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

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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.

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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 20th 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.