Workplace and Occupational Aggression in First Nations and Inuit Health Nursing Stations in Manitoba Region: Incidence, Types and Patterns

by

Wendy (Hawrychuk) Ducharme

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

in partial fulfillment of the requirements of the degree of

MASTER OF NURSING

Faculty of Nursing

University of Manitoba

Winnipeg

Your file Votre référence
ISBN: 978-0-494-87175-1

Our file Notre référence
ISBN: 978-0-494-87175-1

ACKNOWLEDGEMENTS AND DEDICATIONS

I would like to thank the people who made this work possible.

To my committee: Dr. Dauna Crooks, advisor extraordinaire, thank you for agreeing to come into this process when you did, for all of your time, knowledge, wisdom and support. I know that countless hours of your time have been committed to this undertaking. To Dr. Benita Cohen and Mr. Mark Sagan- thanks for being here through "the long haul". Both of your support and direction has been invaluable. Mark - thanks for the hours of discussions about the data- how to set it up, how to analyze it... "so does that mean???" and answering my never ending SPSS questions/queries. Thank you also to U of M faculty and staff who have provided support, encouragement and wisdom along the way.

To FNIH: field and regional nursing directorate staff, this study would not have been possible without all of you. You created the data by living it, sending it forward and acting on it. You have shed more light on a very important issue. To the FNIH management team, thank you for sharing this raw data with me to help bring this issue out of the shadows.

To my friends: without you, this would not be done. A lot of "stuff" happened through it all. Alice, Brenda, Carol, Kellie, Krista, LaVona, Mel, and Tracey, I could not have done this without each of you. You have helped me more than you will ever know....

To my family: you have always been here for me, and for that I am grateful.

This work is dedicated my son, Zachary, my reason for being. Zac, it is for you, in this moment, and for your future that I want to grow, and to be a better person, contributing to a better world.

This work is also dedicated to the memory of my parents, Sharon and Mervin Hawrychuk. Thanks Mom and Dad for always loving and supporting me. W.

ABSTRACT

The existence of workplace violence in remote and isolated nursing station settings has been an area of limited knowledge to date. This descriptive study explored the phenomena of workplace and occupational aggression (WPOA), an operational definition of workplace violence created to capture all exposures to verbal and physical aggression in the 21 First Nations and Inuit Health (FNIH) managed Nursing Stations in Manitoba. Using the Manitoba Region Occurrence Reports from 2008, it was found that nurses in nursing stations experience a range of WPOA exposures with verbal incidents being more commonly reported than physical incidents. Quantitative findings related to patterns of reported WPOA with respect to timing, type, perpetrators and concurrent substance use. Themes related to the impact of WPOA on nursing staff and responses of managers to reported incidents were generated from the qualitative analysis. Recommendations for policy, administration, education and future research were generated.

TABLE OF CONTENTS

LIST OF DIAGRAMS

LIST OF GRAPHS

LIST OF TABLES

LIST OF APPENDICIES

Chapter I: Overview Of The Study

This chapter demonstrates the need to determine the prevalence of reported incidents of workplace and occupational aggression (WPOA) in the provision of nursing services in remote and isolated nursing stations in Manitoba. The context of delivering nursing services in remote and isolated First Nations (FN) communities is introduced. The purpose of the study and the research questions are identified. Critical concepts, terminology and underlying assumptions are explored. The areas of potential significance of the results and future research projects that may ensue are presented.

Background

Consistent with international health care literature, workplace violence has been identified nationally by the First Nations and Inuit Health Program (FNIHP), Health Canada as an area of concern for nursing staff working in federal facilities (Heath Canada, 2006). Incidents of workplace violence are reported by staff using the national First Nations and Inuit Health Branch Occurrence Report (see Appendix A).

Workplace violence (WPV) is a commonly utilized term in health care, business, and social science literature (Alexander, House & Fraser, 2004; Budd, Arvey & Lawless, 1996; Fernandes et al., 1999; Hegney, Plank & Parker, 2003; Howard, 2001; Neuman & Baron, 1998; Rogers & Kelloway, 1997; Schat & Kelloway, 2000). Based on a review of studies in these areas, it was evident that consistency of definitions was lacking which limits the ability to compare or generalize the findings. The lack of a consistent definition further increases the difficulty in determining the extent of the issue in workplaces as identification becomes subjectively based on individual perceptions of what constitutes violence. Terms in the existing research ranged from bad behaviour

(Griffin & Lopez, 2005), workplace incivility (Cortina, Magley, Williams, Langhout, 2001; Hutton, 2006), mobbing, bullying, horizontal violence (Chaboyer, Najman, & Dunn, 2001; Mullen, 1997; Randle, 2003) harassment (Hesketh et al., 2003; Jackson, Clare & Mannix, 2002), aggression, assault, abuse (DelBel, 2003; Hesketh et al., 2003; Jackson, Clare & Mannix, 2002), violence and homicide.

To alleviate the confusion and limitation associated with the term WPV this study utilized the term workplace and occupational aggression (WPOA) to capture the full spectrum of actions and inactions which impact nurses. By considering the literature related to human aggression in the late 1990s, Neuman and Baron (1998) defined workplace aggression (WPA) as "efforts by individuals to harm others with whom they work or have worked, or the organizations in which they are presently or were previously employed" (p.395). Their definition was intended to capture any and all forms of intentional harm doing. Neuman and Baron excluded "...serious instances of physical assault" (p.395) from their definition of WPA as they included these acts in their definition of violence. Mullen (1997) defined exposure to violence as a result of one's workplace and requirement to interact with individuals external to the staff complement as "occupational violence". She suggested that these exposures may be most applicable to service-based occupations such as health care, security/policing, or retail outlets where the employee is directly interacting with dissatisfied individuals or simply due to the intrinsic activities of the position such as aggravating pain symptoms when moving an injured patient within the health care setting or during the process of detaining a suspect in a legal context.

The critical definition for this study is that of workplace and occupational aggression (WPOA): any and all acts occurring within the workplace context, perpetrated by persons internal or external to the health care team resulting in physical, psychological or emotional harm to an individual. In this study, the term workplace and occupational aggression (WPOA) is utilized to capture the full spectrum of adverse exposures that registered nurses and other staff employed in First Nations and Inuit Health (FNIH) nursing stations in Manitoba Region are confronted with.

The continuum of WPOA is lengthy, and ranges from incivility- the nonverbal body language that expresses displeasure, negative comments from patients, families, or colleagues;and the undermining actions and activities of co-workers to the extremes of physical assault and homicide by anyone with whom the nurse interacts in the workplace (Alexander, House & Fraser, 2004; Barling, Rogers & Kelloway, 2001; Burnes & Pope, 2007; Bussing & Hoge, 2004; di Martino, 2003; Farrell, 1997, 1999, 2001; Gerberich et al. 2004; Hislop & Melby 2003; Sofield & Salmond, 2003; and Walsh & Clark, 2003).

Health Canada has developed and implemented policies, procedures and guidelines related to safety and security of staff including a zero tolerance policy, working alone guidelines, a second on call policy, and the occurrence reporting processes (Health Canada, 2004, 2005; 2007). The Health Canada Code of Conduct and human resources initiatives and processes, including informal dispute resolution and grievance processes, assist in providing clear expectations for public servants and mechanisms to improve communication when disputes do occur. It has been recognized by senior management at Health Canada that nurses providing direct patient care services may experience more frequent exposure to violence than staff working in office environments

and that the operationalization of the policies may prove more challenging in settings which are supervised from a distant central location. As a result, a number of additional supports and programs have been established to support nursing staff in the field units. These include the creation and staffing of on-site security guard positions and the introduction of having 24 hour accessibility to a Nurse Manager on Call. A regional security manager and the critical incident stress management/employee assistance program are critical resources to nurses who face or have faced WPOA incidents. In addition, FNIH has developed and implemented a two day nursing safety and awareness program which is aimed at increasing nurses' knowledge of what risks exist, individual and perpetrator characteristics, recognizing escalating situations and de-escalation techniques. The program also introduces nurses to the existing legislation, policies and guidelines within the organization, reporting requirements, mechanisms for identifying and addressing incidents and obtaining appropriate support. FNIH also encourages nurses to attend conflict resolution certification courses or information sessions related to situations that are possible to encounter in the workplace such as harassment, or dealing with difficult people.

FNIH Community Health Nurse Practice Context

In FNIH Manitoba Region, Community Health Nurses (CHNs) work in remote and isolated communities with line authority for staff and facilities management centralized in Winnipeg at the regional office (see Appendix B for the Manitoba Region nursing directorate organizational chart). In these communities, nurses are the primary point of contact for health services 24 hours per day, seven days per week. The CHNs are responsible for conducting complete health assessments and the formulation of

intervention plans that may include further diagnostics, medications or referral to additional health care providers such as physicians. The nurses utilize clinical practice guidelines and treatment protocols to provide services to patients. Nursing practice in remote and isolated communities requires that nurses utilize all of the skills developed and honed in their academic and professional careers. Nurses working in nursing stations deliver health care across the continuum of pre-conception to death, and include prenatal, obstetrical, pediatric, adolescent and adult health care. CHNs are responsible for the delivery of preventative health care, acute episodic illness assessment and management, chronic condition assessment and monitoring and urgent/emergent care for First Nation clients.

Within Manitoba region there are 21 federally managed nursing stations, three of which have year round road access and eighteen which are considered remote/isolated meaning there is only access by air, with a limited period of winter road utilization when weather conditions permit. Appendix C provides a list of the communities included in the study, and Appendix D provides a map. When the winter roads are available, they provide temporary ground access into and out of the community, thus allowing for a less expensive way for people to leave the community and to transport goods into the community. Winter roads also provide unmonitored access into communities and allow for prohibited substances to enter without restriction.

In Manitoba, the on-reserve populations served by the nursing stations range from approximately 300 to 5200 people (FNIH, 2008), with the nursing complement between 3 and 12.5 full time equivalents. Since approximately 2003, FNIH Manitoba Region has been experiencing a considerable nursing shortage, and has been heavily reliant on the

use of itinerant or agency staff to prevent facility closures. FNIH nurses work 37.5 hour work weeks with on-call responsibilities during the evenings, nights and weekends. Willingness to work overtime is a condition of employment and it is not uncommon for nurses to work an average of 35 extra hours per month in the smaller communities and 90 hours per month in the larger sites (personal communication, L. McMullen 2008). The isolation and nature of work presents challenges not typically faced by the majority of registered nurses in Canada. These include the requirement to provide continuous nursing services for prolonged periods of time due to weather and flight delays, the lack of on-site professional supervision, political influence from community leadership, and the separation from family or support networks. Many of these factors have been identified as contributing to increasing the risk of violence directed at nurses (Del Bel, 2003; di Martino, 2002; ILO, ICN, WHO & PSI, 2002; Occupational Health and Safety Administration, 1998).

Current FNIH Nursing Workforce

In 2006, the FNIHB Office of Nursing Services (ONS) conducted a Nursing Workforce Survey (Health Canada, 2006) that included all FNIH employed nurses in the regional offices, nursing stations, health centres and the remaining two federal hospitals. Contracted nurses employed by independent nursing agencies were not included in the survey. Sociodemographic and employment data related to the FNIH nursing staff was collected and is presented below.

Table 1: *Sociodemographic Characteristics of the 2006 FNIH Nursing Workforce* (Health Canada, 2006)

Age	**30 or less**	**31-40**	**41-50**	**51-60**	**61+**
% of nurses- all settings	8	18	34	36	4
% of nurses – nursing stations	11	17	31	36	4

Gender	**Female**	**Male**	**No response**
% of nurses- all settings	91	8	1
% of nurses – nursing stations	89	10	1

Aboriginal Ancestry Claimed	**Yes**	**No**	**No response**
% of nurses- all settings	23	76	1
% of nurses – nursing stations	27	72	1

Table 2: *Employment Characteristics of the 2006 FNIH Nursing Workforce* (Health Canada, 2006)

Years of RN Experience	**Less than 5**	**5-14**	**15+**
% of nurses- all settings	10	26	64

Years of RN Experience with FNIHB	**Less than 2**	**2 -5**	**6<10**	**11<15**	**15+**
% of nurses- all settings	22	24	22	12	20

Of particular note is that while 40% of the 2005 FNIH nursing workforce is age 51 or greater, 46% of the workforce has less than 5 years of nursing experience with FNIH although only 10% have less than 5 years of total nursing experience in any setting. This is important as existing literature has suggested that age and experience influence the frequency of which nurses may experience WPOA. Nurses who appear young, or new to the practice of nursing are more frequently exposed to aggression from patients, families and professional colleagues (Anderson (2002); Carmel & Hunter (1989); del Bel (2003); Fisher, Bradshaw, Currie, Klotz, Robins, Searl & Smith (1996); the ILO, ICN, WHO & PSI (2002); Jackson, Claire & Mannix (2002); and Whittington & Wykes (1996). Health care provider gender has not been found to be a consistent predictor of WPOA (USA Bureau of Labour, 1996; Anderson, 2002; Liss, 1999; Little, 1999; Shields and Wilkins, 2005).

Statement of the problem

WPOA has gained considerable attention in recent years. Within health care settings, the literature demonstrates that nurses and other health care providers regularly encounter situations that place them at risk of physical or psychological harm (Alexander, House & Fraser, 2004; Barling, Rogers & Kelloway, 2001; Burnes & Pope, 2007; Bussing & Hoge, 2004; Canadian Nurses Association, 2002; Cooper & Swanson, 2000; Farrell, 1997, 1999, 2001; Gerberich et al., 2004; Hislop & Melby, 2003; International Council of Nursing, 1999, 2000; Randle, 2003; Sofield & Salmond, 2003; and Walsh & Clark, 2003). Internationally, the areas studied most frequently include acute care settings such as emergency departments, mental health facilities, and operating rooms as well as elderly/long term care settings. As the nursing stations are the only

primary care delivery site in the communities that FNIH serves, CHNs provide services to clients that in other locations would present to emergency departments, mental health facilities or be admitted to long term care centres.

In Canada, WPOA is a recognized concern for the nursing population. The Canadian Nurses Association and nursing regulatory authorities or associations in five provinces have created or adopted position statements articulating that violence against nurses is not acceptable in the workplace (Association of Registered Nurses of Newfoundland and Labrador, 2010; Canadian Nurses Association, 2008; College of Registered Nurses of British Columbia, 2007; College of Registered Nurses of Nova Scotia, 2007; Registered Nurses Association of New Brunswick, 2008; Registered Nurses Association of Ontario, 2008). In Manitoba, the 2008 Annual General Meeting of the College of Registered Nurses of Manitoba (CRNM) saw the passing of a resolution for the CRNM to develop a position statement related to violence in the workplace (CRNM, 2008).

To date, the literature specifically directed at WPOA experiences of health care providers in remote and isolated nursing stations is limited to one Canadian study that explored Post-Traumatic Stress Disorder (PTSD) in Medical Services Branch nurses in Manitoba (Corneil & Kerwin, 1994); an unpublished Masters thesis that examined quality of work life issues of outpost nurses in Manitoba (Martin, 1997); an unpublished Masters thesis that explored horizontal violence among general staff RNs in Manitoba (Quick, 1999); and a single Australian study (Fisher et al., 1996) which aimed to validate anecdotal reports of workplace violence being directed at Remote Area Nurses (RANs).

These studies are discussed in more detail in the literature review which follows in Chapter 2. While these studies do provide valuable information, it must be recognized that the data is dated, and recognition given to the likelihood that while certain elements may remain consistent, changes to the workplace and environments are likely in the past 12-15 years. These studies identified the fact that WPOA has been a concern for nurses in remote and isolated communities for over a decade however the lack of current knowledge reinforces the existence of a knowledge gap related to these practice settings, which are very distinct from all others due to their isolation and expectations for comprehensiveness of care.

Purpose of the study

The purpose of this study was to determine the incidence and types of WPOA as reported by nurses working in Manitoba FNIH nursing stations during the 12 month period from January 1, 2008 to December 31, 2008 and to explore the actions taken at the community and regional levels to respond to the incidents. This study utilized existing administrative data submitted by nursing staff to the FNIH Regional Office Nursing Directorate on the Occurrence Report (OR) Form available in all nursing stations.

The Research Questions

Upon review of the existing literature related to WPOA in health care settings, a lack of current information related to the existence of WPOA in nursing stations in Canada and the responses to these incidents was identified. Based on the Manitoba Region occurrence report data, the incidence, types and patterns of WPOA incidents reported to the regional office in the specified 12 month period by staff working in nursing stations were determined, and the actions taken at the community and regional

levels analyzed. The two primary and four secondary research questions explored in the study are presented in Chapter 3.

Assumptions

The key assumptions related to the study population and organizational factors were identified to ensure that the methodology was appropriate to collect and analyze the data within this context.

Assumptions relative to the occurrence reports were that CHNs in Manitoba region utilize the occurrence reporting form as a standard mechanism to communicate circumstances in which WPOA occurs to their Nurse Manager, and that they utilize the definitions provided with the reporting categories consistently. For the collection and analysis of the data, the assumption was that it will of be of sufficient quantity and quality to determine the incidence of WPOA in FNIH managed nursing stations in Manitoba region and allow for the development of insights into the actions taken to respond to incidents at the community and regional levels.

Significance of the study

WPOA is an area which, while receiving considerable attention in the past decade, remains understudied within the context of nursing in remote and isolated communities. Further, a lack of consistency in terminology impedes the ability of researchers, decision makers and health care providers to interpret the exiting literature.

At the present time, nursing is a high demand profession from two perspectives. Nurses are increasingly responsible for providing care in a health care system being stretched to meet the needs of a growing population with increasing acuity and service demands, as well as the increasing health human resources shortage which is being

exacerbated by an aging nursing workforce (Health Canada 2005 and 2007). For FNIH, both of these factors influence the organization's ability to provide services to communities. As the health care workforce continues to face shortages in providers, it is essential that organizations are clear on factors which may impair their abilities to recruit and retain staff, and that managers are able to provide supports to employees who face circumstances of a negative nature, such as incidents of WPOA.

The study results provide additional knowledge related to WPOA exposures and responses to the incidents. This data will potentially impact the conditions of the existing nursing workforce, as well as having potential implications for recruitment and orientation of new staff. Specifically, it identifies the reported incidence and types of WPOA and the patterns which are present. The responses to the incidents have been analyzed and actions taken to address situations identified. Analysis of patterns was conducted and recommendations were made for staff protection and management of WPOA incidents. A new method to categorize the occurrence reporting data was created, and may be useful for the timely and ongoing analysis of reports submitted. Recommendations for policy, protocol and practice modifications have been made based on the existing research and the findings of the study.

From a broader nursing perspective, this study provides a definition of WPOA that may be used to describe the phenomenon in any practice setting and fully capture the spectrum of behaviours which may be directed at individuals. This definition is valuable to the profession of nursing in that if nurses consistently apply a broad definition of violence, it may assist in the recognition of the magnitude of this issue and the impact on health care providers. Additionally, the information obtained in this study will be useful

in informing employers in settings in which nurses deliver primary health care services of the extent of the issue and possible strategies to reduce the occurrence of, and improve responses to, incidents which do occur. Finally, this study also provide suggestions for areas of further exploration of WPOA in this or other settings, recommendations for the education and preparation of nurses who may encounter WPOA situations, what responses may occur on the part of those involved and the responses required by mangers when incidents do occur.

Conclusion

Nursing in remote and isolated communities is a complex, challenging and rewarding role. WPOA is an ongoing, but understudied, area that impacts nurses' abilities to provide health services and the ability of the organization to recruit and retain qualified nursing staff. This chapter has provided background information about the role of nurses and the circumstances in which they work. WPOA was defined, and research questions and hypotheses identified. The assumptions relevant to the development of the study methodology were presented and implications clarified. The significance of the study for remote and isolated nursing practice, as well as future impacts and opportunities for future research were identified.

