in breach of health and safety legislation if they believe that because nothing serious has ever happened, nurses should problem solve on

the spot without procedures to follow (Beale et al., 1998). Such an attitude ignores the realities of practice that nurses are faced with on a daily basis and suggests that district nurses are indeed reliant on an invisible mantle of protection to meet their safety requirements.

Nurses, as the users of policies and procedures, must be involved in their development to ensure their acceptance. Imposition of non-consultative policy is likely to be greeted with great skepticism and will probably be ignored by most nurses. A complaint about the non-consultative approach of management by a nurse in this study was that when things *'were put in place...nobody ever asks further down the line, is this meeting your needs?* Another positive spin-off of consultation in policy development is that nurses feel valued as having worthwhile contributions to make. Traditionally, nurses have been enculturated to not speak about their work but to just do it and to do it well (Buresh & Gordon, 2000) and this has supported the institutions lack of appropriate risk reduction strategy. Making explicit the exact nature of nurses' work and enshrining it in policy enhances and validates its value.

Development of a best practice model for nursing in the community, similar to Koch and Hudson's (2000) model that includes a client vetting system, client risk assessment and comprehensive professional development for nurses, would address many of the issues identified in this study that are in need of policy development. Many of the organisational issues raised are not so much policy issues but are rather basic security and resource issues that ought to be addressed by any responsible management (e.g. building security, lighting, safety rating for

cars, staffing, and cellphones). The accumulation of the nurses concerns leads to considerable frustration, risk and even danger, when many problems could be easily fixed.

With regard to the presence of dogs in the neighbourhood and homes of clients, a policy needs to be established that clearly states that a nurse is not obligated to visit should dogs threaten her safety. According to Beale et al. (1998) some practitioners in their study carried sonic alarms to repel dogs and this was recommended by the researchers as good practice. Sonic alarms are available in New Zealand at a retail price of approximately NZ\$30 and would be a relatively inexpensive solution to an unrelenting problem.

The temptation thus far may be for the reader to consider the issues that have been discussed as relatively minor points that present mostly hypothetical risks to district nurse safety. Certainly my own position has been one of doubt about the validity of what may be thought of as complaints about having to work, for example, in the evenings and on callout, and this study has merely been a vehicle for the complaint. However, in terms of my chosen theoretical position I have realised that by positioning the nurses as complainers, I am reflecting the discourse of accepted institutional behaviour towards a group of women who are doing women's work.

From a Critical Social Theory perspective, one begins to see that relegating the nurses' concerns to the level of trivia serves an important purpose. One can then say that these issues are not important, and women always complain but the work

still gets done - a point made clear in the data. Hegemonic systems position nurses as women who may complain but can easily be ignored, or at least not taken seriously. The perpetuation of these power systems ensures that district nurses remain vulnerable and relatively powerless and that in itself, according to Freire (1972), constitutes violence.

### **Tolerance for an Unsafe Working Environment**

Without a comprehensive description of violence that encompasses subjective elements, both the organisation and the nurses themselves can readily minimise the nuance of intimidation from clients. An adequate description must include intimidation, fear inducing behaviour, threat and all potentially dangerous situations that might place nurses at risk. These factors can then be addressed with the same strength of conviction as physical assault (Beale, Cox & Leather, 1996). Failure to do so compounds the problem and perpetuates under-reporting and an inaccurate perception of the problem.

There are many reasons described in the literature for under-reporting of incidents and of these, many were mentioned in this study by the participants. Of all the events that the previous chapters describe, not one was formally reported as an incident. A possible explanation may relate to the belief maintained by the nurses in this study and by society that violence is not intimidation and threat, but is restricted to physical assault (Koch & Hudson, 2000). Incident forms are designed to report damage to self, client or property, so if an incident was not thought serious enough or the nurse felt she was over-reacting, it was not documented. The expectation that an unsafe event "goes with the territory" raises the tolerance of violence at work (Ryan & Poster, 1993). It normalises its

occurrence and minimises the seriousness of any events in the eyes of both victim and colleagues (Croker & Cummings, 1995). Additional factors present in this study that are also well represented in the literature were

- fear of blame
- peer pressure
- coping with aggression being seen as part of the job
- not wanting to damage their professional reputation
- being seen as unable to cope

(Beale, Fletcher, Leather & Cox, 1998; Croker & Cummings, 1995; Lanza & Campbell, 1991).

The coping strategies that contribute to under-reporting, described by Croker and Cummings (1995) and White (1999), were also evident as nurses minimised the seriousness of the implications of the event. While all of these reasons for failing to report can be rationalised, their perpetuation can contribute only to ongoing compromised work-safety.

An issue raised by Lanza and Campbell (1991) is that reports which accurately reflect all unsafe incidents at best puts organisations in a highly ambivalent position. They may reflect poorly on the performance of management in an area as well as create the impression that there is much wrong with the service. The message to report only serious events is being clearly communicated to district nurses, as reflected in their feeling that "nothing ever changes anyway". The perception is that their managers would not take helpful action if they did report incidents.

However, without documentation that provides evidence of unsafe incidents, management is under no obligation to do anything. A cycle develops of incidents occurring that are not reported, no resource or commitment is made to remedying the situation, which leads to the occurrence of more incidents. In this way, by keeping silent, nurses can be said to collaborate in their own oppression.