Chapter II: Literature Review

Violence is a part of the world in which we live. The literature review guiding this study explores violence from a broad to increasingly focused perspective, looking at social, cultural, and individual factors which contribute to aggressive acts within societal and workplace environments. In the workplace literature reviewed, researchers discussed prevalence of various types of workplace aggression, as well as situational and individual variables contributing to environments in which violence occurs. Particular attention was paid to workplace violence literature in rural and remote health care settings as this is the context in which this study took place. In conducting the literature review, the health care, social sciences, scientific and business/administrative databases of CINAHL, PubMed, ProQuest: ABI/Inform, PsycINFO, Social Science Abstracts and Violence Abuse Abstracts were searched. The search terms included "workplace violence", "workplace abuse", "workplace aggression", "workplace assault", "nurses", "health care", "occupational violence", "occupational injury" and variations thereof. The most relevant findings are presented below.

Violence- A Global Issue

The World Health Organization (WHO) adopted Resolution WHA49.25 (WHO, 1996). This resolution declared violence a growing public health problem across the world. It drew attention to the short and long term consequences of violence to individuals, families, communities and countries. Resolution WHA49.25 also highlighted the impact of violence on health care resources.

The WHO *World Report on Violence and Health* (2002) raised awareness of visible and invisible violence globally and provided insight into the role of public health

in addressing causes and consequences. Krug, Dahlberg, Mercy, Zwi & Lozano (2002) state that annually, over one million lives are lost due to interpersonal, collective or self - inflicted violence. As non-fatal injuries are more difficult to reliably track, this number does not include individuals injured in violent incidents. Krug et al. (2002) suggest that the financial impact of violence translates into billions of dollars in national economic expenditures due to lost work time, productivity, law enforcement and legal costs, as well as the billions of dollars of direct heath care expenditures in caring for those involved in the violent acts. Some causes of violence are evident, while others are rooted in sociocultural economics. For example, the research of Baron & Neuman (1998) and Krug et al. (2002) demonstrated that biology and other individual factors may explain predisposition to aggression yet the expression of the aggression often occurs as a result of interactions with external factors within homes, workplaces and community settings.

The 2002 WHO *World Report on Violence and Health* defined violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (p.5). The intentionality of the act is a focal aspect of the definition with the outcome being irrelevant. If aggression is intended and the outcome may lead to the consequences identified, then the act would constitute violence. While physical force has been clearly recognized in the literature as constituting violence, the misuse of power had not been clearly articulated as violence until recent years. By the inclusion of power as a variable in the definition of violence, it allows for a greater breadth of acts to be recognized for their detrimental impacts. Krug et al. (2002) state that within the definition of violence

"[the use of physical force or power] should be understood to include neglect and all types of physical, sexual and psychological abuse, as well as suicide and other self-abusive acts" (p.5). Of note is that the definition also identifies potential outcomes of violence. The inclusion of injury, psychological harm, maldevelopment or deprivation is significant in that these less overt and often unquantifiable impacts yield significant burden to individuals, families, communities and countries that may be of short- or long-term duration.

Violence in Canada

According to a report on criminal victimization in Canadian workplaces (de Leseleuc, 2007) 17% of all self-reported incidents of violent victimization occur at a place of work, representing over 356,000 incidents annually. Between 2001 and 2005, there were 69 workplace homicides reported, 3 of which occurred in the health/social services sector. Individuals working in environments with direct client contact were identified as being at increased risk. Of the violent incidents captured in this period, the majority were in the health care or social assistance sector (33%), restaurants/ accommodations industries (14%), and academia (11%). The rates of male and female victimization were similar, 47% and 53% respectively.

The 2004 General Social Survey (GSS) (as cited by de Leseleuc) identified that in the majority of WPOA incidents (66%), the perpetrator is known to the victim, and of those, 38% are patients, clients, former co-workers or others, 18% are coworkers, and 11% are persons "known by sight". Only one third of WPOA incidents are committed by strangers. Most violent acts were committed by individuals (93%) and of those, 93%

were males with most (53%) under 35 years of age. Intoxicants or illicit substances were involved in 46% of incidents and 19% involved the use of weapons.

Physical injuries were reported in 21% of the events, with males reporting slightly more than females (27 % vs 17 %). Emotional/psychological injury was reported by 73%, of those 21% stated they were angered, 20% upset, confused, and frustrated, 15% voiced fear and 25% found it difficult to carry out day to day activities following the incident.

In the GSS, under-reporting of violent acts was identified as a common theme with 73% of incidents going unreported. Respondents provided the following reasons for not reporting; they had "dealt with it another way" (74%), believed it was not important enough (44%), did not want police involved as it was a personal issue (31%) and 30% did not want to have involvement with the police. Conversely, of the 37% of reported incidents, 97% stated they did so due to a duty to protect others. Males tended to report workplace violence more frequently than females (57% vs. 20 % respectively). It was suggested by the author that this may be related to the severity of injury and type of assault, with males experiencing more severe physical assaults. While females experienced more sexually directed assaults, these incidents frequently go unreported for a host of reasons including fear of negative publicity, impact on current and future relationships and self-directed guilt resulting from established stereotypes of victim blaming commonly seen with unwanted sexual advances. However, when weapons were involved in the workplace, 58% of incidents involving either gender were reported. Of the incidents reported to police, the investigation and actions taken when workplace-

related were higher compared to those incidents which occurred outside of work contexts.

The final area discussed in the profile on criminal workplace victimization was victim support. While it is known that many organizations offer employee assistance programs, the majority of victims (96%) sought assistance from informal supports, approximately 9 out of 10 from co-workers, 68% from family, 64% from friends or neighbors and 20% from nurses or physicians.

In a study of violence in the Canadian workplace with employed university student subjects, Leck (2005) found that workplace factors influenced the potential for, and creation of, situations leading to WPOA in conjunction with individual personality factors. This finding is consistent with those of Neuman and Baron (1996, 1997 & 1998) who have done considerable research in the area of workplace and occupational aggression. Leck suggested that change, uncertainty, increased workload, job insecurity, new or changing technology, decreased pay or benefits, poor or non-existent training and poor supervision are factors which contribute to negative workplace climates. She goes on to state that anything that may threaten the personal, physical, financial or social well-being of employees is the most potentially dangerous. Workplace practices such as interactional and procedural injustice which can be seen as a lack of transparency or fairness, modeling of aggressive or violent behavior by supervisors, and rewarding or promotion of employees viewed as "tough" can serve to further damage the work environment. Additional factors which heighten WPOA risk have been identified by the Canadian Centre for Occupational Heath and Safety (CCOHS, 2008). These include: working with the public; handling money, valuables or prescription drugs; inspection or

enforcement duties; providing services, care, advice or education; working with unstable, volatile persons, or those with impaired judgment due to medical or other factors; working where intoxicants are served or purchased; working alone or in low traffic areas; working in community-based settings or with a mobile workplace; and working in intense organizational change circumstances. CCOHS also indicates that geography may impact violence risk such as being in isolation from other workplaces or in proximity to high crime areas. CHNs working in FNIH nursing stations face many of the circumstances described by CCOHS on a regular basis.

In the next two sections, information from Health Canada and other sources will be provided in order to enhance understanding of the community context and geographical issues which impact the delivery of health services to First Nations communities.

Violence in First Nations Communities

The demographics of the on-reserve population served by FNIH nurses are different than that of the general Canadian public. The population is considerably younger than the national average and growing at a higher rate. The *Statistical Profile on the Health of First Nations in Canada (Health Canada, 2005*) identified that on-reserve First Nations form approximately 1.3% of the total Canadian population. First Nations birth rates are two times greater at all ages than the national average, their population proportion between the ages of 15-19 is five times greater, and between 20-24 years of age it is three times greater. The overall mortality rate in First Nations is approximately 45% higher with significant rates of chronic disease burden and mortality due to injury. Communicable disease rates in First Nations were substantially higher than that of the

general Canadian population with diseases such as shigellosis and pertussis were reported as double, sexually transmitted infections reported as seven times greater, and tuberculosis reported as six times greater (Health Canada, 2005). The elevated rates of illness related to chronic conditions, communicable diseases and injury increase the need to access health services, and provide more opportunities for interaction with nursing staff.

Determinants of Health - On-Reserve First Nations Data

As violence has been identified more frequently when social determinants of health are not optimal within communities, (Krug et al., 2002), it is important to consider the major areas of education, employment, income levels, and housing as well. The 2001 Statistics Canada census demonstrated that 58.9 % of people living on-reserve had not completed high school. In 2006, the Statistics Canada census data revealed that 35% of on-reserve First Nations people had completed post secondary education, with females being more likely to have done so that males (44% and 39% respectively). The employment numbers indicate that the on-reserve first nation population experienced higher levels of unemployment than the off reserve First Nation population, (49.1% versus. 43.7%). The unemployment rate, namely those persons who were unemployed but actively seeking employment, was 27.1% for on- reserve First Nations males, and 18.5 % for on-reserve First Nations females. Consistent with the lower education and employment data presented is lower income, with that of on-reserve First Nations being approximately $11, 000.00 less than the median annual income of other Canadians.

Housing was also identified as an area in which Aboriginal on-reserve dwellings were not comparable to those of the general Canadian population with 44.0% requiring

major repairs compared to 7.0% (Statistics Canada, 2006). Indian and Northern Affairs Canada (INAC, 2000) identified overcrowding on-reserve as an additional issue, stating 19% of on-reserve dwellings had more than one person per room compared to 2% of the general Canadian population dwellings. This was re-affirmed by the 2006 census data which indicated that 26% of First Nations people living on reserve lived in crowded homes. Both the quality of housing and the overcrowding have been linked to communicable disease outbreaks (Krug et al., 2002). Brzozowski, Taylor-Butts and Johnson (2006) also suggest that overcrowding may be a factor in the circumstances that lead to aggression and violence.

The determinants of health discussed, combined with age (in particular, youth) and high residential mobility, have been identified as factors in the risk of criminal offending and victimization in the Aboriginal population (de Leseleuc, 2007). Within the context of workplace and occupational aggression in on-reserve nursing station settings, it is important to consider these facts when discussing the experiences of nurses in their interactions with community members.

Violence and Victimization in Aboriginal Populations

Brzozowski et al. (2006) indicate that significantly more Aboriginal people are likely to experience a violent victimization than non-Aboriginal people. Aboriginal people were defined as both status/ non- status First Nations Inuit and Metis individuals The Aboriginal female victimization rates were identified as being 3.5 times greater than that of non-Aboriginal females, and males were almost three times higher. These incidents were more likely to be committed against youths or young adults between the

ages of 15-34 and frequently (56%) were perpetrated by individuals known to the victim such as relatives, friends, neighbours or acquaintances.

In the areas of reporting of violence, weapons use, injury and alcohol or drug use, the numbers involving Aboriginal and non-Aboriginal people remained similar; however spousal violence and homicides are significantly higher. Twenty-one percent of Aboriginal people and 6% of non-Aboriginal people reported spousal abuse in the preceding 5 years. Brzozowski et al. also report that the Aboriginal victims of spousal assault suffered more severe forms of violence including being beaten, choked, threatened or assaulted with a knife or gun, or sexually assaulted (41 % vs. 21%). When considering assault against female victims only, the difference was heightened further (54% vs. 37%). Domestic situations have long been recognized as high risk for social services staff responding to the incident, namely police and health care staff caring for the victims (Health Canada, 2005, 2006). In the case of spousal abuse, alcohol or drug use was identified as a factor, with Aboriginal victims indicating the aggressor had been consuming substances prior to the incident 48% of the time compared to 33% of non-Aboriginal involved incidents. The homicide figures presented indicate that the Aboriginal homicide rate for the period of 1997-2000 was almost seven times higher than the non-Aboriginal homicide rate with the male rates greater than double that of females. Aboriginal victims were more likely to have consumed intoxicants (82% vs. 45% of non-Aboriginal homicide victims) prior to the violent incident.

When considering perpetrators of violence, for the period of 1997-2000, it was found that Aboriginal persons were approximately 10 times more likely to be accused of

committing homicide than non-Aboriginals. However the charges against Aboriginal people tended to suggest more impulsive or emotional acts (Brzozowski et al., 2006).

By utilizing information contained in police databases, Brzozowski et al. were able to determine that the crime nature and rates on and off reserve vary considerably. Of the approximately 93,000 Criminal Code incidents on-reserve in 2004, 55% were classified as "other" Criminal Code offences such as mischief or disturbing the peace, 25% were "violent" and 21% were property offences. Off reserve, the majority of crimes were "property related" (51%), with 38% "other", and 11% "violent" offences. The rate of on-reserve crime was identified as 3.5 times higher, and violent crimes such as assaults occurred at a rate of eight times greater, sexual assault seven times higher and homicides six times greater. The "other" criminal code violations such as disturbing the peace and weapons offences were also identified as occurring more frequently on-reserve, twelve and seven times so respectively.

As can be understood from the information presented, communities are often faced with difficult circumstances and are challenged to meet the basic determinants of health. Community leadership works with community members, government and non-government organizations to provide opportunities for education, employment and infrastructure enhancement. Multiple agencies provide supportive services to the communities including child and family services agencies, education, economic development, health and policing. As part of the service providers to communities, nurses are actively involved with the individuals that are facing these situations daily.

Workplace and Occupational Aggression in Health Care Settings

The administration, health care, social sciences and occupational health and safety literature is rich with studies that explore risk factors for workplace and occupational aggression. For the most part, agreement within the literature exists in recognizing that aggression results from the complex interactions that exist between organizational and individual factors. Societal factors are also discussed in some of the literature and intuitively fit within the context of violence in settings where culturally, or as a result of economic, political or religious considerations, aggression is implicitly or explicitly condoned (Folger & Baron, 1996; Levin, Hewitt& Misner, 1998; Paul & Townsend, 1989). Several authors (Anderson, 2002; Skillen, 1996; and Lee et al., 1999) identify organizational factors such as lack of policy, organizational culture and ineffectual management as factors that may contribute to risk of both workplace and occupational violence. Policies that are viewed as arbitrary or limiting of personal autonomy or professional advancement have also been suggested to be influences that work toward creating negative work environments (Cortina, Magley, Hunter-Williams, & Day-Langhout, 2001; Hershcovis et al., 2007; Howard, 2001; Schat & Kelloway, 2000). Within FNIH, policies related to hours of work, travel and provision of medical supplies, equipment, or pharmaceuticals are often sources of conflict identified by nurses and support staff in communities (personal communication, Nurse in Charge Conference, 2007 & 2008).

Facility issues that place staff at risk include lack of security systems (Skillen, 1996), or ineffective security systems (Lee et al., 1999), improper control of keys, and poor maintenance resulting in breaches of entrance points or barriers to egress points (M.

Purcell personal communication, March 21, 2008). Physical layout that contributes to "blind spots", isolation and room layout that situates staff further from exit points than the perpetrator may also increase risk. Ambient factors such as temperature, lighting, noise, overcrowding, and uncomfortable seating have also been suggested as factors that may contribute to aggressive behaviors in research conducted in emergency departments (Lanza, Kayne, Hickes et al., 1994; Owen, Tarantillo, Jones and Tennant, 1998). In Manitoba region, issues related to facility layout, maintenance and security have been identified as concerns and are being evaluated (personal communication, M. Purcell, June 15, 2008). Increased recognition of these concerns has resulted in modification to the standard facility specifications for construction of new nursing stations and residences.

Health care settings, while not exclusive in needing to contend with the circumstances presented, face increased risk by virtue of the services that are delivered. In addition to the factors identified by CCOHS (2008), working alone or in small numbers, conducting home visits, and working evening or night shifts demonstrated increased risk. Numerous studies have indicated that health care providers face particular risk due to the nature of their interactions and the circumstances under which they occur (Anderson, 2002; Awadalla & Roughton, 1998; Elliott, 1997; Lee, Gerberich, Waller, Anderson & McGovern, 1999; Skillen 1996). Health care professions are frequently in contact with individuals facing difficult and stressful circumstances, possibly related to injury, pain, or life threatening illness, which may influence emotional and cognitive responses to stimuli. Elliot (1995) also suggests that the lack of

community mental health services and the move toward de-institutionalization of mental health patients further increase risk in some health care settings.

Nursing Variables Associated with Increased Risk

Nursing has often been called a caring profession. Inherent in this is the tendency for nurses to put patients' needs first, and in doing so lies the potential for nurses to inadequately assess the risk being faced (Anderson, 2002). Additionally, nurse's own experiences shape their perceptions of situations and definitions of what constitutes violence or aggression, as does the socialization process that occurs throughout the education and work life of a nurse. The belief that certain exposures are "part of the job" serves to increase potential for harm to nurses.

Tolerance of incivility, procedural injustice, and promotion of aggressive personalities has also been implicated in creating work environments that condone or perpetuate aggression. Anderson (2002), Elliot (1997), Skillen (1996), and Whitley , Jacobson and Gawrys (1996) suggest that job stress due to poor staffing, hours of work, and training inadequacy also contribute to increased risk. Within the FNIH nursing stations, nurses are working at minimum staffing levels, providing 24 hours per day, seven days per week services, and are often in situations where the other nurses they are working with may not be adequately prepared for the role (personal communication, NIC conference, 2007 & 2008).

Personal characteristics may also contribute to the level of risk that nurses face. In several studies (Anderson, 2002; Liss, 1993; Little, 1999; and Shields & Wilkins, 2005), males were found to be at increased risk, however, the 1996 US Bureau of Labour Statistics identified that females were at higher risk of exposure to aggression or

violence. While not conclusively proven, it is suggested that males may be expected to manage specific patient types, assist in situations where behaviour becomes inappropriate or that males may report incidents more frequently. Nurses who appear youthful in age or experience have been found to be the targets of violence or aggression more frequently than their older, more experienced counterparts (Carmel & Hunter, 1989 and Whittington & Wykes, 1996). While age and experience may prove somewhat protective from direct aggressive interactions, repeated exposures or witnessing events may impact on the physical and psychological well-being of the nurse, and influence interactions he/she has with patients, families and coworkers.

As a predominantly female workforce, much of the nursing literature has identified gender oppression as a variable in exposure to WPOA and the reluctance to report incidents. Similarly, it has been found that nurses with a past personal abuse experience may be at greater risk of workplace abuse, with Little (1999) and Anderson (2002) suggesting that nurses with a history of witnessed or experienced child abuse may be at a revictimization risk of up to 72 percent. Stevenson (2004) suggests that stressors external to the workplace may influence the judgement of nurses, making them increasingly susceptible to misreading environmental cues. In situations where patient volatility is a factor, the ability to be fully attuned to the circumstances in which the nurse is involved is essential.

Perpetrator Variables Associated with Increased Risk

Inherent in risks associated with providing health services must be consideration of the populations nurses work with. Nurses deal directly with patient and families who may be experiencing considerable stress due to illness, injury or pain. Nurses also work

with patients and families who may be mentally incapacitated due to injury, illness, use of intoxicants, narcotics, or illicit substances. Others with whom nurses may interact include patients who are socially or economically disadvantaged, connected with active criminal activity or in a state of despair. While much of the literature to date has been conducted in urban settings in acute, rehabilitation/chronic or long term care settings, it is important to note that the types of client presentations seen in these settings may also occur in nursing stations.