Feelings of being vulnerable to criticism by colleagues and management accumulate and lead to a syndrome similar to Fisher et al.'s (1995) 'context of silence', which contributes to further underreporting and downplaying of the severity of the problem. Fisher et al. (1995) found that the nurses themselves may reinforce the way in which silence surrounds the issue of violence. Although the context of remote area nursing in Fisher et al.'s (1995) study is very different from urban district nursing, the feeling that the nurses would be blamed by both colleagues and management for an unsafe event was also present in this study.

Freire (1972), too, talks about a 'culture of silence' but in reference to the inability to perceive a situation or critique it. In this context, the very act of participating in this study revealed the nurses' ability to perceive their situation, and the fact that they chose to discuss issues relating to the organisation demonstrated their ability to critique it. The issue was their powerlessness to change what they saw as needing urgent attention, but felt unable to execute alone. One could say that the very act of participation in the study was a political one in terms of the impetus for change and that this research will become a legitimate and timely vehicle for voicing their concerns to which management will be obliged to respond. That the study has sought to speak on behalf of the



nurse participants suggests that Critical Social Theory as a research methodology served an important purpose.

### **Critical Social Theory as Methodology**

I found the experience of engaging with the methodology of Critical Social Theory and the notions of power appropriate for this study, particularly because of its focus on power that emanates from the institution. The Critical Social Theory ontological position I have taken regarding nurses' work safety concerns has been that the nurses are "self-interpreting beings" (Fay, 1987) and as such have interpreted compromised safety on their own terms rather than from a pre-determined definition. Thus, the nurses themselves identified the times they had felt unsafe and the issues that surrounded those events. Had I approached the nurses with my own preconceived notion of violence derived from the literature, the data may have looked very different and the issues that emerged may not have been of significance to the nurses themselves. As it stands, risk to personal safety emerges not only from clients, but also from the employing institution.

Furthermore, the participants, by the very act of involvement in the study and participating in discussion, became acutely aware of their own practices, and the practices of the institution and how these contributed to the perpetuation of an unsafe working environment. The process of being interviewed served to raise awareness of personal safety amongst nurses as expressed in this comment: *<sup>2</sup>the more I've thought about it and reflected on the issues of safety, the more I've realised there are certain things you can do personally, to keep you safe.*

Critical Social Theory may have also allowed me to meet my aim of raising consciousness about personal safety issues within the institution. At the time of writing, one of the institutions in the study has begun developing a hazard register as well as risk management protocols. The district nurse who shared this information with me felt that this was in response to a greater awareness of personal safety needs for district nurses subsequent to the interest generated by this study.

A Critical Social Theory methodology provided me with the means to engage with the participants in a dialogue that changed my understanding of which structures were shaping their experiences. A critical approach looks at how subjective experience is shaped by power and social relationships (White, 1999) and these often previously invisible relationships can be made explicit simply by being aware of their possibility and searching for them.

Critical Social Theory methodology is an approach that has not hitherto been used in research that explores district nurses' experiences of compromised safety at work. While the study by Koch & Hudson (2000) had an emancipatory intent and the White (1999) study, a critical feminist approach, these Australian studies do not expose the hegemony of many of the structures that ensure district nurses remain vulnerable and relatively powerless. The Critical Social Theory approach in this study brings a perspective that is not only unique to the research, but also unique to the New Zealand context.

The concept of power used in this study is based on the Critical Social Theory assumptions that "power is possessed, that it flows from ...top to bottom and that it is primarily oppressive in its exercise" (Manias & Street, 2000, p. 53). Through the research process I came to see that there were places where power appeared to fluctuate rather than remain fixed and this may represent a limitation in the use of Critical Social Theory. The notions of power such as those of Foucault, which are different from this traditional model, may better explain the power dynamic that can occur between researcher and participants. Foucault maintains that power is context specific, and that it changes depending on each particular situation (Manias & Street, 2000).

While Foucault's position on power has not gone unchallenged by many critical theorists who seek to speak on behalf of those individuals who are subordinated, Foucault's reasoning suggests the necessity to be specific about where power dynamics occur. The notion that power moves around implies that power must be examined precisely, and within the context in which it occurs. The movement of power between the participants and myself in the approval and data collection phases of the study now leads me to suggest that Foucault's position on power more closely resembled what actually occurred than the traditional understanding of power and its exercise.

The obligation to write reflexively to enhance methodological rigor (MacBeth, 2001) was a process that was not always straightforward. Incorporating my own thoughts and beliefs about the research process throughout the report has occurred at important moments rather than on a continual basis. At those

moments I have endeavoured to explicate my position, and in particular, when my position made a shift from my normative perspective. From a Critical Social Theory point of view, writing reflexively did allow me to examine my own position of power, not only in my relationship to the participants but in the analysis of the data, and final recommendations. In this way, it served to facilitate personal consciousness raising of my position as the researcher. My previous role as a district nurse prevented me from disengaging entirely from the data analysis and how it was structured. However, I believe that a researcher, who had not worked as a district nurse herself, would not necessarily understand the issues that arose or explain them in the detail I have supplied. In this way, the nursing practise knowledge I have brought to the research, has overall, been of benefit.

## **Conclusion**

The district nurses in this study displayed a high level of tolerance for an unsafe working environment. Unsafe circumstances were minimised, expected, and coped with. There was a sense of defeat about trying to enlist the institution in the prioritisation of nurses' safety. Nurses have modest expectations for their own safety but even these are circumscribed by institutional practices. This leads to the macrostructure of the institution ultimately impacting on the microstructure of nursing practice. This is not a new phenomenon, but one that once again needs to be challenged as it applies to district nursing practice. Nurses are obliged to curtail their nursing practice and intervention in order to ensure their own safety. This would be unnecessary if the institution had the desire to put relatively straight-forward solutions into place. Omitting to manage these institutional

practices ensures that district nurses remain relatively unprotected in their interaction with clients who are felt to be high-risk.

As nurses strive to bring about change, they find that the measures that are introduced are often shortsighted and makeshift and fail to properly address problems. Failure to properly consult with nurses is not only foolhardy but is a waste of a tremendous resource of innovative ideas. Nurses, as the primary resource available to a health service provider, need to be viewed as an investment, supported, cultivated and developed so they can make an optimum return on the institution's core business.

Nurses assume responsibility for their own professional knowledge about nursing practice issues. It is interesting that there were no incidents arising in the data of inadequate nursing knowledge related to client care. However, nurses do see professional development regarding workplace safety as something that their employer should address, and this appears to be supported by the Health and Safety in Employment Amendment Act (1998). Basic issues of building security, communication when away from base and safe vehicles impinge on a nurse's ability to safely and confidently carry out her role and should also be addressed in relation to the Act. Institutional policy and procedure needs to actively support the decisions that nurses make and facilitate safety rather than impede it.

A work environment that fosters nurse safety and genuinely endeavours to mitigate the potential risk to nurses working in isolation in the community would send a clear message to district nurses that they are valued. At present, the

reliance on an invisible force field - a mantle of protection to ensure their safety at work is a myth long overdue to be dispelled.

The next chapter summarises the main points of this discussion in terms of creating a culture of workplace safety, and includes recommendations for implementation. I conclude with implications for research and for the future.

## Chapter Seven

### Conclusions

#### Creating a Culture of Safety

Throughout this thesis I have referred to a rather old fashioned concept, a '*mantle of protection*' that both district nurses and the institution appear to rely upon to ensure that nurses are not harmed in the course of their work. They appear to rely on the mantle because there are few more substantial structures in place on which to rely. My challenge to district nurses is to examine their faith in the mantle and decide if they are prepared to continue to rely on it exclusively, given the changing face of the society they work in. My challenge to the institution is to examine its moral, ethical and legal position about workplace safety and whether or not it is acceptable to have its employees so scantily clad.

The purpose of this study has not been to expose and eliminate all risk to the personal safety of district nurses. Realistically, risk is everywhere and an integral part of our lives. Rather, the study has been about exposing the power structures that ensure that nurses remain vulnerable and tolerant of an unsafe work environment. Mitigation of risk and changing what can be changed is a desired outcome of this study, but that will ultimately depend on the parties involved and how seriously they take up my challenge and the following recommendations. The absence of any major incident serves to consolidate the notion that the mantle of protection is real and lulls people into a false sense of security,

thinking that because it has never been a problem until now, neither will it be in the future.

The creation of a culture of safety requires a commitment to the legitimacy of subjective perceptions of nurses towards what constitutes unsafe circumstances. Both nurses and institutions must respect the fact that violence is whatever the person experiencing it says it is and ensure the concerns are documented. From there, safeguards can be implemented that mitigate the risk and the value of the nurse must be upheld. Caution should be exercised by the institution against awarding token gestures of appeasement that only partially address safety concerns. This mechanism has been used in the past to perpetuate the dominant-submissive relationship evident in oppressed groups (Roberts, 1983) and will serve only to entrench the nurses' sense of powerlessness about improving workplace safety.

A culture of safety would promote open dialogue about concerns, develop policy and procedure for prevention of incidents, as well as follow-up support in the event of an emergency. At present, I know of no such emergency escalation plan or post-incident support for nurses should a serious incident occur. Resources published by Leather, Cox, Beale and Fletcher (1998) about safer working in the community offer detailed plans based around an institutional policy of 'Zero Tolerance' to violence. Essentially this ensures that nurses who spend their lives caring for others are not rewarded with intimidation and violence.



A culture of safety would promote the mutual responsibility of nurses and institution in ensuring a safe work environment. Not only must management assume responsibility for the whereabouts and traceability of nurses, but also nurses must be accountable for their whereabouts. Diaries that list the daily schedule of visits and then accompany the nurse on her visits render the nurse untraceable if she is without a cellphone. If not returning to base at the end of the day, nurses should phone in to verify their safety.

The following recommendations have emerged from analysis of the data collected from six interviews and a focus group of district nurses who had experienced compromised safety in the course of their work. The recommendations are structured as primary, secondary and tertiary level prevention strategies consistent with the Neuman Systems Model used by Gellner et al. (1994). The purpose of primary prevention is to pre-empt unsafe situations before they arise; secondary prevention is to strengthen existing systems and work to mitigate known risk; and tertiary prevention refers to the systems necessary for recovery following untoward events, and the overall safety policy of the organisation. Studies by Beale et al. (1998), Leather et al. (1998) and Koch and Hudson (2000) support the following recommendations.

## **Recommendations**

### ***Primary Prevention***

- That basic security related to the buildings that are used as a base, security guard alert for night call-out, and cellphones for all staff be attended to as outstanding issues requiring urgent attention.
- That information concerning clients must be readily available and a prerequisite for visits to commence or continue. This is especially important for clients with mental health illnesses, whether or not their current mental status is stable. Information about potential risks to district nurse safety must be complete, including history of aggression and alcohol or substance abuse. Strategies must be put in place that facilitates information sharing between various services involved in client care.
- That district nurses should be entitled to an appropriate buddy when visiting new referrals, clients with a known history of violence or domestic violence, a history of drug or alcohol abuse, or when visiting a high crime area. An appropriate buddy may be a colleague or supervisor, community psychiatric nurse or a member of the police.
- That an efficient means of establishing staff whereabouts and checking when they have finished work safely at the end of the day is essential for fulfilling employer responsibility for the safety of nurses while at work.