It has long been recognized that some medical conditions may contribute to decreased impulse control or a demonstration of aggressive behaviour. While not excusable, nurses must be cognizant that persons with specific psychiatric diagnosis or cognitive impediments such as borderline personality, schizophrenia, bipolar disorders, mania, postpartum psychosis, depression, and mental retardation may present increased risk, in particular when medication compliance is questionable (Distasio, 2002; Lewis & Blumenreich, 1993; Littrell & Litrell, 1998). Lewis et al. (1993) found that brain dysfunction was present in 11% of incidents in which patients lost control. Increased risk of violence is sometimes associated with organic brain disorder, dementia, delirium, metabolic disorders (anoxia, hypoglycemia, hyperthyroidism, Cushing syndrome, electrolyte imbalance, hypo/hyperthermia, vitamin deficiency), seizure disorders (post-ictal states and temporal lobe epilepsy), substance abuse (intoxication and withdrawal), brain trauma, brain tumor, meningitis and encephalitis (Distasio, 2002; Lewis & Blumenreich, 1993; Littrell & Litrell, 1998; Presley & Robinson, 2002; Whitley et al., 1996). In the studies by Martin (1997) and Fisher et al. (1996), similarities related to perpetrators were identified, with many individuals being patients or family of

individuals receiving care, predominately male, and often under the influence of alcohol, drugs or other mood altering substances. Perpetrators tend to be young males with lower socio-economic status, education levels and a lack of strong social or familial networks (Lewis & Blumenreich, 1993; Littrell & Litrell, 1998; and Mossman, 1995). Anderson (2002), Lee et al., (1999) and Littrell & Litrell (1998) suggest that patients or families with a past history of abuse or a chronic pattern of self-harm are also present an increased risk to health care staff.

It is important to note perpetrators of WPOA may not only be persons external to the health care team. Research has demonstrated that professional colleagues are a common source of aggression in the workplace. Nurses have been identified in the literature as a group who "eat their young" (Longo, 2007) and the phenomenon of horizontal violence has been demonstrated in studies conducted in numerous clinical and academic settings (Duncan et al., 2001; Farrell, 1997, 1999; Glass, 2003, 2003; Hegney, Eley, Plank, Buikstra & Parker, 2006; McKenna, Poole, Smith, Coverdale & Gale, 2003; McKenna, Poole, Smith & Coverdale 2003; Randle, 2003). These studies also demonstrate that nurses may experience WPOA from fellow nurses, physicians, professional colleagues, managers and, occasionally, subordinates (Quine, 1999).

Recognition and understanding of factors associated with and contributing to violence is essential in order to equip staff with the tools to be prepared for aggression; however aggression and violence, while endemic in health care, must not be considered an acceptable occupational hazard (Forrester, 2002).

Workplace and Occupational Aggression Statistics in International Health Care Settings

In 2000, the International Council of Nurses (ICN) created two position statements directed to the recognition and need for elimination of violence in health care workplaces. In recognition of the issue, the ICN collaborated with the International Labour Office (ILO), the World Health Organization (WHO), and Public Services International (PSI) to define and study the phenomenon of WPOA. Studies using the same research protocol were conducted in Australia, Brazil, Bulgaria, Lebanon, Portugal, South Africa, and Thailand. The data collected demonstrated that in a 12-month period, between 3 and 17% percent of respondents experienced an assault, 11% to 31% had been bullied, and 27% to 67%had experienced verbal abuse. The data obtained in the studies indicated that in all countries, of the health care providers considered, nurses and ambulance staff were at the greatest risk for workplace violence.

Numerous studies have been done internationally, however it is challenging to compare the findings as the definitions are not consistent, nor are the methods used to collect and analyze the data. However, in the emergency department and psychiatric or mental health settings, which share similar practice populations as CHNs in remote and isolated communities, nurses reported exposure to WPOA frequently. While the terminology and measures differed, consistent themes emerged in the types of exposures and the perpetrator characteristics. Verbal abuse and threats were most common, with varying degrees of physical abuse also occurring on a frequent basis. Particular patient groups were identified as high risk and the studies suggest that nurses working with these populations require the ability to recognize the potential for violence. The presence of a

mental health diagnosis or use of mind altering substances/intoxicants by patients/families was also identified as being a common theme in violence exposures. Organizationally, it was identified that staff education and management recognition of the significance of WPOA were essential in supporting an already taxed workforce. Specific findings and recommendations from studies in emergency and psychiatric/mental health practice settings are provided in Appendix E and F.

Workplace and Occupational Aggression in Canadian Health Care Settings

Canada has long recognized the existence of workplace violence in health care settings. The Canadian Nurses Association (CNA) *Position Statement on Violence* indicates that "nurses are at particularly high risk of verbal and emotional abuse, physical violence and sexual harassment in the course of their work" (CNA, 2002, p.1). The CNA statement calls for the elimination of violence toward nurses and supports zero tolerance policy implementation. Nursing regulatory bodies and professional associations in Ontario and Nova Scotia have created practice guidelines aimed at supporting nurses and employers in creating work environments that are respectful and move to eliminate violence and aggression. However, the impact of these actions has yet to be demonstrated.

In exploring the violence in a large acute and tertiary care facility in Manitoba over a two year period, Yassi (1993) identified that there were 242 abuse related injuries reported and 646 incidents of verbal abuse and threatening behavior reported. Of these, the vast majority involved nursing staff. The findings of her study were directed at the exploration of types of injury, productivity, work time lost and compensation and, while dated, they are valuable in illuminating the extent of violence in the early 1990s. Yassi

found that over 8000 work hours were lost due to injuries sustained as a result of violence, with psychiatric nurses experiencing the highest rate of injury. For an assault-related injury, the Workers Compensation Benefit wage loss cost for one case was in excess of $65, 000.

Hesketh et al. (1999) surveyed registered nurses in Alberta and British Columbia and determined that the incidence of violence was dependant on type of work setting. In the 1999 study, nurses were asked to consider their previous five shifts when responding to the questionnaire. The data related to type of violence per specialty is provided in Table 3.

Table 3:*Percentage of nurses experiencing violence by type and nursing specialty*

Hesketh et al. (1999)

	Medical/ Surgical	**Critical Care**	**Emergency**	**Psychiatry**	**All other units**	**Multiple units**
Physical assault	24.2	11.8	21.9	20.3	14.4	18.1
Threat of assault	22.6	8.9	39.9	43.3	12.8	18.6
Emotional abuse	41.4	28.2	62.4	55.0	30.3	36.9
Verbal sexual harassment	8.6	5.4	12.7	19.5	5.5	6.6
Sexual assault	0.7	0.7	0.5	0.8	0.7	0.3

As is demonstrated, nurses working in emergency, psychiatry, and medical surgical units experienced workplace violence to a greater extent than other settings. In most settings, the common perpetrators of violence were patients and their families or

friends. However, in critical care, hospital co-workers were the primary aggressors of emotional abuse (56.7%) and verbal sexual harassment (53.6%). When considering the five previous shifts, 14% of critical care nurses had been subject to emotional abuse by a co-worker in contrast to 7.8% of nurses in all other settings cumulatively. While these numbers identify significant concerns, the authors indicate that they may still be an under-representation as the survey captured only the proportion of nurses experiencing violence, and not actual frequency of events. Hesketh et al. (1999) noted that only 42% of patient related abuse and 33% of family /visitor abuse was reported. The reporting of violence perpetrated by physicians and nursing co-workers was found to be even lower, at 27% and 19% respectively. These findings demonstrate that WPOA is under-reported regardless of the perpetrator and their relationship to the nurse.

In the 1996 study of a Vancouver emergency department, Fernandes et al. found that 68% of respondents had noted an increase in the frequency of violence and 60% noted an increase in severity over time. Contrary to many studies, most respondents included witnessing verbal or physical abuse (78%) or threats of physical abuse (86%) in their definitions of violence. The authors found that 92% of respondents had experienced verbal abuse, 97% physical threats, and 92% had been physically assaulted. Of these, the majority felt that the incidents were under-reported with 54% who had incurred no physical injury with the assault only "rarely" reporting incidents. Individuals who had been injured reported at only a slightly greater percentage (56%). The impact was significant in that WPOA had resulted in twelve people leaving the department, and employees who had been abused or witnessed abuse reported reduction in performance during the reminder of the shift or even the next several shifts. Staff reported feeling

fearful of patients (73%), hiding their identities (49%) and experiencing reduced job satisfaction (74%).

The 2005 *National Survey of the Work and Health of Nurses* (NSWHN) collected data related to workplace injuries, violence and stress. Reporting on the findings, Shields and Wilkins (2005) indicated that 9% of nurses experience injuries on the job. Of those reporting injuries, 11% were hospital based, and 10% occurred in long term care settings. Injuries in community and other settings occurred less commonly. However, the survey demonstrates that nurses experience both physical and emotional abuse in the majority of work settings. In the year preceding the study, 28% of female nurses and 44% of male nurses were assaulted by patients. Analysis of the data could not attribute the male/female gap to any specific factors and it was suggested that reporting patterns may have contributed to the difference. Of the patient initiated assaults, 50% occurred in long term care, 30% in hospitals, 9% in community, and 10% in other unspecified settings. Emotional abuse was more frequently identified by nurses in all settings, and 44% of nurses involved in providing direct care reported experiencing emotional abuse from patients. Of those, 54% were male, and 43% were female. The age of nurses who experienced increased incidents of emotional abuse were younger than 45 years (47%), with the nurses aged 55 or greater reporting fewer incidents (38%). Of the patient-initiated emotional abuse, 48% of staff in long term care, 46% in hospitals, 34% in community, and 29% in "other" settings reported having been exposed. Emotional abuse by visitors was reported by one in 6 nurses, and by 20% of hospital staff. One in 12 nurses reported emotional abuse by physicians, of which 12% were in hospital settings, and 2-4% in other settings. Co-workers were indicated as perpetrators of emotional

abuse by 12% of nurses. Co-worker abuse was more common in long term care and hospital settings.

The NSWHN linked violence to workplace stress and respect in the workplace. It demonstrated that low co-worker support, low supervisor support, high job insecurity and high physical demands all contributed significantly to job strain in nursing. In all of these areas with the exception of low co-worker support, slightly more female nurses reported experiencing these states. For both males and females, the percentages reporting job strain, low support levels, and high physical demands were greater than those expressed by employed Canadians overall. This finding serves to demonstrate the intensity of the health care context and the impact it has on nurses. Respect is also central in nurses' ability to function, and has been identified as a factor in perpetration of violence. The NSWHN identified that in all settings, nurses felt they were not respected by supervisors (between 11-20%) and colleagues (4-9%), nor were they viewed with what they felt to be the appropriate prestige for the work they were doing (11-19%). As was identified in the discussion about risk factors for workplace and occupational aggression, lack of respect erodes the work environment and has been identified as a potential factor in perpetuating aggression.

Several Canadian studies looking at work organization and staff mix have yielded findings that are relevant to the discussion of workplace and occupational aggression. Of note is the 2003 study by Ostry et al. which explored care models for elderly patients requiring alternate levels of care. In their study, it was demonstrated that violence-related patient care injuries to staff increased in units that had a mix of patient types (general medical floors- 33.3%) compared to those dedicated to elderly patients (16.7%)

or specialized geriatric assessment units, or units that did not provide care to this patient group (13.5%). This is significant in that nursing station environments deal with populations across the lifespan and would be comparable to a mixed patient type setting/general medical unit versus a specialized unit. Yassi, Gilbert and Cvitkovich (2005) also explored injuries, illness and policies in health care settings and discovered that, in Canada, up to 4.4 violent incidents per 100 person years causing injury are occurring. It was determined that most do not result in overt time loss; however, as will be discussed in the impacts section to follow, the outcome may not be directly quantifiable but may have significant personal and organization implications

Workplace and Occupational Aggression in Rural and Remote Health Care Settings

While aggression in health care is a widely studied area, a gap in the literature remains when considering rural and remote practice contexts. Specific to rural and remote practice settings, only studies in Australia and Canada were found. Tolhurst et al. (2003) explored rural general practitioners' apprehension related to work-related violence. They found that concerns related to violence had impacted the practice of rural physicians. While the majority of practitioners continued to provide services as they had in the past, many had altered their approach to situations that were deemed to be high risk, particularly in relation to home visiting. Physicians also indicated that they had implemented policies for dealing with violence in their practices, enhanced security measures, discussed aggression with staff and partners in practices and carried cellular phones when conducting home visits. Male physicians demonstrated lower frequencies of feeling apprehensive than their female counterparts although very few practitioners

indicated feeling apprehensive "almost always" in any of the work circumstances discussed, with "sometimes" and "almost never" making up the majority of responses. The study demonstrated that concern related to the potential for violence can impact service delivery and health resources in communities. As such, the implications for consumers, funders and providers of health care services are significant, with the potential for health care provision in rural areas to experience a shift in how after-hours services are accessed being a possible outcome.

In the second Australian study (Alexander, House and Fraser, 2004) exploring occupational violence in rural settings, the authors included allied health providers, general practitioners and nurses. They found that nurses experienced all types of violence, with the exception of telephone threats from all sources (patients, families, co-workers), more frequently than allied health providers or General Practitioners (GPs). Table 4 presents the types of violence experienced by the care providers.

Table 4: *Types of Violence experienced by health professionals (Alexander et al., 2004)*

Type of violence experienced	**Nurses**	**Allied Health**	**General Practitioners**
Verbal abuse	82%	64%	62%
Threatening behavior	61%	37%	49%
Physical violence	34%	11%	21%
Obscene behavior	59%	12%	24%
Telephone threats	25%	17%	28%

The authors indicate that the study confirms that violence in health care is not confined to any unit or practice setting, and must be part of the considerations undertaken by health care managers in education, priority setting and resource allocation decisions.

The third and final Australian study (Fisher et al., 1996) is most similar to the practice context of FNIH nursing station staff and explores the emotional, verbal and physical violence experiences of Remote Area Nurses (RANs). The study was both qualitative and quantitative with a response rate of 41% to the questionnaire component. Greater than three quarters of respondents had worked in remote areas for more than two years. Respondents worked in communities of varying sizes, 35% of which had populations of less than 500, 36% in communities between 501-1200, 21.9% between 1201 and 3000, and 6% with community populations exceeding 3000 people. Nurses provided the available on-site health services in the communities, 29.3% of whom worked with another health care provider but were the sole Registered Nurse, 25.5% of whom were the sole health care provider in the community, and 30.4% of nurses who worked with another Registered Nurse. Forty-one percent of respondents indicated that they were not operating at their full staff complements, and 82% indicated that 24-hour call services were included in their responsibilities. Physician services varied widely with approximately half of the communities receiving services on a weekly or biweekly basis and the remainder receiving sporadic services on a monthly basis or when emergently required. RANs frequently lived alone (63.4%) and in government-supplied residences (58.6%). The study identified that nurses who did live in government housing tended to be exposed to all types of violence more frequently than did their counterparts living in community provided or their own accommodations.

Nurses identified that they had felt unprepared for aspects of their role including the clinical and cultural competencies and skills required. The majority had not received an orientation, and of those who did, most did not feel it was sufficient. As has been demonstrated in other workplace violence literature, reporting of violence was not undertaken regularly when incidents did occur. RANs indicated that previous responses to reporting of incidents had influenced their willingness to report situations, and only 52.8% indicated that they officially report all incidents of violence.

The study explored the RANs experiences with violence over a twelve-month period using a structured, retrospective recall questionnaire. The findings are presented in Table 5.

Table 5: *RANs violence experiences for the previous 12 months when 24-hour call responsibilities were or were not required* (Fisher et al., 1996)

Type of violence experienced	**Overall %**	**24 hour call required**	**24 hour call not required**
Verbal aggression and obscene behavior	82.1	88.4	11
Property damage	46.7	93	7
Physical violence	48.1	92.6	7
Telephone threats	31.8	87.5	12.5
Stalking	17.0	100	0
Sexual harassment	10.6	82.8	17.2
Sexual abuse	8.3	90	10

The researchers also requested that participants provide examples of situations to which they had been exposed. Fifty-six examples were provided, from which themes regarding perpetrators, types of violence, timing and location of incidents, responses to incidents and contributing factors. Perpetrators tended to be Aboriginal males, either clients or family members, with incidents most commonly being verbal, occurring at night within the clinic or hospital and with intoxicants involved. Nurses' responses to incidents included fear, sleeplessness, stress, shock and helplessness. Contributing factors identified included dissatisfaction with services, unreasonable requests, mental illness, grief and rioting. Nurses identified violence as an issue within communities, but tended to perceive the frequency and severity of their exposures to violence as being low. Violence was viewed from a broader social context and, as such, responses may have been a result of RANs becoming desensitized or socialized to community and cultural norms. As has been stated, the practice context of FNIH front line nurses is very similar to that of RANs, although differences related to staffing, orientation, education, and access to health care providers do exist.

Martin (1997) explored outpost nurses' quality of worklife issues in Manitoba. The themes relevant to WPOA that emerged were related to interpersonal relationships and a sense of fear. The two were linked in that ineffective relationships with colleagues, nurses in charge, physicians, support staff and regional managers led to a lack of trust and sense of professional and personal isolation. Of the 11 nurses interviewed, 8 reported feeling unsafe, and indicated situations in which they were left alone, had to deal with patients with mental health diagnoses, substance abuse issues or a history of

violence as being particularly concerning. Physical facility issues were also identified as being of concern in that nurses may be living in detached residences, and would be required to go outside alone to attend to patients in the clinic. Visibility and communication with patients wanting to see the nurse were also indicated as problematic as many of their doors did not have "peepholes" or windows thru which the nurse could assess risk or patient behaviors prior to opening the door. Related to the themes of relationships and fear, the study also identified the challenging dynamics between community leadership and federal nursing stations, with the nurses identifying a sense of powerlessness and threat related to Band Council Resolutions which had historically been used to ask nurses to leave communities. While the intent of the study was not to explore WPOA, it became evident that potential for violence in northern Manitoba communities was of concern for nursing staff.

The 2006 FNIHB *Nursing Workforce Survey* explored nurses' satisfaction with their current work context. The survey did not specifically explore WPOA however factors which have been identified for placing health care providers at risk were included. In existing literature, quality of care and the resultant level of patient satisfaction have been identified as a potential risk, and for 31% of FNIH nurses there was dissatisfaction with their ability to deliver quality care. Situational factors such as wait times, physical layout, and comfort level related to seating, space, light or temperature have been cited as contributors to aggressive behaviors and were identified as concerns by a majority of FNIH nurses who expressed low levels of satisfaction in relation to their work settings and physical space.

The literature also demonstrates that lack of cohesiveness and teamwork influence potential for violence, and 44% of FNIH nurses indicated that their workplaces require improvement in fostering effective work relationships. As had been identified in the RAN survey (Fisher et al., 1996), support from nursing supervisors was a critical element found to be lacking. FNIH nurses stated that nursing management support and feedback are lacking, with considerable dissatisfaction in these areas identified (63% and 68% respectively). Overall, 46% of FNIH nurses expressed satisfaction with their work life balance. As was noted, personal characteristics of health care providers influence their interactions with others, and may result in negative outcomes should the imbalances manifest themselves in a manner that is not understood or appreciated by others with whom the nurse interacts. The impact of nurses' dissatisfaction in their workplaces influences their abilities to provide services to clients, and their interactions with other members of the health care team. Workplace and occupational aggression serves to create negative responses in those who are directly or indirectly involved. The impacts on individuals, organizations and society will be introduced in the section which follows.

Impacts of Workplace and Occupational Aggression

It is evident that the impact of violence on individuals and their families can be significant. What is becoming more apparent is the cost to organizations, communities and society at large. Violence may result in disruption of personal relationships, employment impacts such as decreased productivity, absenteeism, and costs to society related utilization of social services and heath resources, law enforcement, judicial and penal systems (Alexander, House & Fraser, 2004; Barling, Rogers & Kelloway, 2001; Bussing & Hoge, 2004; Burnes & Pope, 2007; Farrell, 1997, 1999, 2001; Gerberich et

al.,2004; Hislop & Melby 2003; Randle, 2003; Sofield & Salmond, 2003; and; Walsh & Clark, 2003). Krug et al. (2002) state the annual economic burden of violence may be in the billions of dollars per country. While globally, there is not the ability to fully capture the incidence of violence and its resultant impacts, within workplaces it is incumbent upon employers to be aware of violence and the impacts that it may have on their employees, their families, the organization and the communities and society in which is exists.