- That personal safety should be addressed formally in induction and orientation programmes that are specific to the needs of nursing in the community. Defensive driving courses should be included in professional development plans.

### ***Secondary Prevention***

- That all nurses making visits in the community should receive professional development in personal safety from competent and experienced trainers. This should include training in the management of aggression, de-escalation and break-away techniques. Refresher training should occur regularly, preferably annually.
- That no-fault incident reporting and discussion be encouraged at all levels within the organisations as a means of monitoring safety and mitigating risk.

### ***Tertiary Prevention***

- That a Safety Committee comprised of clinically active nurses, managers and professional representatives should meet regularly to oversee the development of policy, implementation and review of workplace safety.
- That policy and procedure development must be based on thorough risk management, as well as reflecting the needs of the district nurses and not just those of the institution. Policy must clearly state that nurses are not obligated to proceed with a visit and that they are entitled to an appropriate buddy if they do not feel safe. This includes withdrawal of home visits if the presence of animals will compromise the nurses' safety. Policy should be trialled and

be subject to ongoing quality assurance processes to ensure that what is set up continues to meet the needs of nursing in a changing community.

- That post-incident plans and a formal policy which supports nurses who become victims of violence be required for rapid implementation in the event that support is urgently required. The policy should include provision for access to a trained trauma counselor.
- That the issue of how we expect nurses to care for others when they are not provided with structures to care for themselves should be addressed by providing appropriate external clinical supervision.

It is my belief that attending to these recommendations and a culture of safety, rather than adherence to the belief in a mantle of protection, will ultimately improve work satisfaction for both nurses and managers alike. A culture of safety may even contribute to the resolution of the staff retention problems discussed by the participants that have plagued Community Health Services for some time now. Policy and procedure that prioritises safety will demonstrate the value with which nurses are held by the institution.

### **Implications for Further Research**

To implement these recommendations, a research project involving the district nurses in a participatory action research methodology would be a highly consultative way to create strategies that address the particular problems specific to the communities in which they work. Koch and Hudson (2000) used this approach in their model for best practice in the community. While they have

established a highly workable model, superimposing that structure on a New Zealand context may be unsuccessful as it may not be compatible with our existing health care structures. A participatory action research approach would ensure a commitment for all concerned and empower both nurses and institutions towards a culture of safety in community practice.

Investigating the problem of an adequate definition of what constitutes workplace violence in the community would further build on the existing body of knowledge, as would an exploration of the perception of managers towards workplace violence. This point was raised by Lanza and Campbell (1991) who suggested that reports of compromised safety may reflect poorly on managers performance. The use of a Foucauldian framework as the theoretical approach for a study may further explicate the position that power has in relation to determining behaviours and attitudes towards workplace safety.

### **Implications for the Future**

As a nurse educator involved in undergraduate nursing education in New Zealand, this study has highlighted for me the importance of nurses being comprehensively prepared. The KPMG (2001) review of undergraduate nursing education attracted a number of submissions from the profession that sought a return to single psychiatric registration as an alternative to comprehensive registration. However, comprehensive registration continues to be supported by the KPMG review and, as illustrated by this study, to assume that nurses in any area of practice will not encounter clients with general health needs as well as mental health issues is unwise. Nurses must be prepared to deal with an immense variety of clients and conditions, irrespective of their specialty area.

Finally, from a district nurse:

*<sup>2</sup>You know, statistically probably we're safer going into homes in the middle of the night - in view of the fact that nothing's ever happened - than we are driving on the road to get there. But we can't be unwise about potential risk and the fact that society is changing out there. Life's not going to be a hundred percent safe. But it's just managing the risks really, and I don't know that that's done with a lot of forethought really, at this point in time.*

## References

- American Nurses Association (1994). *Workplace violence: Can you close the door on it?* Retrieved July 2, 2001 from <http://www.nursingworld.org/dlwa/osh/wp5.htm>.
- American Psychiatric Association. (1995). *Diagnostic and statistical manual of mental disorders*. (4<sup>th</sup> ed.). Washington, DC: Author.
- Arnetz, J., Arnetz, B., & Petterson, I. (1996). Violence in the nursing profession: Occupational and lifestyle risk factors in Swedish nurses. *Work & Stress*, 10(2), 119-127.
- Asensio, M. (n.d.). *Choosing NVivo to support phenomenographic research in networked learning*. Retrieved August 30, 2000, from <http://collaborate.shef.ac.uk/nlposters/asensio-nvivo.htm>
- Ballard, J. (1994). District nurses - who's looking after them? *Occupational Health Review*, Nov/Dec, pp.10-19.
- Beale, D., Cox, T., & Leather, P. (1996). Work-related violence - is national reporting good enough? *Work and Stress*, 10(2), 99-103.
- Beale, D., Fletcher, B., Leather, P., & Cox, T. (1998). *Review on violence to NHS staff working in the community*. UK: University of Nottingham.

---

\* The referencing style in this thesis is in accordance with:  
American Psychological Association. (2001). *Publication Manual of the American Psychological Association*. (5<sup>th</sup> ed.). Washington, DC: Author.

- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo-Park, California: Addison-Wesley.
- Bent, K. (1993). Perspectives on critical and feminist theory in developing nursing praxis. *Journal of Professional Nursing*, 9(5), 296-303.
- Berman, H., Ford-Gilboe, M., & Campbell, J. (1998). Combining stories and numbers: A methodologic approach for a critical nursing science. *Advances in Nursing Science*, 21(1), 1-15.
- Browne, A. J. (2000). The potential contributions of critical social theory to nursing science. *Canadian Journal of Nursing Research*, 32(2), 35-55.
- Bullough, V. (1990). Nightingale, nursing and harassment. *IMAGE: Journal of Nursing Scholarship*, 22(1), 4-7.
- Buresh, B., & Gordon, S. (2000). *From silence to voice: What nurses know and must communicate to the public*. Ottawa: Canadian Nurses Association.
- Carper, B. (1978). Fundamental patterns of knowing. *Advances in Nursing Science*, 1(1), 13-23.
- Chambers, N. (1998). We have to put up with it - don't we? The experience of being the registered nurse on duty, managing a violent incident involving an elderly patient: A phenomenological study. *Journal of Advanced Nursing*, 27, 429-436.
- Cheek, J., & Rudge, T. (1994). Been there, done that? Consciousness raising, critical theory and nurses. *Contemporary Nurse*, 3, 58-63.



- Cody, W. (1998). Critical theory and nursing science: Freedom in theory and practice. *Nursing Science Quarterly*, 11(2), 44-46.
- Coffey, M., & Hanley, J. (2000). *Population-based strategy for preventing violence in the health care workplace*. Retrieved July 3, 2001 from <http://www.nurseadvocate.org/coffey.html>
- Conger, M., & Mezza, I. (1996). Fostering critical thinking in nursing students in the clinical setting. *Nurse Educator*, 21, 11-15.
- Croker, K., & Cummings, A. (1995). Nurses' reactions to physical assault by their patients. *Canadian Journal of Nursing Research*, 27(2), 81-93.
- Denzin, N., & Lincoln, Y. (2000). *Handbook of qualitative research*. (2nd ed.). Thousand Oaks, California: Sage.
- Duchscher, J. E. (1999). Catching the wave: Understanding the concept of critical thinking. *Journal of Advanced Nursing*, 29(3), 577-583.
- Duffin, C. (2000). Mobile phones promised in bid to reduce violence. *Nursing Standard*, 15(4), 6.
- Elliott, P. (1997). Violence in healthcare: What nurse managers need to know [Electronic version]. *Nursing Management*, 28(12). Retrieved July 3, 2001, from <http://www.springnet.com/ce/m712a.htm>
- Emden, C. (1991). Ways of knowing in nursing. In G. Gray & R. Pratt (Eds.). *Towards a discipline of nursing*. pp.11-30. Melbourne: Churchill Livingstone.

- Escorts offer security on home visits. (1996). *Nursing Times*, 92 (32), 8.
- Fay, B. (1987). *Critical Social Science*. Cambridge: Polity Press.
- Fisher, J., Bradshaw, J., Currie, B.A., Klotz, J., Robins, P., Searl, K., & Smith, J. (1995). *Context of silence: Violence and the remote area nurse*. Faculty of Health Science: Central Queensland University.
- Foley, D. (1998). *Quantitative vs. qualitative research*. Retrieved September 11, 2001, from [http://www.windsor.igs.net/%7Enhodgins/quant\\_qual.html](http://www.windsor.igs.net/%7Enhodgins/quant_qual.html)
- Freire, P. (1972). *Pedagogy of the oppressed*. London: Penguin.
- Fulton, Y. (1997). Nurses' views on empowerment: A critical social theory perspective. *Journal of Advanced Nursing*, 26, 529-536.
- Fulton, J., & Oliver, D. (2001). Clinical supervision: A psychodynamic approach. *Research for Nursing Practice*. Retrieved May 31, 2001, from [www.graduateresearch.com/Fulton.htm](http://www.graduateresearch.com/Fulton.htm)
- Gage, M., & Kingdom, D. (1995). Breaking the cycle of aggression. *Journal of Nursing Administration*, 25(12), 55-64.
- Gellner, P., Landers, S., O'Rourke, D., & Schlegel, M. (1994). Community health nursing in the 1990's - risky business. *Holistic Nursing Practice*, 8(2), 15-21.

- Grbich, C. (1999). Qualitative research design. In V. Minichiello, G. Sullivan, K. Greenwood, & R. Axford (Eds.), *Handbook for research methods in health sciences* (pp. 124 - 145). Sydney: Addison-Wesley.
- Guba, E., & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. Denzin, & V. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105 – 117). Thousand Oaks, California: Sage.
- Habermas, J. (1971). *Toward a rational society: Student protest, science and politics*. (J. Shapiro, Trans.). London: Heinemann Educational.
- Hagan, B., & Sayers, D. (1995). When caring leaves bruises: The effects of staff aggression on resident aggression. *Journal of Gerontological Nursing*, November, 7-16.
- Hall, J., & Stevens, P. (1991). Rigor in feminist research. *Advances in Nursing Science*, 13(3), 16-29.
- Hansen, B. (1996). Workplace violence in the hospital psychiatric setting: An occupational health perspective. *American Association of Occupational Health Nurses*, 44(12), 575-580.
- Harulow, S. (2000). Ending the silence on violence. *Australian Nursing Journal*, 7(10), 26-9.
- Health and Safety in Employment Amendment Act (1998). Wellington, New Zealand: Government Print.
- Health & Safety at Work Act (1974). Great Britain. Retrieved September 11, 2001, from <http://www.healthandsafety.co.uk/haswa.htm>