Workplace and occupational aggression has been recognized by the WHO, ILC, ICN and PSI Joint Programme on Workplace Violence in the Health Sector as having profoundly negative effects (WHO, 2002). In a study (di Martino, 2003) of the relationship between work stress and workplace violence in the health sector, the spiral that ensues is clearly articulated. The author suggests that the effects of stress and violence culminate exponentially and the outcome is adverse for individuals, organizations and society. The European Foundation for the Improvement of Living and Working Conditions (2000) indicated that stress was experienced by 40% of workers exposed to physical violence, by 47% of workers exposed to bullying and by 46% of workers exposed to sexual harassment (p.4), and the work of Denton, Zeytinoglu and Webb (2000) speaks to the violence-related work situations faced by home care workers that are highly correlated with stress reactions.

Considerable research has demonstrated that exposure to WPOA may have serious short-and long-term consequences for individuals (Fernandes et al., 1999; Henderson, 2003; McKenna, Poole, Smith, Coverdale & Gale, 2003; McKenna, Poole, Smith, & Coverdale 2003; Randle, 2003; 2003; Rogers & Kelloway, 1997). These

include emotional symptoms such as fearfulness, restlessness, irritability, anxiety, helplessness, hopelessness, depression, and alterations in self-esteem, confidence and motivation. Physical manifestations may include fatigue, weight changes, sleep disturbances, migraines, gastrointestinal disturbances or ulcers, hypertension, heart and cerebrovascular disease, inflammatory bowel disease, musculoskeletal disorders and immune system disturbances. Self-destructive coping mechanisms such as tobacco use, alcohol or drug consumption and risk-taking behavior may occur. Interpersonal relationships both internal and external to the workplace may be eroded and isolation may develop. Homicidal and suicidal outcomes have been recorded in the literature discussing workplace and occupational aggression.

Organizationally, incidents of WPOA may create both insidious and overt impacts. As has been reported in the incivility literature (Fernandes et al., 1999; Glomb, 2002; Hegney, Eley, Plank, Buikstra & Parker, 2006; Henderson, 2003; Rogers & Kelloway, 1997), organizational productivity may be impaired by withholding of information, erosion of work relationships and sabotage of subordinate, colleague or supervisor efforts. WPOA may result in overt economic impacts to organizations due to lost work time due to absenteeism, illness, and employee resignations (Budd, Arvey & Lawless, 1996; Bryant & Wolfram-Cox, 2003; Fernandes et al., 1999; Henderson, 2003; Mayhew et al., 2004; Sofield & Salmond, 2003; Rogers & Kelloway, 1997). Additionally, the impact on organizational reputations may hamper recruitment efforts and further tax the remaining workforce. Within health care it has been demonstrated that quality of service is impacted, staff errors are more frequent and continuity of care

may be disrupted. Any and all of these factors could potentially lead to adverse patient outcomes and legal risk to organizations.

Societal impacts of workplace and occupational aggression may be noted when individuals are unable to contain, or cope with the effects of workplace stress. These individuals may be unable to meet their obligations to their employers, families and social networks. Employment may be lost, and the physical and psychological harm may result in utilization of rehabilitation or retraining services when reintegration into previous occupations can not be resumed or limitations required. Hoel, Sparks and Cooper (2002) conducted a review of industry and economic reports to formulate a general impression of the economic impact of stress and violence. When factoring in individual, health care, productivity, legal, lost work time due to absenteeism, injury, illness, disability, early retirement, education retraining and workforce replenishment, reputation rebuilding and recruitment costs, the approximated costs were staggering. Based on the available data, they suggest that stress and violence may account for approximately 30% of all ill-health and accident costs internationally, yielding costs ranging from 0.5% to 3.5% of the Gross Domestic Product annually.

Responses to Workplace and Occupational Aggression

Internationally, workplace violence has been deemed a problem of epidemic proportions. Within the health industry, a strong stance has been taken by the ICN in the creation of two position statements, namely the *Occupational Health and Safety for Nurses* (ICN,2006) and the *Abuse and Violence against Nursing Personnel* (ICN, 2006). As was previously noted, in collaboration with the ILO WHO and PSI, several resources have been created to assist in the recognition and management of workplace violence in

the health sector. Within Canada, the CNA and regulatory bodies in Ontario and Nova Scotia have created practice guidelines aimed at supporting nurses and employers in creating work environments that are respectful and move to eliminate violence and aggression. Legislatively, all Canadian jurisdictions have Occupational Health and Safety legislation inclusive of a general duty provision which requires employers to protect employees from known risk physical, psychological and emotional harm created by aggression and violence [1]. British Columbia, Saskatchewan, Nova Scotia, Alberta and Quebec all have regulations, guidelines, codes or legislation specific to workplace violence or harassment[2]. Federal employees are protected by the Canada Labour Code [3] which requires supervisors and managers to take prescribed steps to prevent and protect against workplace violence. Many organizations and academic institutions have recognized the need for education and training of staff to better prepare them for potential exposures to aggression, and it has been demonstrated that design and timing of the sessions are important, as is ongoing refinement of the information presented, (Arnetz & Arnetz, 2000; Beech, 2001; Beech & Leather, 2003;Farrell & Cubit, 2005; Hegney, Eley, Plank, Buikstra & Parker, 2006; Henderson, 2003; McKenna, Poole, Smith, Coverdale,& Gale, 2003; and Pozzi , 1998). However, the most critical intervention identified in the research is the need for management recognition of the issue, willingness to intervene and support of staff involved in incidents. (Duncan et al., 2001; Farrell,

---

[1], [2, 3] Alberta Employment and Immigration, WorkSafeBC, SAFE Manitoba, WorkSafeNB, Newfoundland and Labrador Occupational Health and Safety Branch, Workers' Compensation Board of the Northwest Territories and Nunavut, Nova Scotia Occupational Health & Safety Division, Ontario Occupational Health and Safety Branch, Prince Edward Island Occupational Health and Safety Division, Commission de la santé et de la sécurité du travail du Québec, Saskatchewan Occupational Health and Safety Division, Yukon Workers' Compensation, Health and Safety Board, Human Resources and Skills Development Canada Occupational Health and Safety: Labour Program are the authorities responsible for Occupational Health and Safety Legislation in their respective province or territory.

1997; Gacki-Smith, Juarez, Boyett, Homeyer, Robinson, & McLean, 2009; Henry & Gin, 2002; King & McInerney, 2006; Martinko, Douglas & Harvey, 2006; and Merecz, Rymaszewska, Moscicka, Kiejna & Jarosz-Nowak, 2006). Management is also required to be introspective and consider the modeling that may exist in organizations and the perceptions that may be created by interactions with staff. Procedural justice and fair treatment of employees was indicated as being pivotal in employees' appraisal processes and influenced responses to events in the workplace (Cortina, Magley, Hunter-Williams & Day-Langhout, 2001; Dietz, Robinson, Folger, Baron & Schultz, 2003; Dupre & Barling, 2006; Hutton, 2006; Jockin, Arvey & McGue, 2001; and Kennedy, Homant & Homant, 2004).

Summary

Extensive research into the phenomenon of workplace and occupational aggression has been undertaken in the past 20 years in a variety of occupational contexts. Challenges in interpreting and comparing these studies stem from the use of different definitions, theoretical underpinnings that lack congruence, and tools that measure information in different manners, and over variable timeframes. Despite the challenges in comparing studies, it is evident that aggression is commonplace in workplaces, and in particular health care settings internationally. Nurses have been demonstrated to be at particular risk of aggression from patients, families, coworkers and supervisors. For FNIH, the similarity of male and female victimization rates is significant in that CHNs provide direct client care on a 24-hour and 7-day per week basis with limited on-site health professional and technological resources. CHNs provide care when clients and families are experiencing fear, pain anxiety and may be unable to fully cope with the

emotions they are feeling. As the burden of illness increases in populations and the health human resources availability decreases due to aging of care providers, the health care workforce must be proactive in recognizing and addressing aggression across the continuum. Within FNIH, the practice setting is one that deals with geographical and professional isolation. When violent incidents do occur, FNIH CHNs are often geographically removed from their family/friend support networks, and as research has demonstrated, co-workers are most commonly the source of support. This is significant in that in many instances, their co-workers may have also been exposed to the incident and requiring support as well.

The risk factors for WPOA are present within the work settings of CHNs however little is known about the current rates of WPOA in FNIH nursing stations in Manitoba region. As the responsibility for reduction of workplace aggression lies with organizations, managers and individual employees, knowledge regarding WPOA in the nursing stations is critical. In order to address WPOA, education for managers and staff alike is essential, as is an ongoing commitment to open, respectful communications.

Chapter III: Methodology

Design

This research project was a non-experimental descriptive study. Qualitative and quantitative methods were utilized to explore the types and incidence of WPOA in FNIH Manitoba Nursing Stations as well as the actions taken to address the incidents reported. Occurrence reporting data submitted by field staff to the FNIH Manitoba regional office over a 12 month period was utilized to conduct an analysis of the reported incidents of WPOA. A detailed discussion of the tool utilized is located in the Instrument and Data Collection in this chapter.

The Research Questions

Using administrative data available in Occurrence Reports (ORs) submitted by field staff in FNIH Manitoba Region nursing stations, the following research questions were explored:

1) What was the reported incidence and pattern of WPOA in FNIH Manitoba Region nursing stations during the 12 month period from January 1, 2008 to December 31, 2008 as documented by nurses on Occurrence Reports?
    a) On a monthly basis, how many incidents of WPOA were reported within Manitoba region?
    b) What are the types of WPOA to which nurses have been exposed?
2) What types of actions, if any, were taken to respond to the reported incidents of WPOA?
    a) How frequently were community level actions taken to address the reported WPOA incident?

b) How frequently were regional level actions taken to address the reported WPOA incident?

Operational definitions

The OR form utilized in Manitoba was created nationally and utilizes standard definitions to categorize events and activities which are reported. The OR form and definitions are contained in Appendix A. For this study, workplace and occupational aggression (WPOA) encompassed any and all acts occurring within the workplace context, perpetrated by persons internal or external to the health care team resulting in physical, psychological or emotional harm to an individual and was the foundation for the inclusion of ORs when the categorization occurred.

Study Population

The study utilized OR data submitted for incidents occurring between the dates of January 1, 2008 and December 31, 2008 inclusive by staff in the 21 Manitoba nursing stations (see Appendix B - FNIH Nursing Stations) for which FNIH was responsible for the hiring and supervision of Community Health Nurses (CHNs). There are a total of 108 funded nursing positions to provide services to the communities. The OR form is the written mechanism by which concerns in the community are communicated to the Nurse Manager and the regional leadership. The primary source of ORs are community health nursing staff who may be FNIH or agency employed, although other health care providers including physicians, dentists or mental health therapists and support staff also utilize these forms.

Instrumentation and Data Collection

The First Nations and Inuit Health Branch OR was a national data collection tool implemented in 2006 (see Appendix A). The OR was intended to provide a standardized approach to collecting data across the regions to inform policy and practice in the remote and isolated communities served by FNIH. With this form, staff members are able to advise the region of incidents which occur in six categories: security violations; self harm; community; process issues; nursing practice and substance use related.

For the purpose of this study, incidents reported in the categories of security violations; community; process issues; nursing practice and substance use were reviewed for applicability and potential inclusion in the study

FNIH intends to collect all data electronically thus allowing for timely and ongoing analysis of the occurrence reports and generation of relevant and useful information. However, at present, the full potential has not been actualized as the forms are not submitted electronically due to infrastructure technology challenges which remain unresolved. This study relied on ORs that were filled out manually and submitted to the FNIH Manitoba Nursing Directorate by fax or mail.

Data Collection Methods

Data collection occurred following receipt of approval from both the University of Manitoba Education/Nursing Research Ethics Board and the Health Canada Research Ethics Board. The data was derived from the 2008 ORs submitted to the FNIH Manitoba Nursing Directorate. All ORs for incidents occurring between January 1, 2008 and December 31, 2008 were photocopied, and original documents returned. The

photocopies were identified with a community code and number. Community and individual identifiers were removed from all photocopied ORs.

The coded and numbered ORs were screened to determine which met the established inclusion criteria. Since the ORs include reporting of non-violence-related incidents, only ORs in which one of the following categories was selected by the originator of the document were included in the study. The inclusion categories were: security violation (violence/assault/threats to nurse; threats to other HCP in community; security guard issues; policing issues; theft; damage to property; other); community (political issues); process issues (medical evacuation; on call/receiving; workforce; other); nursing practice (policy, medication); and substance use related (alcohol; narcotics and controlled substances; solvents, drugs OTC/illicit; unknown; other). This process was referred to by Sandelowski (2000) as stratified purposeful sampling in which the researcher includes certain cases which vary based on pre-selected parameters. A secondary review of all included ORs was conducted using the narrative descriptor of the incident to determine if the incident was consistent with the operational definition of WPOA being applied for this study. Appendix G provides a graphic representation of the process used to determine OR inclusion and exclusion. A total count of all ORs was kept to allow for the calculation of the percentage of occurrences that are WPOA-related.

Demographic, incident and response data for each OR meeting the inclusion criteria were included for analysis. Demographically, the date and time of incidents were collected as well as the individuals ("perpetrators") involved - patient, family/friend, community leadership, nurse, other health care providers or support staff where

identified. The individual completing the report was coded by gender and profession to the extent that this information was provided on the form.

The OR form requires that the individual completing the document identify the actions taken with respect to consultation, intervention and notification as well as the follow-up required. For the eligible ORs, the actions taken at the community and regional levels were reviewed and categorized in terms of the current literature recommendations related to resolving incidents and supporting staff. Limited narrative data describing both the incidents and responses was available on some of the ORs submitted. This information was categorized into thematic groupings and included in the analysis of incidents and responses.

Data Storage

The data collected was secured in a locked filing cabinet when not required for entry and analysis. The computer and memory storage devices which will hold project-related data were encrypted and password-protected. Raw data collected was accessible only to the researcher, research assistant, thesis committee and statistician. All records were and continue to be maintained with the highest level of confidentiality possible in accordance with the FNIH records retention policy. At the end of a two-year period, the data storage device will be destroyed, and all data files on the computer hard drive removed.

Data Analysis

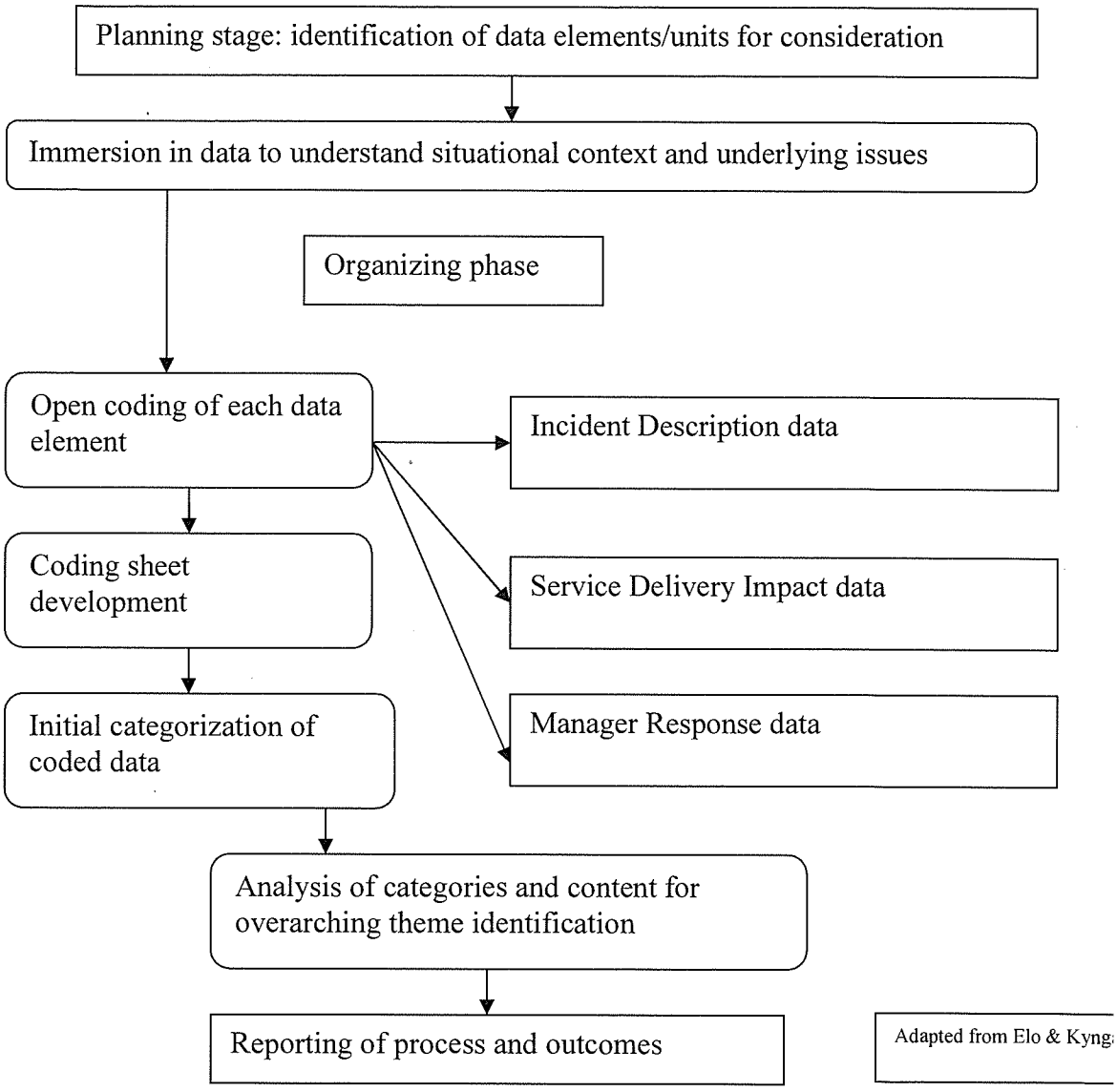
FNIH ORs allowed for the retrospective study of reported violence impacting the health care team, primarily nurses, in existing administrative data. To determine the responses to the research questions explored in the study, both quantitative and

qualitative techniques were employed to analyze the data. All quantitative data was entered into Statistical Package for the Social Sciences (SPSS) version 12 software by the research assistant to allow for the generation of descriptive statistics and graphic representations of the findings. The data collected was at the nominal level which limited the types of statistical analysis possible. However bivariate descriptive statistics were obtained using contingency tables. Chi-square analysis was possible using the variables of type of incident, timing of incident, perpetrator gender, and concurrent use of intoxicants or other substances.

Content analysis was conducted with the qualitative data in the descriptive, impact and follow-up areas of the ORs. This process commenced with the identification of anticipated themes. This process was inductive, and allowed for the emergence of themes that the researcher and previous literature may not have discerned (Sandelowski, 1995). Using an inductive approach, the data available in the descriptive sections of the OR was identified, coded and categorized using the process described in diagram 1 below.

Diagram 1

Qualitative Data Content Analysis Process



The content analysis process used was based on the approaches described by Sandelowski (2000), and Elo and Kyngas, (2007). The themes emerging from content analysis of this data were described separately in the findings to ensure that any richness of data captured was fully represented in the study. This content analysis utilized Guba

and Lincoln's criteria of credibility, dependability, confirmability and transferability to ensure quality of the data (Polit and Beck, 2004).

The research assistant reviewed the coding, categories and themes established by the researcher to ensure that the criteria were met. All information available was considered in relation to the existing knowledge of WPOA within the broader health care context as well as in remote practice settings.

Ethical considerations

In conducting this research, it was imperative that the rights of study participants were protected (Polit et al., 2004). As this was a review of existing administrative data, no individuals were contacted for information. The names of the individuals who have completed the OR were coded by gender and occupational group where such data was present. No names were included, nor were communities identified by name. In the area of regional response, no individual manager distinctions were made as these identifiers were removed as well. Communities were grouped based on population size and only aggregate data was presented.