- Heath-Caldwell, H., & Raill, M. (1992). *Violence to IHC staff from intellectually disabled adults*. Wellington: IHC.
- Henderson, D. J. (1995). Consciousness raising in participatory research: Method and methodology for emancipatory nursing inquiry. *Advances in Nursing Science*, 19, 394-402.
- Heslop, E. (1997). The (im)possibilities of poststructuralist and critical social nursing inquiry. *Nursing Inquiry*, 4, 48-56.
- Hill, K. (Interviewer). (2001). Interview with Bernice Buresh. August 10, 2001. Radio New Zealand.
- Holter, I. (1988). Critical theory: A foundation for the development of nursing theories. *Scholarly Inquiry for Nursing Practice* 2(3), 223-232.
- Huntington, A. (1994). Women's work. *Kai Tiaki Nursing New Zealand*, April, pp. 20-22.
- Huntington, A. (2000). *Blood, sweat and tears: Women nursing women in the gynaecology ward - a feminist interpretive study*. Unpublished doctoral dissertation, Victoria University of Wellington, Wellington, New Zealand.
- Huntington, A. (in press). Working with women experiencing mid-trimester termination of pregnancy: The integration of nursing and feminist knowledge in the gynaecological setting. *Journal of Clinical Nursing*.
- International Council of Nurses. (2001). *Guidelines on coping with violence in the workplace*. Retrieved June 26, 2001, from [www.icn.ch](http://www.icn.ch)

- Jacobs, J. (2000). Preventing workplace violence. *Association of Operating Room Nurses*, 6(5), 42-50. Retrieved June 19, 2001, from the Proquest database (Research Library Periodicals) on <http://proquest.umi.com/pqdweb>
- Jones, A. (2001). The influence of professional roles on clinical supervision. *Nursing Standard*, 15 (33). Retrieved June 14, 2001, from the Proquest database (Research Library Periodicals) on <http://proquest.umi.com/pqdweb>
- Jones, J., & Lyneham, J. (2000). Violence: Part of the job for Australian nurses? *Australian Journal of Advanced Nursing*, 18(2), 27-31.
- Kincheloe, J. & McLaren, P. (1994) Rethinking critical theory and qualitative research. In N. Denzin, & V. Lincoln (Eds.), *Handbook of qualitative research* (pp. 138 – 157). Thousand Oaks, California: Sage.
- Kincheloe, J. & McLaren, P. (2000) Rethinking critical theory and qualitative research. In N. Denzin, & V. Lincoln (Eds.), *Handbook of qualitative research* (2<sup>nd</sup> ed.). (pp. 279 – 314). Thousand Oaks, California: Sage.
- Koch, T. & Hudson, S. (2000). *Preventing workplace violence: Towards a best practice model for work in the community*. Retrieved March 3, 2000, from [www.workcover.com/documents/rdns\\_final.doc](http://www.workcover.com/documents/rdns_final.doc)
- KPMG Strategic Review of Undergraduate Nursing Education: Report to Nursing Council. (2001). Retrieved September 19, 2001, from <http://www.nursingcouncil.org.nz/pub.html>

- Kuokkanen, L. & Leino-Kelpi, H. (2000). Power and empowerment in nursing: Three theoretical approaches. *Journal of Advanced Nursing*, 31(1), 235 - 241.
- Lanza, M. (1992). Nurses as patient assault victims: An update, synthesis and recommendations. *Archives of Psychiatric Nursing*, VI(3), 163-171.
- Lanza, M. & Campbell, D. (1991). Patient assault: A comparison study of reporting methods. *Journal of Nursing Quality Assurance*, 5(4), 60-68.
- Lanza, M., Kayne, H., Hicks, C., & Milner, J. (1991). Nursing staff characteristics related to patient assault. *Issues in Mental Health Nursing*, 12, 253- 265.
- Lanza, M., Kayne, H., Pattison, I., Hicks, C., & Islam, S. (1996). The relationship of behavioural cues to assaultive behaviour. *Clinical Nursing Research*, 5(1), 6-19. Retrieved June 19, 2001, from the Proquest database (Research Library Periodicals) on <http://proquest.umi.com/pqdweb>
- Leather, P., Cox, T., Beale, D., & Fletcher, B. (1998). *Safer working in the community: A guide for NHS managers and staff on reducing the risks of violence and aggression*. Department of Health, Wetherby, England: Royal College of Nursing & NHS Executive.
- Levin, P., Beauchamp-Hewitt, J., & Misner, S. (1998). Insights of nurses about assault in hospital-based emergency departments. *IMAGE: Journal of Nursing Scholarship*, 30(3), 249-254.

- Lipscomb, J., & Love, C. (1992). Violence toward health care workers - an emerging occupational hazard. *AAOHN Journal*, 40, 219-228.
- Lobiondo-Wood, G., & Haber, J. (1998). *Nursing research: Methods, critical appraisal and utilization*. (4<sup>th</sup> ed.). St. Louis, Missouri: Mosby.
- MacBeth D. (2001). On "reflexivity" in qualitative research: Two readings, and a third. *Qualitative Inquiry*, 7(1), 35-68. Retrieved March 3, 2001, from the Proquest database (Research Library Periodicals) on <http://proquest.umi.com/pqdweb>
- MacDougall, C., & Fudge, E. (2001). Planning and recruiting the sample for focus groups and in-depth interviews. *Qualitative Health Research*, 11(1), 117-126. Retrieved March 23, 2001, from the Proquest database (Research Library Periodicals) on <http://proquest.umi.com/pqdweb>
- MacInnes, P. (1972). Safety in the district. *Kai Tiaki Nursing New Zealand*, December, pp. 4-5.
- Manias, E., & Street, A. (2000). Possibilities for critical social theory and Foucault's work: A toolbox approach. *Nursing Inquiry*, 7, 50-60.
- Mental Health (Compulsory and Treatment) Amendment Act (1999). Wellington, New Zealand: Government Print.
- Ministry of Health (1998). *Guidelines for clinical risk assessment and management in mental health services*. Wellington: Author
- Mullen, E. (1997). Workplace violence: Cause for concern or the construction of a new category of fear? *Journal of Industrial Relations*, 39(1), 21-32.

Mullen, P.E. (1997). Mental disorder and violent behaviour. *Australian and New Zealand Journal of Psychiatry*, 31, 3-11.

Murray, P. (1999). *The Neuman Systems Model*. Retrieved November 18, 2001, from <http://www.lemmus.demon.co.uk/neumodel.htm>

Naish, J. (1996). Counterstrike. *Nursing Times*, 10(92), 16-17.

National Institute of Occupational Safety and Health [NIOSH] Facts. (1997). *Violence in the workplace*. Retrieved July 2, 2001, from <http://www.cdc.gov/niosh/violcont.html>

No warning patient could be violent. (1998, December 2). *The Evening Post*, p.3.

Occupational Safety and Health Association, U.S. Department of Labour. (1998). *Guidelines for preventing workplace violence for health care and social service workers*. Retrieved July 2, 2001, from <http://www.osha-slc.gov/SLTC/workplaceviolence/guideline.html>

O'Connor, T. (2001). Acting to combat violence. *Kai Tiaki Nursing New Zealand*, April, pp. 32-33.

Opie, A. (1999). Unstructured interviewing . In D. Davidson, & M. Tolich (Eds.), *Social Science Research in New Zealand: Many Paths to Understanding* (pp. 220- 230). Auckland: Longman.

Paterson, B., Leadbetter, D., & Bowie, V. (1999). Supporting nursing staff exposed to violence at work. *International Journal of Nursing Studies*, 36, 479-486.



- Paterson, B., Leadbetter, D., & Bowie, V. (2001). Zero in on violence [Electronic version]. *Nursing Management*, 8(1). Retrieved August 21, 2001, from the Proquest database (Research Library Periodicals) on <http://proquest.umi.com/pqdweb>
- Paterson, B., Leadbetter, D., & McComish, A. (1997). De-escalation in the management of aggression and violence. *Nursing Times*, 93 (36), 58- 61.
- QSR (n.d.). *Products/NVivo*. Retrieved September 19, 2001, from <http://www.qsr.com.au/products/nvivo.html>
- Rickford, F. (1995). Saved by a bell. *Nursing Times*, 91(34), 14-15.
- Roberts, K. & Taylor, B. (1998). *Nursing Research Processes: An Australian Perspective*. Melbourne: Nelson.
- Roberts, S.J. (1983). Oppressed group behavior: Implications for nursing. *Advances in Nursing Science*, 5(4), 21-30.
- Roberts, S. (1991). Nurse Abuse: A taboo topic. *The Canadian Nurse*, March, pp. 23-25.
- Robertson, I. (1989). *Society: A brief introduction*. New York: Worth.
- Rose, P., & Parker, D. (1994). Nursing an integration of art and science within the experience of the practitioner. *Journal of Advanced Nursing*, 20, 1004-1010.
- Ryan, J., & Poster, E. (1993). Workplace violence. *Nursing Times*, 89(48), 38-41.

- Safety Advice. (2000). *Occupational health and safety law in Australia*. Retrieved August 22, 2001, from <http://www.safetyadvice.com.au/SafetyOnTheNet/legal.htm>
- Sandelowski M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(3), 27-37.
- Sandelowski M. (1994). Focus on qualitative methods: The use of quotes in qualitative research. *Research in Nursing & Health*, 17, 479-482.
- Schmidt, J. (1996). The flavour of fieldwork in "the Big Apple". *Home Healthcare Nurse*, 14(1), 10-13.
- Shutting the gate. (2001). *60 Minutes* [Television broadcast]. Retrieved June 18, 2001, from [http://tvone.nzoom.com/programmes/60minutes/story.html?story\\_june17\\_02.inc](http://tvone.nzoom.com/programmes/60minutes/story.html?story_june17_02.inc)
- Smith, S. (1988). Take care, be aware. *Community Outlook*, April, pp.10- 12.
- Stevens, P.E. (1989). A critical social reconceptualization of environment in nursing: Implications for methodology. *Advances in Nursing Science*, 11(4), 56-68.
- Suzy Lampugh Trust. (n.d.). Retrieved July 2, 2001, from <http://www.suzylamplugh.org/index.htm>
- Thomas, B. (1995). Risky Business. *Nursing Times*, 21(7), 52-53.
- Ungvarski, P. (1996). Challenges for the urban home health care provider. *Nursing Clinics of North America*, 31(1), 81-94.