Conclusion

This chapter has presented a comprehensive research protocol that guided the collection of data and its analysis. The research design was identified, the processes related to data collection methods, and the tools utilized were discussed. Data storage was highlighted as an area requiring particular attention and the steps undertaken identified. The approach undertaken in the analysis of both quantitative and qualitative data elements was presented and considerations for the discussion of the findings to respect confidentiality noted. The ethical considerations were identified and rationale for

the approaches taken provided. The study significance was presented. It was identified that the expectation of the study was to generate an improved understanding of the WPOA faced by FNIH nurses working in remote and isolated communities, provide recommendations to reduce WPOA exposure and enhance organizational preparedness and responses. The study also provides suggestions for future research activities in this understudied nursing workforce and setting.

Chapter 4: Results

This chapter presents the results of the quantitative and qualitative data analysis. The research questions proposed were answered based on the data analysis conducted.

Data Collection and Inclusion Process

Permission to access all FNIH Occurrence Reporting Data for the period of January 1, 2008 to December 31, 2008 was granted by Mr. Jim Wolfe, Regional Director of FNIH, Manitoba Region (Appendix H & I). Following granting of ethics approval by the University of Manitoba Education and Nursing Research Ethics Board (Appendix J), copies of the Occurrence reports (ORs) from the 21 FNIH managed nursing stations were made. Staff from each of the 21 communities had submitted between 0-269 ORs in the time period studied, with a total of 999 ORs received in the regional office for the specified timeframe. Prior to the principal investigator (PI) accessing the ORs, and in accordance with REB requirements, all individual identifiers were removed by the research assistant. Community names were removed, and replaced with a code which was based on population. OR originator names were removed and replaced with gender by the research assistant. The data sorting process established in the methods chapter was undertaken with one unanticipated data categorization process being required (Appendix G). It was found that existing categories in the OR did not provide sufficient breakdown of events to allow for meaningful data analysis and that re-coding of the available data into categories described in the incidents would lead to clearer generation of new knowledge.

Occurrences were reported in the categories of security violations, self harm, community, process issues, nursing practice and substance use related incidents. The

security violations category included violence/assault/threat to nurses, threats to other health care providers, security guard issues, policing issues, theft, damage to property and "other" incidents. Incidents in the self harm category included suicidal ideation, attempts, completed suicides, self destructive behaviours and other. Within the community category, incidents related to vehicular events, death, environmental, communicable disease outbreaks, political issues, violence to clients and other were reported. The process issues heading captured medical evacuation, on-call/receiving, workforce issues and other related incidents. In the category of nursing practice, policy, scope of practice, interventions, medications, good catch/near miss and "other" situations were reported. Within the substance use related category, incidents involving alcohol, narcotic/controlled substances, solvents, over the counter(OTC)/illicit drugs, unknown and "other" were reported. Of the total OR reports submitted, initially 197 (19.7%) met the criteria for inclusion. The second review identified that of the 197 ORs, 51 were not WPOA related and thus not suitable for inclusion in the study. The types of ORs excluded involved equipment/supply problems, medication or immunization errors, or non-insured health benefits issues related to patient entitlements. In these ORs, there was no aggression or violence demonstrated toward the nurse, nor did the nurse identify a sense of risk. The final number of ORs that met the inclusion criteria was 146 or 14.6% of all ORs in the January 1 to December 31, 2008 time period.

A third review of the data was done by the PI and research assistant to recode the data within the security violation category. This was done concurrently by both the PI and research assistant to ensure consistency in the inclusion and categorization of the data. Recoding occurred only where additional information in the incident description

provided sufficient detail for the PI and research assistant to re-categorize the event. The categories created were unspecified aggression, verbal aggression, verbal threat, verbal threat related to practice, verbal threat related to political involvement, physical threat and physical violence. This step was necessary to be able to categorize the incidents into types of exposures as the OR form lacked specificity. In this recoding stage, where supported by information in the descriptive comments area of the report, it was possible to separate events into verbal, physical or both types of incidents.

While 146 ORs were included in the study, 19 (13%) identified multiple issues and were reported in more than one area. Additionally, as per the inclusion criteria, security guard-related ORs were included as perception of risk was an important consideration for nursing staff as demonstrated in the literature. As a result, the sum of the number of cases considered in each variable may not equal 146.

The intent of this research study was to describe the WPOA incidents reported by staff in FNIH nursing stations in Manitoba Region, and the types of responses to the reported incidents. The findings below provide new information related to WPOA in this understudied work environment.

Demographics and WPOA Incidents Reported

Community demographics.

All communities included were considered remote/isolated with nursing stations as the sole point of contact for primary care and emergency health services. Three of the 21 communities were accessible to Thompson by year-round roads, while all others were accessible by air and, for a limited period of time each year, by winter road. The ORs were submitted from First Nations communities with on-reserve populations of 300 to

5200 according to the Status Verification System data available for 2008. Communities were grouped based on population with 9 between 300 to 999 residents, 5 with 1000 to 1999 residents, 4 with 2000 to 2999 residents and 3 with over 3000 residents. The occurrences reported by community size are presented in Table 6.

Table 6: *Reported WPOA Incidents: Community Groupings by Population*

Community size	*Number of communities*	*Total ORs submitted*	*Verbal WPOA*	*Physical WPOA*	*Average WPOA ORs per community*
< 999	9	73	34	8	4.7
1000- 1999	5	41	27	17	8.8
2000-2999	4	11	3	4	1.75
3000 +	3	21	7	2	3
Total	21	146	71	31	4.86

When number of communities was factored into each of the categories, it was found that, on average, communities with populations between 1000-1999 residents reported the most WPOA.

Nursing demographics.

FNIH Manitoba Region employs nurses within a central office in Winnipeg, which is referred to as "the region" or "the regional office" as well as in the 21 nursing stations, 2 hospitals and one health centre which were located in 24 First Nations communities. In the communities, Community Health Nurses (CHN) who staff the nursing stations, hospitals and health centre report to the nurse in charge. The nurse in charge (NIC) is the on-site manager of the facility and is the day to day manager. The

nurse in charge reports to a Nurse Manager (NM) in the regional office who is responsible for 2-6 communities. Appendix J provides an overview of the Nursing Directorate organizational structure. From January 01 to December 31, 2008 Manitoba region employed 108 female RNs and 18 male RNs in field based CHN positions (personal communication, C. Stadnichuk June 16, 2010). During this period, nurses employed by private agencies were also utilized to provide nursing services to communities. Due to the removal of personal identifiers, it is not possible to distinguish between FNIH and agency staff within this study.

The FNIH OR is an administrative tool which captures limited information about the originator of the report. Of the ORs meeting the inclusion criteria, 118 (81%) involved female staff, 12 (8%) involved male staff and 14 (10%) involved both female and male staff. Two (1%) ORs did not specify the individuals involved. Within the regional office, both female and male Nurse Managers were involved in responding to the ORs submitted. For the period of the study, of the 7 Nurse Manager positions involved in Nursing Stations, 5 were female and 2 were male. Female Nurse Managers were involved in 106 (73%) ORs while 37 (25%) were managed by male Nurse Managers.

Perpetrator demographics.

The FNIH ORs do not require identifiers related to the individuals involved other than age, however many nurses will also include gender in their description of the event. In the 2008 ORs submitted, the age range of persons perpetrating WPOA incidents was from 14 to 93 years. Sixty-five percent of 2008 ORs did not include age of perpetrators.

Gender was identified in 54% of the ORs, with 26% of perpetrators being male, 25% female, and 3% of incidents involving both females and males.

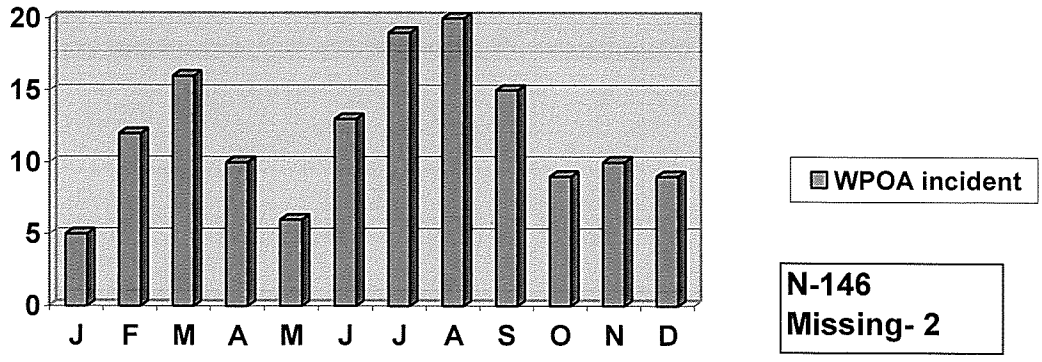
Incidence, Type and Patterns of WPOA

The purpose of this study was to determine the reported incidence and patterns of WPOA in FNIH Manitoba Region nursing stations during the 12 month period from January 1, 2008 to December 31, 2008 as documented by nurses on Occurrence Reports (ORs).

Reported incidence of WPOA.

WPOA-related occurrences were noted in all months of 2008. The highest numbers were submitted in August (20), July (19), and March (16). In February, April, June, September and November there were between 10 to 15 ORs submitted, and in January, May, October and December 9 or fewer ORs were completed. These numbers capture all incidents included in the study; however a breakdown by specific type of ORs will follow in the relevant content area. See Graph1 for the total WPOA incidents by month.

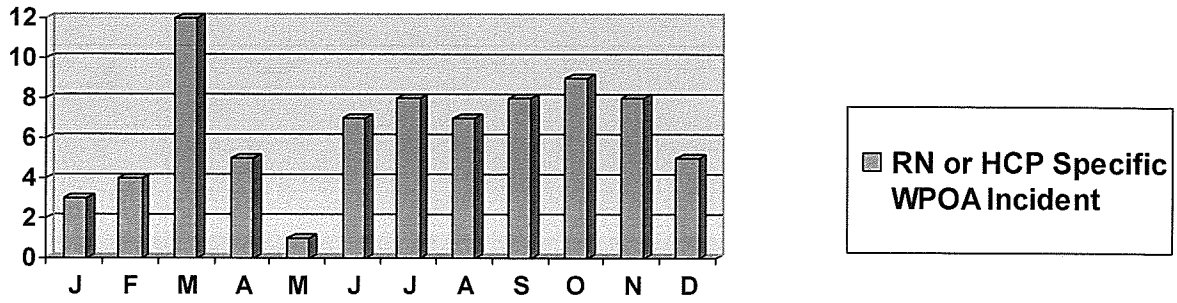
Graph 1: Total Monthly WPOA Incidents



WPOA that specifically involved nurses or health care providers was reported on

91 (62%) of the 146 ORs included. Graph 2 illustrates the monthly incidents directed at this group.

Graph 2: Reported WPOA Incidents: RN or HCP Specific



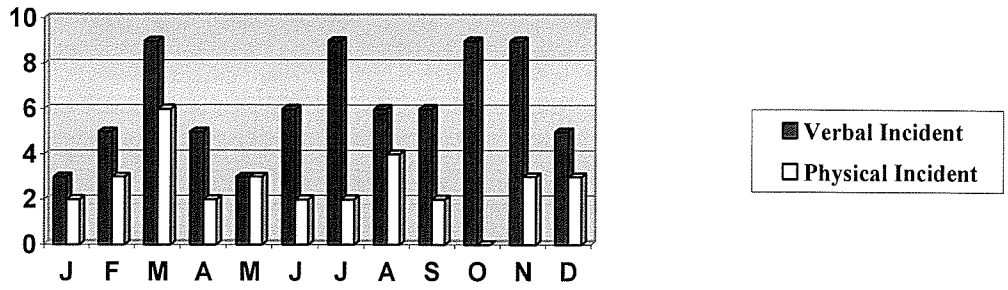
From the two graphs, it is notable that March continued to demonstrate high incidents of WPOA, however, when security guard, policing, theft and property damage were removed, the months of July and August demonstrated fewer reports. The ORs included in both monthly breakdowns were captured concurrently with incidents reported in the "Security Violations" heading which follows.

Reported incidence and types of WPOA directed at nurses and other health care providers.

The data within the category of "security violations: violence/assault/threats to nurse" speaks to the first research question of: how many incidents of WPOA were reported within Manitoba region on a monthly basis as well as the second question of what types of WPOA were nurses exposed to during the study period. It was found that of the 146 ORs submitted, 74 (51%) were identified as involving violence, assault or threats to the nurse. It is important to note that non-specific aggression captured in the "other security violation" is not captured in the numbers specific to verbal and physical

incidents. Graph 3 presents the nurse- or health care provider-directed verbal and physical abuse comparison on a monthly basis.

Graph 3: Verbal and Physical Aggression Directed at RNs or HCPs-Monthly Reports



Physical contact in which the OR originator was struck, bitten, or exposed to biological substances occurred in 20 (14%) of the ORs submitted, and threat of physical violence demonstrated by perpetrator actions was reported in 23(16%) submissions. Verbal aggressiveness was reported in 65 (45%) ORs. Verbal threats which were suggestive of imminent or future physical harm were identified in 20 (14%) cases. Threats related to professional practice such as "if I die it will be your fault", or "if ... then I'll sue you" were identified in 19 (13%) ORs. In addition, there were a small number (n=2) of incidents in which nurses identified that nursing peers or other health care professionals were questioning their clinical judgement which was believed to have an impact on the credibility of the nurse submitting the report. Political involvement or suggestion that if a certain course of action did not occur, someone or multiple parties from the community leadership including the chief, councillors or band-employed health director would be engaged were reported in 14 (10%) ORs submitted. As 19 of the ORs

reported incidents included in multiple categories, the number of verbal and physical incidents exceed 146. No statistical significance by month of incident was demonstrated when reports of verbal and physical WPOA were limited to the nursing and health care provider group alone

While nurses were the predominant group identified in the ORs submitted, they were not the only health care providers to which WPOA was directed. In the category of "security violations: threats to other health care providers", incidents involving dentists, dental therapists, mental health therapists and community support staff were also reported. Eight (6%) ORs were submitted involving this group. The types of situations identified included professional threats and aggressive verbal behaviours. Substance use, including alcohol, narcotics/controlled drugs, over the counter medications, illicit drugs or other intoxicants were reported in 3 (38%) of the ORs in this category. As an example of this, one report stated: "Mother of a --year old child brought in to see visiting physician. Mother became verbally abusive to physician."

Reported incidence and types of WPOA related to security guards, policing services, theft and property damage.

Security guards.

Security guard services were funded by FNIH, however these individuals were band employees in all but one community. The band is responsible for determining the experience, education and training requirements for these employees. FNIH provides a list of security guard performance expectations in the funding agreements established with the band.

The majority of incidents reported in the "security violations: security guard issues" category were related to the failure of security guards to report to duty rather than direct WPOA events. However, as the lack of security impacts on nurses' perceptions of safety and ability to deliver services, these have been included in the study. Of the 41 (28%) security guard-related ORs, 25 (61%) were related to security guards not arriving for scheduled shifts, 4 (10%) involved guards leaving the facility early or without authorization, and 4 (10%) were related to leaving the facility unsecured. Nurses documented these incidents with the following comments: "Today security guard did not show up in am. Fishing derby taking place. This was not prearranged, I was not informed acting/Nurse in charge. Poor communication by band? Security guard?" In another incident the nurse reports: "Chief of Security arrived at midnight. Door to nursing station/residence open and no security. The security guard is the [relative of community leader]...He has a long history of security breaches and not showing up for shifts".

While the majority of ORs in this category were related to absenteeism or performance issues, WPOA incidents in which the security guard was directly involved were reported on three (7%) occasions. Of these, two involved security guards being involved in altercations within the facility or on the facility grounds. With one incident, the security guard was required to intervene in a physical fight between individuals who had accompanied a patient and another individual who was waiting to receive care. In the second incident, the guard was assaulted while doing hourly rounds on the exterior of the nursing station. Five ORs did not provide incident details therefore categorization

was not possible. Of all incidents in this area, only once was substance use by perpetrators reported concurrently.

Policing services.

In First Nations communities in Manitoba, there are two types of policing services. The majority of communities have local constables hired by the Band. Band constables, in addition to their regular policing duties, are responsible for providing assistance in emergency situations and supporting security and nursing staff when there are safety concerns or assistance is required with aggressive or intoxicated clients. The Royal Canadian Mounted Police (RCMP) also provides support to nurses in the same situations, however RCMP are not on-site in all communities, and may only provide itinerant service which may be quite limited. For some communities in this situation, should an emergency occur, there may be the possibility of RCMP flying in, however considerable delays often exist.

Policing issues were identified in 12 (8%) ORs submitted. The majority of ORs in this category (n=8, 67%) were related to poor response time to nursing concerns or a failure to respond to an incident. Occurrences reported captured concerns with both band constables and RCMP. Two of the 12 reports were related to community violence targeting local RCMP which nurses identified as impacting their sense of safety and security in the community. Nine (75%) ORs reported concurrent involvement of substances. In this category, descriptions of events included the following: "Patient stepped on glass in party house. Called RCMP (not in community) and band constable (no answer) for ride to NS. Taxi driver refusing to go because everyone drunk at house".

The nurse stated that no service was provided to the client due to lack of a safe escort for the driver.

Theft and property damage.

While theft and damage to property were separate categories on the FNIH OR form, these sections were being reported as aggregate data as in most instances they occurred concurrently. A total of 16 (11%) theft or property damage ORs were submitted. The nursing station, residences and vehicles used by nursing station staff were the targets of the damage reported. There were no reports of personal property damage. Theft of both crown and personal property was reported in two instances. Unauthorized entry into residence spaces was reported in three ORs, with time of day of incident variable. Attempted entry to residences or the nursing station was reported in three additional instances. The individuals submitting these reports did not have direct contact with the perpetrators making it impossible to track gender or concurrent use of intoxicants. This example stated: "sometime after midnight there was a break in at the old nursing station and someone walked through the nurses' residence to go out the emergency exit. There was various exercise equipment stolen. The broken window was open all night and still not secured at 1000 when the writer left."

Reported incidence of other security violations.

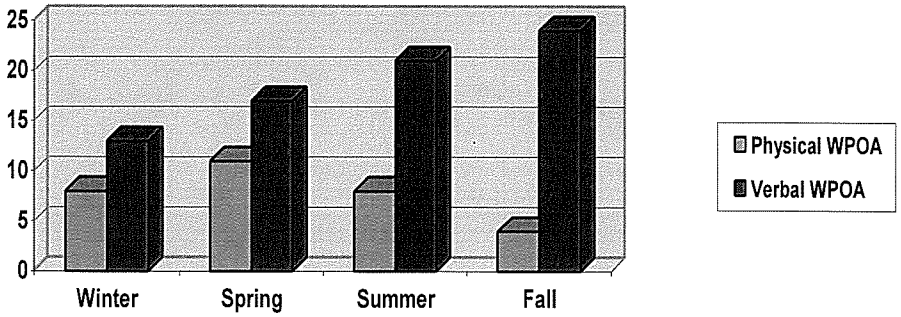
One hundred eleven ORs submitted were classified as "other" security violations. Of these, 48 reported the concurrent use of intoxicants. Based on the available descriptors, staff identified they had been subjected to unspecified aggression on 34 occasions. Physical violence was documented in 19 (13%) ORs, and physical threat in 23 (16%) instances with substance use identified in 19 and 17 ORs respectively. Verbal

abuse and threats were reported frequently with 64 (44%) reporting verbal aggression, 20 (14%) being threatened, 19 (13%) experiencing professional threats, and 14 (10%) contending with political threats. Of the verbal abuse and threat submissions, 34 identified concurrent substance use

Pattern of reported WPOA incidents.

Seasonal patterns of WPOA were explored using the existing data. Seasons were defined by groupings of months with winter being December to February, spring being March to May, summer being June to August and fall being September to November. Based on season, it was found that the patterns of verbal and physical WPOA exposures which included the total ORs submitted did not occur in the same distribution over the course of the year (See Graph 4).

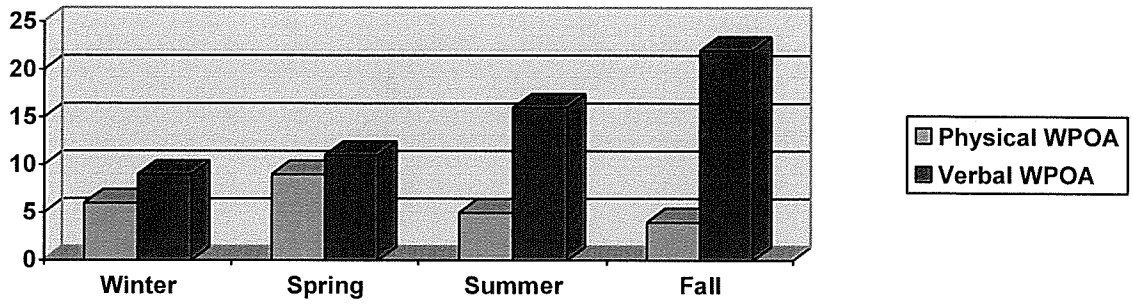
Graph 4: All Reported WPOA Incidents by Season



Chi-square analysis analysis of both verbal and physical incidents reported by all staff by season were found to be approaching statistical significance with of p=0.056 and 0.057 respectively, suggesting that the likelihood of exposure to verbal WPAO was greatest in the fall months and physical WPOA exposures was more likely to be experienced in the spring.

When only RN and HCP provider WPOA incidents were considered, it was noted that most physical WPOA incidents (n=24) reported occurred during the spring and most verbal incidents (n= 58) occurred during the fall (see Graph 5). Chi square analysis of the subgroup of RN and HCP specific WPOA incidents did not demonstrate statistical significance by season for either verbal (p= 0.073) or physical (p= 0.506) WPOA incidents.

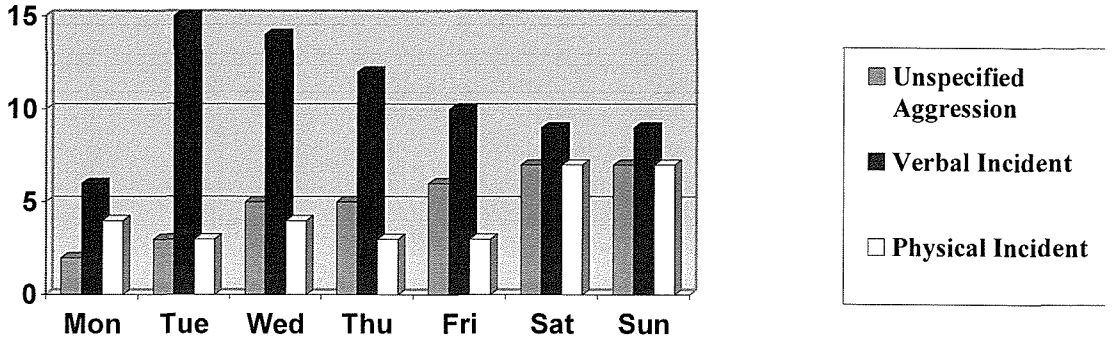
Graph 5: WPOA Incidents by Season Involving RNs and HCPs



FNIH nursing stations in Manitoba region were open for regularly scheduled clinics between 0830 to 1700 hours Monday to Friday excluding statutory holidays. Nurses provide on call after hours emergency services for the periods between 1700 hours and 0830 hours (weekdays) and on weekends and statutory holidays. When all WPOA incidents were considered, it was noted that most incidents reported occurred on Sundays (26), Tuesdays (24) and Saturdays (23). The least number of incidents were reported on Mondays. Chi square analysis of the verbal incidents by day demonstrated statistical significance only for exposures to verbal WPOA incidents, with p= 0.021. P values for physical and unspecified aggression incidents by day of the week were 0.785 and 0.617 respectively. See Graph 6 for the total WPOA incidents reported by the day of

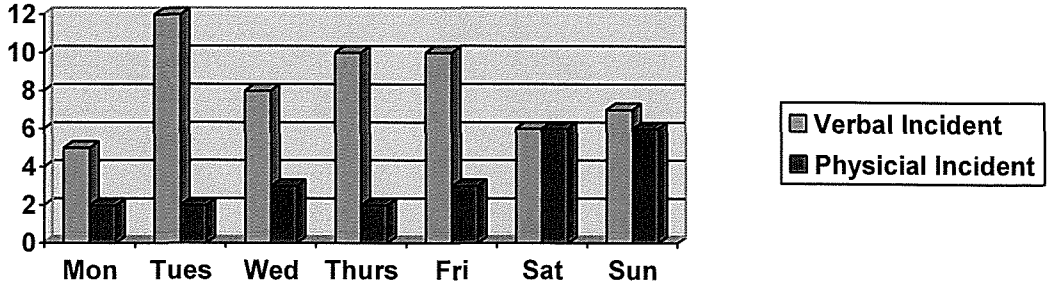
the week.

Graph 6: Days of Week-Total WPOA Incidents Reported



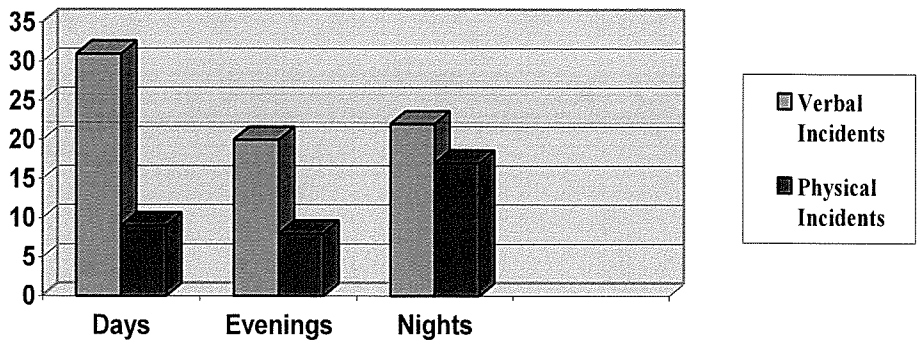
When only RN and HCP provider WPOA incidents were considered, it was noted that there was a fairly equal distribution of incidents on all days of the week, with the exception of Mondays, which had very few verbal or physical WPOA incidents reported. Chi square analysis of the subgroup of RN and HCP specific WPOA incidents did not demonstrate statistical significance by day of week for either verbal ($p= 0.607$) or physical ($p= 0.452$) WPOA incidents. See Graph 7 for the RN and HCP related WPOA incidents reported by the day of the week.

Graph 7: Days of Week- WPOA Incidents Involving RNs and HCPs



Nursing stations do not operate using standard hospital shifts. In order to consider smaller time periods, the 24 hour period was divided into a typical health care shift pattern of 8 hour blocks to correspond with the standard work day in a nursing station. Day shift represented the standard hours of work for the regular clinic operations, and the evening and night shift corresponded with standby time in which the nurse would provide services as call-backs. Based on these shifts, there were 47 ORs involving all staff submitted for the day shift, (0800 and 1659 hours), 33 for the evening shift (1700 to 2159 hours) and 55 for the night shift (2200 to 0759 hours). Incidents of a physical nature were reported most commonly during the night shift time period, while verbal incidents occurred most frequently on the day shift. Chi square analysis for both physical ($p= 0.030$) and verbal ($p= 0.022$) interactions by shift demonstrated that the patterns of reporting verbal interactions on day shifts, and physical interactions on night shifts were statistically significant. Graph 8 illustrates the reported total verbal and physical WPOA incidents reported by shift.

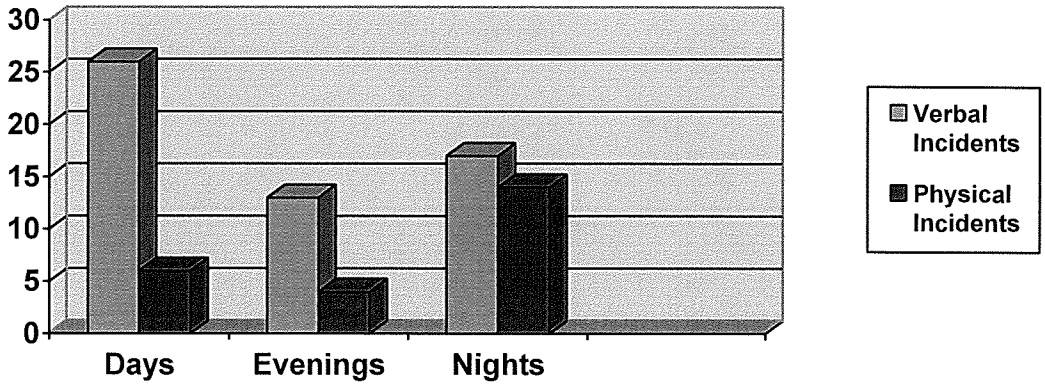
Graph 8: Total WPOA Incidents Reported by Shift



When the sub-group of RNs and HCPs was considered, there were 32 submitted for the day shift, (0800 and 1659 hours), 17 for the evening shift (1700 to 2159 hours)

and 31 for the night shift (2200 to 0759 hours). Incidents of a physical nature were reported most commonly during the night shift time period, while verbal incidents occurred most frequently on the day shift. Chi square analysis for the verbal interactions did not demonstrate statistical significance (p= 0.093), however it was noted that physical interactions were statistically significant (p= 0.03) with nights being the most likely time for physical WPOA to occur. Graph 9 illustrates the reported the total verbal and physical WPOA incidents reported by shift.

Graph 9: WPOA Incidents Involving RNs and HCPS by Shift



Patterns based on gender also emerged in the data available in the 2008 ORs. Of the ORs in which perpetrator gender was identified, it was found that females were engaged in verbal WPOAs more often (57%) than males (43%), and that males were involved in more physical incidents (67%) than females (33%).

Incidence and patterns of reported WPOA involving substance use.

In addition to the type of incident, substance use noted by the OR originator is also captured on ORs. Within the incidents reported in the RN violence and threat category, 50% (n=37) reported involvement of alcohol/solvents or substances. A typical

interaction reported under this category of incident included statements such as "patient found in building after 0000 hrs. Into Nursing Station. Alert & Oriented X 3, drowsy. Patient became aggressive and left x 2. Band constables picked up. RCMP called in to help. Patient ...and sent to St Boniface General Hospital with band constable escort". A second incident was described as "16 year old female brought in by RCMP. Blood on hand laceration. Right hand. Verbally abusive, uncooperative, flinging hand around, splattering blood over RCMP and walls. Unable to assess. Discharged to RCMP." While the prior two examples occurred with the patient in direct face to face contact, CHNs were also exposed to WPOA over the telephone as was described in the following incident: "While attempting to gain patient info via telephone triage, relative of patient verbally abusive to nurse and threatened to kill writer".

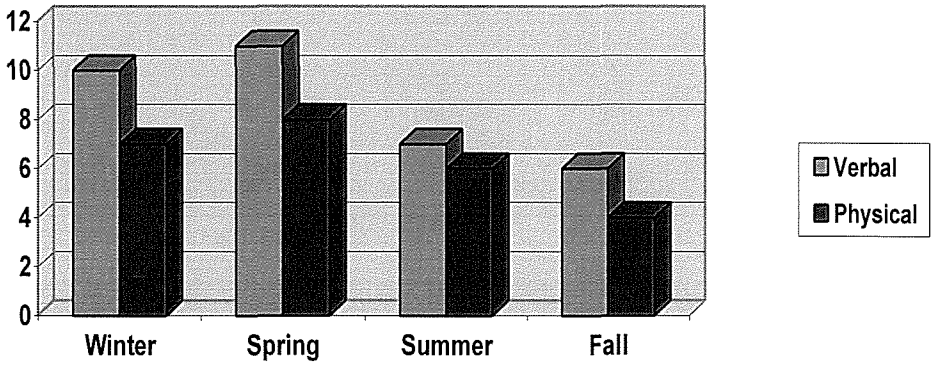
Of the total (n=146) incidents meeting the inclusion criteria for this study, 52 reported substance use. Reporting by type of substance occurs in the following categories: alcohol; narcotics and controlled substances; solvents; OTC/illicit; unknown; and other. In the substance use-related ORs included in the study, no statistical significance was demonstrated by time period. While not statistically significant, it was noted that there were variations in types of substances used most commonly, and the pattern of use on a 24-hour basis. Table 7 identifies the number of ORs by type of substance use reported by shift.

Table 7 *Substance Use Type Reported by Shift*

Substance	*Day Shift*	*Evening Shift*	*Night Shift*
Alcohol	11	8	26
Narcotics/Controlled Substances	3	0	0
Solvents	1	2	4
OTC/Illicit Drugs	1	1	2
Unknown	2	1	4

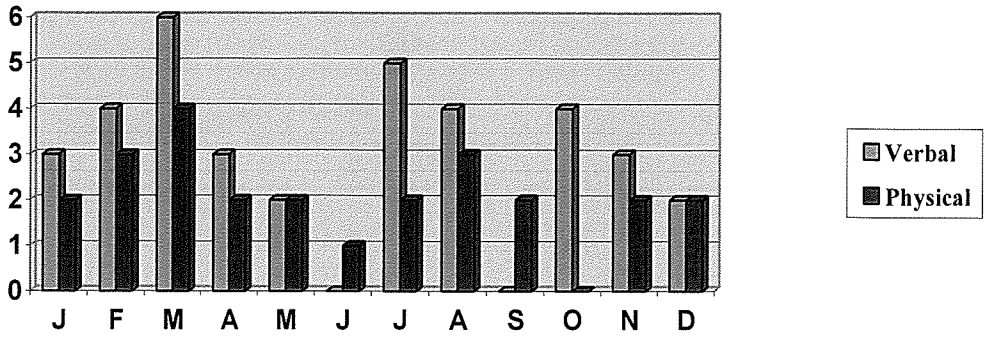
It was possible to determine the types and timing of incidents occurring when substance use was concurrently identified for both physical and verbal WPOA interactions. This data is presented by season, month and shift in Graphs 10, 11, and 12 below.

Graph 10: WPOA Incidents Involving Intoxicants by Season



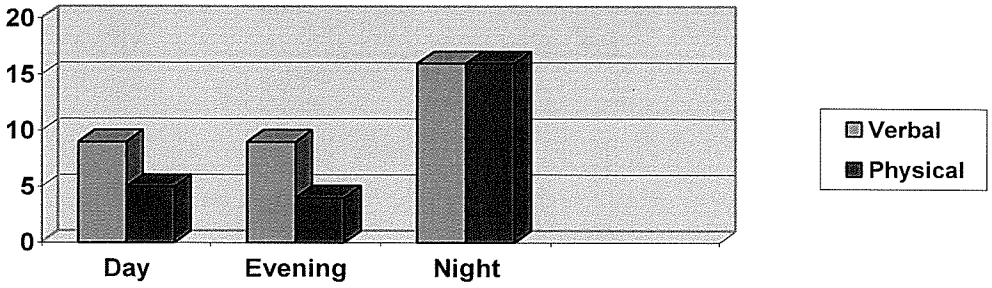
No statistically significant patterns emerged related to use of intoxicants and WPOA reporting by season although there was increased reporting of both verbal and physical incidents in the winter and spring.

Graph 11: WPOA Incidents Involving Intoxicants by Month



While the Graph 11 demonstrated spikes in verbal and phsical WPOA reporting in March and July, there was no statistical significance found.

Graph 12: WPOA Incidents Involving Intoxicants by Shift



Of the physical WPOA incidents, 25 involved the use of substances, with the majority of interactions (n=16) occurring during the night shift. The predominantly identified substance was alcohol. Verbal WPOA incidents involving substances were reported most frequently on the night shift as well, with 12 involving alcohol and 4 involving alcohol and other intoxicants. Chi square analysis of verbal and physical WPOA incidents involving intoxicants were found to be significant on a shift basis

($p=0.002$ and $p= 0.046$) with exposure to WPOA being most likely to occur on night shifts.

Frequency of responses to occurrence reports.

ORs were completed by individuals at the field level, and submitted to the regional office. Interventions to respond to the incident may be initiated at the field level by the nurse in charge who is the on-site manager or at the regional level by the Nurse Manager. Community level activities typically include involvement of local policing, child welfare agencies, or community leadership. While all ORs were to be reviewed by the Nurse Manager, not all originators will specify that they were requesting engagement of the Nurse Manager to assist with the situation. Where warranted, the Nurse Manager will initiate actions without the direct request for assistance from the report originator. Regional level activities may be to note the incident, or may involve engagement of stakeholders within the community, or external health service providers at a regional health authority or provincial organization. Internal Health Canada program areas such as security, facilities, community or non-insured health benefits program managers and the critical incident stress management/employee assistance program may also be engaged in the management of the situation or the support of the staff involved.

Community and regional stakeholder engagement incidence.

The data available from the 146 ORs included in the study demonstrated that community level engagement occurred in 103 instances. Consultation or notification of the nurse in charge occurred in 63 instances, local police were engaged 45 times, the community Health Director involved 19 times, and Chief and Council included in 34 cases.

Regionally, Nurse Managers, health programs, non-insured health benefits, regional security, or facilities staff were involved in the response to the OR. Regional level actions were taken in 80 of 146 cases. At the regional level, the Nurse Manager was consulted or notified for 77 situations, facilities involved in 2 instances and the Regional Security Manager engaged in 7 incidents. In these instances, managers were either contacted by telephone during office hours, or while on call for direction or support. In the cases identified in this section, the nurse originating the report identified that the involvement of the specific party by checking off the relevant party. The Critical Incident Stress Management (CISM) Program was directly engaged by field or management staff in relation to 34 of the ORs submitted. Incident management themes are presented in the qualitative findings later in this chapter.

Qualitative responses to WPOA

In analysis of the descriptions of incidents reported, several themes emerged. These are discussed within the context of the impact on delivery of health services reported by the staff involved. The themes related to the negative impacts of WPOA on nursing recruitment and retention, service delivery, and relationships within communities. Examples of comments which typify the themes were presented.

Impact of WPOA incidents on Community Health Nurses

Individuals completing ORs indicated that lack of security services, verbal aggressiveness, physical threat or contact, and community level politics contributed to added stress, unease, fear, inability to properly assess clients or provide care and factored in to consideration of leaving the community. One CHN described a situation in which an intoxicated client was being seen with an acute injury that included facial swelling and

abrasions. The client became increasingly aggressive as the nurse attempted to assess the injury and was stating "not here for that...need my nose fixed" when the nose had been fractured two years prior. The nurse documented that when the referral process was described, the client became increasingly aggressive and angry stating, "You're just a bunch of a**holes anyway" and left without the assessment being completed. The nurse identified that this interaction resulted in added stress, and felt that the safety of the health care providers involved had been compromised as had their ability to provide appropriate care.

In another incident, the CHN described a situation in which a family member had called the NS regarding an elder who had fallen, and the decision was made that the elder did not need to be seen. Shortly after, the CHN received a call from a Councillor "demanding to know why an elder was refused care." The Councillor then stated the client would be coming to the clinic now to be seen. The CHN indicated that the councillor was asked why the council members in the community "...are always demanding nurses to see patients" to which the Councillor responded "Well, that's the name of the game". In this situation, the CHN again reported increased stress. The nurse stated that there had been a sense of being bullied and "pushed around by everyone in the community and being told how to do their jobs". The nurse indicated that she and another community health nurse would not return to the community as a result of the incident.

Many ORs described incidents in which community expectations for services were not met and WPOA resulted. One such incident was described by the CHN as follows: "Patient arrived in nursing station at 1310. At 1327, patient stood up, asked if

he was to be seen, patient responded "I've been waiting a f***ing hour." Explained to the patient that it was necessary to inform reception staff of their arrival so that their chart could be pulled. Patient punched door and replied "I don't give a f**k about that." Patient then threw bag of garbage at writer's head. Incident witnessed by front desk staff, physician and other registered nurse. With this incident as well, the CHN indicated that they felt the environment was unsafe for all members of the health care team.

Impact on delivery of health services reported by Community Health Nurses.