- Waldegrave, C. (1999). Focus groups: Participation in poverty research. In D. Davidson, & M. Tolich (Eds.), *Social science research in New Zealand: Many paths to understanding* (pp. 231-242). Auckland: Longman.
- Wasserfall, R. (1997). Reflexivity, feminism, and difference. In R. Hertz (Ed.), *Reflexivity and voice* (pp. 150-168). Thousand Oaks, California: Sage.
- White, H. (1999). *Violence towards nurses: Is it part of the job? A study of client aggression in community practice*. Unpublished honours thesis, Flinders University, Adelaide, Australia.
- Whittington, R., Shuttleworth, S., & Hill, L. (1996). Violence to staff in a general hospital setting. *Journal of Advanced Nursing*, 24, 326-333.
- Wilkinson, J. (2001). Nurses must be aware of their power. *Kai Tiaki Nursing New Zealand*, February, p.20.
- Wilson, H. (1987). *Introducing research in nursing*. Menlo Park, California: Addison-Wesley.
- WorkCover Corporation. (1998). *Guidelines for reducing the risk of violence at work*. Retrieved April 3, 2000, from <http://www.workcover.com/documents/Home.pdf>
- Workplace Health and Safety Act (1995). Queensland, Australia. Retrieved September 10, 2001, from <http://www.whs.qld.gov.au/whsact/index.htm>

Wright, S. (1999). Physical restraint in the management of violence and aggression in in-patient settings: A review of issues. *Journal of Mental Health*, 8(5), 459-472. Retrieved August 21, 2001, from the Proquest database (Research Library Periodicals) on <http://proquest.umi.com/pqdweb>

Yassi, A., Tate, R., Cooper, J., Jenkins, J., & Trottier, J. (1998). Causes of staff abuse in health care facilities: Implications for prevention. *American Association of Occupational Health Nursing*, 46(10), 484-491.

# Appendix One



COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Health Sciences

Private Bag 11 222,  
Palmerston North,  
New Zealand  
Telephone: 64 6 356 9099  
Facsimile: 64 6 350 5688

## Information Sheet for District Nurse Participants.

### *Personal Safety for District Nurses.*

This study has received ethical approval from the \_\_\_\_\_ Ethics Committee (phone xx xxx xxx ext. xxx) and Massey University Human Ethics Committee (phone 06 350 5622).

Dear District Nurse,

I am undertaking a research project toward the completion of a Master of Arts (Nursing) at Massey University. My supervisor is Annette Huntington, nursing lecturer at Massey University in Wellington. The research study is a qualitative study aiming to look at the ways district nurses may be exposed to unsafe circumstances in the course of their work and how to minimise any risk.

I would like to interview 6 to 10 nurses from both \_\_\_\_\_ and \_\_\_\_\_ about their experiences of compromised personal safety while working as a district nurse. If you meet the following criteria I would be grateful if you would consider this invitation to participate in the study:

- ◆ You currently work as a RN district nurse, providing care to clients in the community.
- ◆ You have worked as a district nurse for at least 12 months
- ◆ You work either part time or full time
- ◆ You can describe a time when you felt your personal safety was compromised.

#### What will you be invited to do?

*Participation is two-fold - a private interview and later joining a focus group of all the participants (details over the page).*

- ◆ Prior to meeting with me I will ask you to write an exemplar or vignette (no more than a page) about a time when you felt your work circumstances compromised your personal safety. You would then be interviewed by me to talk about your story, how you felt and reacted and how the situation could have been made safer.
- ◆ The interview should take no longer than 60 minutes, and will be conducted at a mutually agreeable time and private venue.
- ◆ With your permission, I would like to audio tape the discussion and have the tape transcribed by a typist who will sign a declaration of confidentiality.
- ◆ I will send a transcript of the interview back to you for confirmation, or to enable you to make any changes. You have the right to delete any parts of the transcript, and to withdraw from the study at any time until you return the transcript to me for data analysis.
- ◆ I will ask that you return the transcript to me within a month. The data from both your story and the interview will be used for my thesis, and for any publication or presentation that may arise in association with this study.

Te Kunenga ki Purehuroa

Inception to Infinity: Massey University's commitment to learning as a life-long journey

**Consent Form for District Nurse Participants.**  
***Personal Safety for District Nurses.***

- ◆ I have read the information sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.
- ◆ I understand I may participate in only the interview part of the study if I choose.
- ◆ I understand I have the right to decline to answer any question.
- ◆ I agree to provide information to the researcher on the understanding that my name will not be used without my permission. The information will be used only for this research and publications arising from this research project.
- ◆ I am aware that there is a risk that my identity could inadvertently be linked to my story or stories at the focus group. I understand that Jill will make every effort to minimise this risk.
- ◆ I am aware that my identity will be revealed to the other study participants at the focus group.
- ◆ I understand the interview may be approximately 60 minutes in duration and that Jill may take notes during the interview.
- ◆ I understand the focus group discussion may be approximately 60 minutes in duration.
- ◆ I understand that the interview and focus group transcript will be returned to me for confirmation, or for me to make changes.
- ◆ I will respect the confidentiality of all participants and not disclose any information made available to me within the focus group.
- ◆ I am aware of my right to participate, not to participate, or to participate with the right to withdraw from the study, until such time as I return each of the transcripts to the researcher for analysis.

**Te Kunenga ki Purehuroa**

Inception to Infinity: Massey University's commitment to learning as a life-long journey

**Please circle your choice**

- ◆ I agree to be interviewed and participate / but not participate in the focus group
- ◆ I agree / do not agree to the interview being audio taped. I also understand that I have the right to request the audio tape to be turned off at any time during the interview.
- ◆ I agree/do not agree to the focus group being audio taped. I also understand that I have the right to request the audio tape to be turned off at any time during the focus group.
- ◆ I wish to have the audio tape and final transcript of the interview returned to me/I consent to disposal of the audio tape and transcripts five years after completion of the research.
- ◆ I wish to have the final transcript of the focus group returned to me/ I consent to disposal of the transcripts five years after the completion of the research. (The researcher will retain and destroy the focus group audio tape.)
- ◆ I agree to participate in this study under the conditions set out in the information sheet.

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_