The ORs allow for comments from staff completing the form with respect to the impact of the incident on their ability to deliver services. The themes emerging in this area were related to feeling unsafe in the workplace, residence and community, added stress related to dealing with violence and threats, delays in providing health services due to lack of security or police services, the perception of a lack of support from on-site and remote colleagues and insufficient support from community leadership. This was documented by the nurses with statements: "nurse bullied to see non-urgent client during night" in which the nurse was referring to a case in which a client's mother called reporting a fever for 12 hours. Telephone triaging had been done and an appointment for the next morning booked. The client was then brought to clinic during the night after being told by the health authority (community-based department responsible for the delivery of band-administered elements of the health programs) to bring the child in. In another scenario, the nurse had provided telephone advice for a child who had hit his or her head on the door of a vehicle. One hour later, the nurse received a call from the health councillor stating the child needed to be seen as it was a serious head injury and that if the patient was not seen, it would be reported to "the FNIH people". The nurse

went on to state "Chief and Council should not become involved in deciding whether or not a patient should be seen. It is our job as nurses to decide this when there is political interference with Chief and Council. It simply undermines the role of the nurse and nursing station....Personally it makes me feel defensive. Why should I have to justify my reason for seeing versus not seeing someone who does not understand. He simply wants the family to like and respect him...".

The lack of security services were also highlighted in a number of ORs submitted. These situations resulted in CHNs communicating frustration, fear for safety and concern about communities being unable to access health services. One nurse remarked: "security continues not to arrive and this results in the security of the last shift trying to replace, calling nurses at very late hours. Little support from councillors at times....this is compromising the safety of nurses and clients". Another nurse stated: "No security from 0900-1700. A security showed up at 1415....ongoing issue. This is a problem waiting for a disaster to happen. The community is at risk of having no service in emergency crisis".

Direct service modifications occurred with incidents that required closure of the facility due to nurse fatigue, absence of security staff to ensure a safe work environment (n=24) and the inability of the nurse to conduct appropriate assessments due to client refusal or unsafe behaviours (n=8).

Management responses to occurrence reports.

Managers' responses to ORs demonstrated two themes: affirmation of community level interventions and direction and support to staff. Affirmation of community level interventions was reported on ORs in which the writer had provided sufficient detail to

indicate that the incident was resolved or actions taken to mitigate risk of reoccurrence. These responses included statements that the actions taken by the nurse in charge or field nurse were sufficient, no further action was required or that the occurrence had been "noted". Within the theme of direction and support to staff, three sub-themes emerged. These included engagement of community leadership, engagement of community stakeholders/program staff and facility repair/reinforcement.

Engagement of community leadership includes actions such as Nurse Manager and NIC follow up with Chief and Council following incidents of abuse or aggression in which specific situation s are reviewed. One such dialogue occurred after the following report was received "patient very upset upon arrival at nursing station, yelling and swearing at writer during entire visit. Patient stated "f**k you, and f**k off, I don't need your bulls**t" and then left the nursing station. The nurse reported that the assessment was not complete due to the patient's departure. In this scenario, it had been anticipated that a complaint may be lodged with community leadership, and the approach taken was to ensure that Chief and Council could be informed of the situations faced by nurses. This discussion also provided an opportunity to communicate expectations of both FNIH and community leadership about how to manage challenging situations in which conflict between community members and health team staff occurred.

Community stakeholder or program staff engagement included activities such as responding to an incident in which a patient felt that the services provided at the nursing station were not sufficient and became angry and verbally abusive. In this situation, the community health administrator was engaged and intervened with the community member. In another case, nurses were faced with inappropriate behaviour from a child

welfare worker in the community which resulted in a difficult working situation in the management of a child who was in the care of the child welfare agency. With this situation, the nurse in charge and Nurse Manager engaged local and regional child care supervisors to address the identified concerns and resolve the behaviours that had been demonstrated

Facility repair or reinforcement was initiated after incidents such as when a patient with multiple lacerations and the two individuals that were accompanying him broke the window of the NS while banging on it yelling and curing at the nurses and guard. The maintenance man was called in after hours to reinforce the window, and the regional maintenance crew was dispatched the following workday. A review of the area adjacent to the broken window was conducted to assess access to the remainder of the facility should access have been gained. Safety was reviewed with the nurses and guards-reinforcing the need to find a safe, locked area with phone access to contact police should unauthorized access occur. With these occurrences, managers advised staff of the steps which should be followed, or initiated these steps on behalf of the nurses involved. In some instances, these actions to be taken were immediate whereas others were aimed at longer term activities to improve the current and future conditions.

Conclusion

In this chapter, the data relevant to WPOA incidents was presented. Quantitative information related to incident type, involvement of intoxicants, timing and responses to ORs was available. Qualitative information related to incident descriptions, impact on the delivery of health services and the responses of managers was also presented. This study found that nurses were exposed to a range of WPOA incidents including verbal

abuse, verbal aggression, verbal threats, threats related to professional practice or political action as well as physical threats, and physical aggression. Based on the data analysis, the following conclusions were drawn: CHNs working in remote and isolated communities were subjected to WPOA while at work; exposure to verbal threats and abuse occurring more frequently than physical threats or abuse. Of these, verbal WPOA exposures occurred more frequently during day shifts (0800-1659 hours) and physical WPOA during night shifts (2200 to 0759 hours). It was found that female perpetrators were more commonly engaging in verbal WPOA incidents, and males were the more common perpetrators of physical WPOA incidents. Intoxicants (alcohol, solvents, OTC medications, illicit substances) were reported concurrently with a large number of both verbal and physical WPOA incidents. It was also noted that CHNs experienced questioning of their professional competence and judgement by non- health care providers in the communities which led to frustration and job dissatisfaction. The study demonstrated that actions to respond to the ORs occurred at community and regional levels and had been initiated by field staff as well as Nurse Managers at the regional office. While the engagement of community and external stakeholders such as regional health authorities, chief and council, mental health staff, child and family services agencies and local band constables or RCMP were reported, there was not clear evidence of what impact, if any, these activities had for field staff. The final conclusion, while not related to incidents of WPOA directed at nurses or other health care providers, was important to the overall sense of safety and wellbeing within the community. It was found that security services and availability of police support played a role in the ability of CHNS to deliver health services, and their overall sense of safety in the community.

Chapter 5: Discussion and Conclusions

This chapter discusses the patterns which emerged in the WPOA related ORs submitted from January 1, 2008 to December 31, 2008. Where possible, discussion of contributing factors and relationships are identified. Existing research is considered with the findings of this study and parallels or differences are articulated. Limitations not previously identified in the various areas of the study are discussed. Implications of the study for nursing practice, administration, education and research are presented. Recommendations for policy change to reduce and respond to WPOA within the FNIH practice context are proposed.

This study provides new knowledge about the phenomena of WPOA in federal nursing stations in Manitoba. From a research perspective, the study is limited as the study instrument does not provide sufficient data related to the perpetrators, staff involved or situational variables. However, the demonstration of the presence of WPOA provides an opportunity for further exploration to be considered.

This study utilized existing administrative data to explore the understudied area of WPOA in FNIH Manitoba nursing stations in remote and isolated FN communities. As a result of this study, new knowledge about the phenomena of WPOA in this practice setting was generated. With the data available on the FNIH ORs, it was possible to identify the types of WPOA interactions that nurses faced, patterns of when incidents occurred and to what extent intoxicants were concurrently involved in the interaction. Impacts on nursing as well as responses taken to address the incidents were captured and discussed.

Demographics and WPOA Incidents Reported

Community demographics

Based on the information available in the 2008 ORs, it was found that communities with populations of between 1000 and 1999 residents reported the highest incidence of WPOA events. While these are not the smallest communities in Manitoba Region, this finding is consistent with the study by Fisher et al. (1996) who noted that smaller communities reported increased WPOA incidents. It is anticipated that individual community circumstances and nurses' reporting practices may influence these findings and warrant further exploration.

Nursing demographics

This study provides useful information for nurses and administrators related to the reporting of incidents by CHNs. Female CHNs represented 85.7 % of the FNIH workforce, and were involved in 81% of the WPOA incidents reported, and the 14.3 % of male CHNs were involved in 8% of incidents. In the remaining 11% of incidents, either both males and females were involved, (9%), or gender was not specified (2%). This study demonstrated that the ratio of incidents for females was almost 1:1, while for males it was approximately 1:2. However it is not clear why this was the case. This may be by virtue of staffing patterns and on call responsibilities, or may also be related to variables such as gender perceptions, individual personalities and reporting tendencies. There was no statistical significance found, and the study did not provide any further insight into gender distinction as an indication of increased risk.

CHNs working in remote and isolated First Nations communities reported incidents of WPOA directed at them personally as well as incidents directed at co-

workers and the facilities. In communication with Nurses in Charge (NICs) at the 2008 NIC conference and with field staff at 2008 Nursing Safety and Awareness Training (NSAT) sessions (personal communication, 2008), it was identified that many nurses define workplace violence, abuse and threat differently. This was consistent with what was demonstrated in the literature (Chaboyer, Najman, & Dunn, 2001; DelBel, 2003; Hesketh et al., 2003; Jackson, Clare & Mannix, 2002; Mullen, 1997; Neuman & Baron, 196, 1997, 1998; Randle, 2003) with a variety of terms used across the continuum of workplace exposures. As a result of these differences, the use of the term WPOA would provide an all encompassing definition of incidents to which staff may be exposed. This is important in that nurses tend to minimize and normalize many interactions in the workplace that are captured within the definition of WPOA. The use of the term WPOA will be helpful in future studies and allow for data collection to be approached consistently.

During the NIC conference (2007, 2008) and the NSAT sessions (2007, 2008), it was identified that nurses frequently deal with clients who use disrespectful and explicit profanity during the delivery of health care services. It was stated that aggressive physical actions occur on "a regular basis" in some communities; that other health care professionals such as colleagues, medevac staff, or physicians can be a source of aggression and that political influences at the community level were common. In this study, it was found that health care providers do experience WPOA in the course of performing their professional duties, although it was not possible to identify specifically who the perpetrators were in the majority of incidents.

It was identified that these interactions with patients, families, other health care providers and community leadership impacts the nurses' ability to use effective clinical reasoning, self esteem, commitment to the organization and ongoing employment considerations. These impacts were also noted in the work by Fisher et al. (1996) who had studied violence in remote area nursing (RAN) in Australia. The findings of this study also supported the anecdotal reports of the NICs and NSAT participants in the qualitative analysis of the impacts comments. In the ORs, nurses identified intent to leave specific communities, general dissatisfaction with the work circumstances and frustration with the lack of security supports which impacted their ability to provide health services.

Also consistent with Fisher's 1996 RAN study was the reluctance or refusal to report incidents. The NICs as well as NSAT participants indicated that the majority did not identify verbal abuse/threat or physical threat and aggression as being relevant to report. In many cases, these actions have been normalized, with nurses stating that the perpetrator was seen as being incapable of controlling their actions, that "no one had been hurt", or past reporting had not demonstrated a response from the manager/region that was satisfactory to the nurse. As a result, it is likely that the data presented in this study is an under-representation of the WPOA to which nurses are exposed. This would also be consistent with the under-reporting identified in the acute care, long term and community based settings. Studies conducted in emergency rooms, home and community care, long term care and psychiatric settings, suggested that up to 70 % of incidents involving health care professionals are not reported (Fernandes et al., 1996, Hesketh et al.l 1999, Farrell, 2000).

Perpetrator demographics

Existing international health care WPOA literature indicates that perpetrator factors share certain commonalities across settings, including age ranges, gender, and the presence of concurrent mental health issues or use or intoxicants. None of these studies provided a breakdown of perpetrator characteristics by type of WPOA be it physical or verbal, however other studies did indicate that the most common age perpetrators of WPOA incidents were young males with lower socio-economic status, education levels. Other factors included a lack of strong social or familial networks (Anderson, 2002; Littrell & Litrell, 1998), patients or families with a past history of abuse or a chronic pattern of self-harm (Lee et al., 1999; Lewis & Blumenreich, 1993, and Mossman, 1995). This study was not able to support or refute previous findings, however it did demonstrate that males were more likely to engage in physical WPOA incidents, and females to be more likely involved in verbal WPOA incidents. This finding presents new information related to perpetrator gender and types of WPOA incidents initiated by each.

Reported incidence and types of WPOA

While it is expected that the incidents reported under-represent the full extent of WPOA in nursing station settings, the ORs demonstrated that WPOA directed at nurses and other facility staff members occurred on average 12 times per month within the region. Verbal abuse directed at nurses was reported between 3 and 9 times per month, and physical abuse between 0 and 6 times per month. As there are no other studies in the literature which utilized similar administrative data as the information source, it is not possible to directly compare these findings with existing research. However, multiple studies (Farrell, 1999; Hesketh et al.1999, Sofiel & Salmond, 2003) identified that nurses

are exposed to verbal abuse and threats more frequently than physical threats or aggression. Within this study, it was found that patterns of abuse existed with verbal abuse occurring more frequently during day shifts and physical abuse more frequently occurring on the night shifts. This has implications for educational programs aimed at preparing nurses for the workplace and for policy related to staffing and security.

Dodd and Johnson (1995) and Fisher et al. (1996) indicated that remote area nurses, like FNIH CHNs, encountered political threat and what was deemed "political interference" in clinical care decisions. Political interference can be described as coercion to take a certain course of action that the nurse does not believe is warranted, be it to see a patient after hours, initiate a course of treatment, send the patient out for further assessment or send the patient with an escort. As the practice context for Australian and FNIH nurses are similar, it is interesting to note that both reported these incidents as being present in the workplace. This was a finding that appeared to be unique to the remote area nursing station context versus the general health care literature. As a result of these particular types of interactions, nurses in both the FNIH and Australian nursing stations reported increased stress, frustration and job dissatisfaction.

Reported incidence and types of WPOA related to security guards, policing services, theft and property damage

As most health care research to date has been conducted in institutional settings, little consideration has been given to having sufficient people around to maintain a safe work environment should an incident occur. However, in a nursing station setting, there are often limited numbers of people present while health services are being delivered. This is particularly true in the case of after-hours services in which the nurse is on call.

Fisher et al. (1996) found that nurses who were on call for the 24-hour period were "more likely to experience all types of violence" (p. 193) which in their study, included verbal aggression and obscene behaviour, property damage, physical violence, telephone threats, stalking, sexual harassment and sexual abuse. The FNIH ORs submitted also demonstrated that nurses were exposed to WPOA incidents outside of the regular clinic hours of 0830 to 1700 hours. Nurses in Manitoba region reported exposure to all of the types of incidents reported by remote area nurses with the exception of stalking and sexual abuse.

As a preventative measure, FNIH has funded security guard positions to ensure that nurses are not alone while clients are present, and so that there is monitoring of the facility on a continual basis. The 1996 study by Fisher et al. identifies the presence of security as a protective factor, stating "those without access to a security escort were more likely to experience violence" (p. 193). However, Fisher et al. (1996) also noted that 40% of nurses who had experienced physical violence, and 50% who had been harassed did have access to security escorts. The study of FNIH nursing stations demonstrated that the incidents occurred both when security staff were scheduled to be present (n=108) as well as when security were not required to be on-site (n=32). Day of week or time of incident was missing for 6 incidents so it is not possible to determine if security availability was a factor. There are no security staff present during the regular clinic day of 0830 to 1700 hours from Monday to Friday in FNIH nursing stations.

While the intent of FNIH is to ensure that security is available for nursing staff, the 2008 ORs demonstrated that there are challenges being experienced at the community level with the reliability of security staff, and the job performance of security staff. This

in turn impacts the ability of the CHN to provide health care services and the nurses' perception of risk. Of the 146 ORs included, security guard-related issues were identified in 41. From this, it is evident that the concerns ranging from not arriving for scheduled shifts or leaving early without notice (n=30), leaving the facility unlocked or unattended (n=4), failing to respond to nursing requests for assistance with clients or with disturbances on the grounds (n=4) were significant to nursing staff. Nurses and other health care providers reported 3 incidents in which security staff were on-site, however the response was not sufficient and resulted in nurses feeling unsafe. The four other incidents that identified security guards becoming involved in WPOA altercations or having to work extended hours also included comments related nurses feeling safety was compromised.

Reporting of policing issues identified a sense of vulnerability for CHNs in the communities. There were 12 ORs submitted related to this area, most of which identified a lack of police availability or a failure to respond to requests for assistance (n=7). While the research in similar settings is limited, the Australian study by Fisher et al. (1996) also speaks to the need for, and concerns with, the policing available to respond is consistent with the findings of this study.

The descriptions provided by nurses related to the security guard and policing issues demonstrate frustration and concern that they will be unable to provide necessary health services of the nursing station was closed due to the lack of adequate security services. This resulted in a sense of professional vulnerability and concern about adverse outcomes that may have been prevented if care had been available. In turn, this has implications for job satisfaction and may influence nurses decision-making related to

remaining in specific communities or within the organization overall. This finding was consistent with the sentiments expressed by nurses at both NIC conferences and NSAT sessions (personal communication, NIC Conferences 2007 and 2008, NSAT 2007).

Pattern of reported WPOA incidents.

This study was intended to demonstrate how frequently nurses were exposed to the differing types of WPOA. In data available in the 2008 ORs, it was possible to determine the number of incidents by month (n=144), day (n=144) and time (n=135) for the majority of reported incidents. As the numbers were small for many of these parameters, the grouping of data by season, by weekday/weekend, and by shift, allowed for the emergence of some patterns of WPOA activity. While the OR data related to day, month or season was not statistically significant, the shift was demonstrated to have statistical significance for both verbal (p= 0.022) and physical (0.030) WPOA incidents. It is important to note that awareness of incident timing does have implications for policy and education initiatives. When use of intoxicants were considered, statistical significance was also demonstrated with respect to verbal interactions by shift (p=0.002), month (p=.0024) and season (0.010).

It was found that cumulative WPOA incidents occurred most frequently in the fall (September to November) months (30%), followed by the summer (June to August-28%). However, when the verbal and physical incidents were separated, the majority of verbal incidents happened in the fall (32%) and physical incidents, in the spring (March-to May-36%). This was contrary to what was anticipated, as based on anecdotal reports of staff at NSAT sessions (personal communication, NSAT session 2008), and the personal experience of the PI. Probable access to substances brought into communities

on winter roads tended to correlate with higher numbers of both verbal and physical WPOA incidents, with 16% of both verbal and physical WPOA incidents occurring in March although it was not possible to definitively identify what communities were able to utilize winter roads vs all year roads in this study due to the removal of community identifiers. Existing research related to WPOA did not explore seasonal patterns, so it is not possible to identify how congruent this finding would be with that of other health care settings.

Based on anecdotal reports of field staff at NSAT sessions (personal communication, NSAT 2008), it had been anticipated that the majority of WPOA incidents would have occurred on weekends. While this was found to be accurate for physical incidents, it was not the case for verbal incidents. Sixty-three percent of all verbal incidents occurred on weekdays, while 55% of all physical incidents occurred on weekends. Again, existing literature did not provide analysis based on these specific parameters, so it is not possible to compare these findings with other settings. It is possible that interactions on weekdays are more frequent as a result of exposure to more client contact overall, or that there is more of a requirement to engage with other components of the health care system such as non-insured health benefits or external referrals. It is also possible that the nurse or health care provider is seen as a "safe" outlet as opposed to family or community members/leaders and therefore increases the expression of frustration.

While this study found that WPOA incidents had been reported on all shift periods, verbal incidents occurred more often on day shifts (43%), and physical incidents occurred more often on the night shifts (61%). This may or may not have been related to

a larger number of people being present and available on day shifts rather than nights for the verbal incidents and possibly related to the types of client presentations and use of substances for the night shifts. With the exception of an unpublished master of nursing thesis (Quick, 1999) which explored horizontal aggression in nursing, there had not been a separation of incidents by shift in the existing literature. Quick (1999) found that over 50% of the horizontal violence incidents occurred on day shifts, with the fewest episodes occurring on night shifts. While the FNIH OR allowed for the reporting of horizontal violence, this type of incident was reported twice, providing an insufficient number of events for the generation of any conclusions or comparisons. The existing research suggests that horizontal or colleague-instigated incidents are reported less frequently than those initiated by patients or families (Farrell, 1999, Hesketh et al.1999). Based on discussions at 2008 NSAT education sessions, this would be consistent in the FNIH environment as well (personal communication, NSAT 2008). Both the findings related to overall WPOA exposures by shift, and the lack of reporting of peer initiated WPOA, have implications for education and support for staff which are discussed later in this chapter.

Incidence and patterns of reported WPOA involving substance use.

In the analysis of the 2008 ORs, it was identified that the use of intoxicants (alcohol, solvents, OTC medications, illicit substances) impacted the type of WPOA exposure. It was noted that when use of intoxicants were concurrently reported, nurses were exposed to more verbal WPOA and physical incidents on day and night shifts than during the evening hours, however the physical incidents were most evident on the night shift. It is not possible to eliminate all interactions with clients who are under the

influence of intoxicants as there are often concurrent health and injury issues that necessitated the visit to the nursing station. As a result, it is essential that nurses are equipped to recognize patients who are behaving in a manner that may place the nurse at risk and that appropriate supports are sought and available during the interaction as well as after the client has left the facility. Again, the existing literature is limited in how data related to concurrent substance use was reported. In the majority of studies, use of intoxicants was captured under the description of the characteristics of the perpetrators (Distasio, 2002, Lewis & Blumenreich, 1993; Littrell & Litrell, 1998; Presley & Robinson, 2002; Whitley et al., 1996; Martin, 1997; and Fisher et al., 1996). This is discussed further in the implications and recommendations which are presented later in this chapter.

Impact of WPOA incidents

As previous research has demonstrated, exposure to WPOA contributes to increased stress, deceased job satisfaction and job performance, as well as personal consequences for nurses related to physical and emotional well-being (Hoel, Sparks & Cooper, 2002). For the organization, the consequences may include decreased productivity, decreased work investment, increased utilization of sick time or health benefits and possibly resignations (Walsh & Clark, 2003; Farrell, 1997, 1999, 2001; Alexander, House & Fraser, 2004; Bussing & Hoge, 2004; Barling, Rogers & Kelloway, 2001; Burnes & Pope, 2007; Sofield & Salmond, 2003; Hislop & Melby 2003; Gerberich et al. 2004; and Randle, 2003).

This study demonstrated similar themes, with nurses indicating that WPOA interactions resulted in added stress, fear for their safety, and that their ability to provide

services to communities were being compromised by the situations they were facing. Decreased work investment was demonstrated with statements related to the questioning of their abilities and the frustrations that arose. In at least two instances, this resulted in nurses deciding to not return to specific communities. In some of the ORs, nurses reported feeling unsafe in the nursing stations, residences and community which has also been found to result in nurses choosing to pursue alternate employment (Fisher et al., 1996). Nurses expressed dissatisfaction with incidents that required closure of the facility due to nurse fatigue, absence of security staff to ensure a safe work environment and the inability of the nurse to conduct appropriate assessments due to client refusal or unsafe behaviours. This frustration further affects the ability of the nurse to provide quality health services, and the employer to retain and recruit new staff. It is important that nurses be adequately prepared for these possibilities and are supported when such situations do occur to reduce the negative impact which has implications for both nursing education and administration.

Responses to occurrence reports.

Health Canada has a number of policies and guidelines aimed at the protection of staff within the workplace such as the code of conduct, zero tolerance policy, working alone guidelines, second on call policy, and the occurrence reporting processes. Research has demonstrated that these may provide some protective benefit however organizational commitment to enforcement and ongoing review is essential (Howard, 2001; Nachreiner et al., 2005).

As existing research has demonstrated, management support is critical for nurses to remain engaged and committed to their work post-incident (Duncan et al., 2001;

Farrell, 1997; Gacki-Smith, Juarez, Boyett, Homeyer, Robinson, & McLean, 2009; Gallant-Roman, 2008; Henry & Gin, 2002; King & McInerney, 2006; Martinko, Douglas & Harvey, 2006; Merecz, Rymaszewska, Moscicka, Kiejna & Jarosz-Nowak, 2006). The managers' responses to the 2008 ORs demonstrated that they either provided affirmation of actions taken, or provided support and direction to resolve incidents. However, it was noted that not all managers responded to situations in a similar manner. Best practice literature (Registered Nurses Association of Ontario, 2007) offers suggestions for reduction of WPOA incidents, and management responsive should incidents occur. Possible approaches will be introduced in the recommendations later in this chapter.

Study Limitations

This study was a retrospective analysis of existing data, and as such, there was no opportunity to advise individuals who would be completing the reports what the study definition was, or what the reporting expectations would be for the purposes of conducting this research. While the ability to have informed nurses of the study may have improved reporting, this study provides a baseline for WPOA incidents with a reporting threshold that did not demonstrate any enhanced or heightened attention to safety or security within the FNIH Manitoba region nursing workforce during the year of 2008.

WPOA, while extensively discussed in the business, social sciences, and health literature, was not defined consistently and as such, makes interpretation and comparison of study results challenging. Therefore, the definition of WPOA identified in chapter one guided the study content analysis. As submission of ORs was subject to individuals'

completion at the community level, reporting biases such as appraisal of risk related to the experience, training, and general situational awareness of the nurse may be a significant factor. Nurses completing the ORs may also not have the same threshold for reporting. How individuals define violence, assault and threat may differ despite the existence of definitions and examples which accompany the form. Additionally, the OR definition of violence does not encompass verbal abuse, harassment or any non physical encounter in the definition of nurse-directed violence which may cause nurses to infer that this was acceptable and not reportable. Within the nursing literature, horizontal and lateral violence were identified prominently as concerns, yet the FNIH OR does not specifically speak to this issue, presenting yet another limitation to the available data. The FNIH OR organization and categorization of incidents was an additional limiting factor in this study. For incidents directed at nurses, the heading combines violence, assaults, and threats. As nurses may interpret security violations differently, it is anticipated that there may have been under-reporting. As verbal abuse/aggression and horizontal violence were not explicitly identified as being reportable, nurses may minimize incidents or see them as part of the workplace expectations. While some nurses identified these types of incidents in the "other" category, it is possible that some incidents were not reported. The study was also imited in being able to determine the type violence exposure except where the description of the event provided additional information.

This study utilized only existing administrative data and in doing so had a number of inherent limitations. In using the ORs as the data source for the study, it was recognized that completion of an OR was dependant upon the nurse categorizing an

incident as significant enough to warrant the completion and submission of the document. In general health care literature, it has been demonstrated that up to 70% of WPOA incidents are not reported. WPOA was often viewed as part of the job, there was an element of shame or embarrassment, apathy, fear of reprisal, or concern related to management response (Duncan et al., 2001; Fernandes et al., 1995; Kingma, 2001). In addition, when the WPOA perpetrator was a supervisor or subordinate, there may be reluctance to use the OR form to communicate these concerns. As a result of these issues, an under-reporting limitation was likely present in the data available. Data quality was an additional issue noted as the field related to individuals ("perpetrators") involved in incidents was not consistently filled in, with age being the required element. In this area, or in the description, 51% of report originators provided gender despite it not being a requirement of the form. Incident descriptions, impact on services and management comments were found to be very brief and most contained only minimal information about the situation or the response.

An additional limitation of conducting a retrospective analysis of existing data from an administrative tool is that community-specific variables are not well captured on the current OR form. As a result, community specific data such as isolation/road accessibility, pay periods, weather and traumatic events was not captured consistently, nor is it possible to reliably gather these details retrospectively for 21 communities. This instrument does not allow for a full understanding of the circumstances occurring around the incident, resulting in the data being presented in isolation from the community and workplace factors that may contribute to client/ family-nurse interactions.

As a result of the limited information captured on the forms, the quantitative analysis possible was limited as only nominal level data was collected. With respect to the qualitative analysis, it was not possible to capture the full experience of the nurses or assess the influence of community, staffing, individual or situational factors which may have impacted the interactions as OR form originators generally provided minimal details of the incidents. The level of detail available in regard to the community, originator and person's involved demographic data as well as the incident descriptions was limited. For the qualitative elements, the data available was limited in that it has been collected for administrative purposes rather than research and does not demonstrate the fullness that would be anticipated in a study being created specifically to explore a given phenomena. Descriptive data was produced and demonstrates that more in-depth exploration of WPOA in remote and isolated nursing practice contexts may be warranted. Quantitatively, the data was nominal in nature which limited the statistical analysis possible.

Requirements of the ethics approval process created additional limitations with respect to the demographics related to nurses and communities. In order to maintain anonymity of the report originators and communities, all identifiers were removed with the exception of gender and size-based grouping of communities. An unanticipated limitation on the study was related to the removal of staffing identifiers as it created the inability to determine employment type such as FNIH vs. agency, full time vs. part time or itinerant, education or experience. As a result, it was not possible to explore how staffing numbers or individual staff characteristics may have impacted reporting. Information about employment status with respect to full time vs. part time, or FNIH vs.

agency employed would have been useful in assessing if there were differences in reporting thresholds between the two groups of nurses or if staffing consistency was a factor in the reporting or possible exposure to WPOA incidents. It is possible that itinerant staff may be confronted with increased WPOA incidents due to their unfamiliarity with communities or that there may be differences in the reporting threshold of itinerant staff. Reporting bias based on normalization of incidents, lack of prior management responsiveness, fear of repercussion or lack of engagement in the workplace within the context employment type and tenure was not able to be explored as a result of this limitation

Despite the information restrictions created by the removal of identifiers required for ethics approval, the ORs did provide raw data which allowed for analysis and generation of information that was not previously available in a usable manner. The study was a non-experimental descriptive design and intended to determine the reported incidence and types of WPOA in FNIH Manitoba Region nursing stations. This was possible using the available information. This study provides information from which policy and education decisions may be considered as well as makes recommendations for further study

Significance of the Study

Nurses who currently work, or are considering employment in remote or isolated settings are often unprepared for the range of situations that they will encounter. To practice in the community health nurse role requires nurses to be generalists, with skills that meet the health care needs of populations from pre-conception to advanced ages (Fisher et al., 1996; Kirwan & Corneil, 1994; Martin, 1997). These skills are applied in

communities that may struggle to meet basic determinants of health. In these instances, nurses provide care to clients who may demonstrate aggressive or violent behaviours toward the health care provider (Fisher et al., 1996; Kirwan & Corneil, 1994; Martin, 1997). This study provides new insight into WPOA issues and allows for the generation of recommendations and future research activities.

Defining and reporting WPOA

WPOA is a poorly defined phenomenon to which nurses in all health care settings are exposed. This study implemented a definition of WPOA that encompasses the full spectrum of workplace incidents that may result in harm to individuals in the workplace. WPOA was defined as any and all acts occurring within the workplace context, perpetrated by persons internal or external to the health care team resulting in physical, psychological or emotional harm to an individual. Use of a consistent and all encompassing definition will be useful for future studies and development of occurrence reporting tools. As this study demonstrated, valuable information having the potential to influence change is available from the ORs. With modifications suggested by this study, ORs will capture required data elements, and education will reinforce the importance of reporting all WPOA incidents on an ongoing basis.

With appropriate and timely management responses to OR reports, the perception that "nothing happens" with the ORs will be modified. At present, ORs submitted from the nursing stations are reviewed by the Nurse Manager and the incident noted, comments made/actions taken. The OR is then forwarded to the assistant director of nursing for further review, comment and action as required. At this point, the OR is to be returned to the originator. However, nurses in charge reported that while verbal

review of incidents with their Nurse Managers did occur, reports were not consistently returned to the originating nursing stations with the managers' comments (personal communication, NIC conference 2008). In addition to providing feedback to the originator of the report, the data contained would be of benefit in informing community leadership of issues being faced by the nursing station staff. It would be beneficial to have the nurse in charge and Nurse Manager review aggregate data from the specific community with leadership on a quarterly or semi-annual basis. At the community level, this information would be valuable for leadership in understanding the issues from the perspective of staff at the nursing station. With the use of a reliable electronic system for the submission, review and response to a revised OR form the capacity to assess the individual event, aggregate the information and respond within both community specific and regional prioritization contexts would be significantly enhanced. In order for this to occur, the development of a system for aggregating, analyzying and presenting this data in a user friendly format is required.

Exploration of WPOA variables

Prior to this study, there had been no analysis of FNIH OR data which would quantify the extent of WPOA in remote and isolated communities in Manitoba. This study utilized existing administrative data to conduct a descriptive analysis of WPOA in First Nations and Inuit Health Nursing stations in Manitoba Region. The results demonstrated that there were sufficient ORs submitted to identify that nurses are exposed to both verbal and physical WPOA in FNIH Manitoba Region nursing stations.

This study provided the opportunity to explore variables that have not been considered in other studies. While this study does not have the richness of data available

from tailored questionnaires or interviews, it does allow for exploration of WPOA incidents by time of day, day of week, month and season. As this OR captures the event contemporaneously, recall bias is eliminated as occurred in other studies (Badger & Mullen, 2003; Bussing & Hoge, 2004, Fisher et al., 1997; Hesketh et al., 1999; and Menckel & Viitasara, 2002) It is an expectation that ORs are utilized for all incidents which occur, and should that be the case, the ORs would be a rich data source that have the potential to be analyzed on an ongoing basis and provide longitudinal information about WPOA incidents in FNIH communities. This study also allowed for the separation of incidents into the categories of verbal, physical, practice and political related threats or actions by day of week, month and time, unlike any other studies conducted to date.

WPOA-related education requirements

While the majority of studies to date suggest that WPOA-specific education is required, there is increasing support for the education to occur early in their employment. As this study has identified that CHNs with FNIH face exposure to WPOA incidents, it will be important to ensure that nurses are adequately prepared to recognize, respond and report incidents which may occur. In addition, nurses new to remote and isolated nursing station settings must be aware of scenarios unique to this environment such as the questioning of clinical decisions by non-health care providers, political pressure by community leadership to see or manage clients in a specific way, frequent exposure to profanity, personal and professional isolation and, for non-First Nation nurses or First Nation nurses from an alternate tribal affiliation, possible discrimination.

The research and responses of FNIH staff at NIC conferences (2007 & 2008) as well as at the NSAT sessions (2007 & 2008) also reinforced the need for ongoing

reinforcement of WPOA related education. The findings suggest that these sessions need to be offered or delivered in a variety of formats such as print or paper based, electronic media or direct face to face , as well as at varying time periods. Preparation of nurses at the commencement of their employment is critical, with the full NSAT session to be available within the first six months of work. Annual reviews of how to recognize and respond to situations, as well as a review of the importance of what to report, and how, are recommended. As fostering effective teams plays an important part of delivering cohesive services and responses to community need, it would be recommended that the annual reviews be conducted on-site, and include a review of the aggregate data for each community. This review could be conducted by the Nurse Manager and member of the regional security team. In addition, should there be periods of time in which escalation in the community is identified, or a significant issue occurs, a modified review specific to the type of incident should be undertaken with the staff for that community. While it is important to conduct the community-specific reviews, sharing and validation of experiences across communities is also important and could be achieved during face to face education sessions, or with the use of telehealth/video-conferening or webinars.

Practice supervision and support

In the analysis of the managers' responses to WPOA incidents, it was found that inconsistencies existed in how situations were addressed. The responses ranged from simply noting the incident, to actively engaging with community leadership or regional senior managers including the director of nursing or regional security staff. Severity of incident did not consistently correspond to actions taken which is a significant finding for managers to be aware of. Inconsistency in responses can further perception of managers

responsiveness and level of support being offered to staff, thus influencing job satisfaction and retention. This study demonstrated the need for managers to be aware of the range of response options available to them and to have the necessary resources or skills to respond consistently.

Current practice related to communication of management responses to ORs is that the manager will speak with the NIC about incidents rather than always speaking directly with the report originator. This practice, while allowing for feedback to the community level, may not be optimal in that the originator does not have direct contact with the manager and may not receive all of the information provided to the nurse in charge. Should the nurse in charge not communicate the feedback, the originator may not be apprised of the management actions and frustration or apathy may result.

Political involvement in the clinical elements of health service delivery was identified as a factor impacting continuing employment within the specific community, as well as with the organization in general. Mitigation of this impact may be achieved by preparing nurses for this possibility during their orientation process, as well as providing ongoing support through continuing education by teleconference/video conferencing, webinars or during face to face education events. On a community level, establishing effective working relationships with local leadership including the chief, councillors and health administration team will be pivotal in reducing these types of incidents. The NIC will be the primary resource to assist community leadership to recognize the impact of staff and community interactions of this manner. It is essential that the NIC be supported in this activity, which may be accomplished thru similar approaches as would be used with staff. The regionally based Nurse Manager is a critical partner in this process and

will need to be an active participant in meetings with local community leadership to ensure that there is a forum for open communication which will contribute to an increased trust and engagement of all parties. It is anticipated that political engagement in health issues may be reduced should there be a mechanism to address and resolve community concerns in a timely and consistent manner.

Policy implications

For FNIH, this study highlights several areas in which existing policy is not sufficient, or implementation has been delayed or inconsistently applied. These are identified, with recommendations to follow in a later section. FNIH has a zero tolerance policy for violence however this study demonstrated that nurses are exposed to significant, albeit under-reported, WPOA incidents while at work. The study will be beneficial to policy makers in exploring what, if any, modifications to existing policy are required. Enforcement of the zero tolerance policy does not occur consistently, and has implications for community relationships. It is essential that ongoing dialogue with community leadership and support of this policy occur.

The Health Canada policy related to facility safety and security also requires review and commitment to implementation. This policy establishes standards for facility construction and security however the provisions and stipulations of this policy have not been implemented retroactively in existing structures. This has significant cost implications, however also presents potential risk to nursing safety and employer liability if not actively addressed.

The Occurrence Reporting policy requires that all incidents as described on the OR form be reported and responded to by managers, with the event and the response

entered into a national database for aggregation and analysis of the data. This policy is not enforced as nurses are not sufficiently familiar with what events require reporting and/or nurses opt not to report incidents for a number of reasons including normalization, apathy, lack of recognition of significance or workload. In addition to lack of reporting, the database established does not work effectively or as intended. Resolution of this problem is required immediately in order for the data being collected to be utilized to inform future policy decisions on a national level.

Security guard issues were identified as problematic in a number of communities. Anecdotally, feedback from NIC conferences and NSAT sessions suggest that this is a more frequent issue than has been reported. As these positions are FNIH-funded but band-administered, NICs and Nurse Managers do not have direct authority for the day to day activities and actions. The recourse of FNIH, should adequate security services not be provided, is the withdrawal of nursing services until security is in place. In situations in which the community is not able to ensure this, the financial recovery and cessation of community based funding for this service may occur. At this point, FNIH would be responsible for the hiring and education of security staff and the ongoing delivery of security services. The findings of the study suggest that adequately trained and reliable security staff is a critical element in nurses' perception of safety with anecdotal feedback suggesting that this would be the preferred circumstance because the direct authority for supervision and scheduling would then be within the FNIH-managed administration (personal communication, NIC conference, 2007 & 2008, NSAT sessions, 2007 & 2008). From an organizational perspective, this would be contrary to the intent of transfer and would increase the costs and administrative burden of managing these positions however

this may be balanced by reduction in staff turnover in communities that have instability in their security services.

This study identified that night shifts most frequently expose nurses to physical WPOA incidents. Outside of the Monday to Friday 0830 to 1700 hours time periods, nurses work alone, with security guards present within the station. While there is a second nurse on call, in most instances, this person does not attend until the first on call nurse has conducted an initial assessment of the client. Should there be aggression which incapacitates the lone nurse, it may not be recognized until significant injury occurs- depending on the location of the security guard while the incident is occurring. While this has significant cost and health human resource implications, it is necessary to consider modification of how services are delivered during the "silent hours" of the nursing station.

This study also provides insight into the impact of WPOA on nurses. At the present time, nurses have access to the Critical Incident Stress Management (CISM) program services. These services include up to 13 weeks of leave and counselling/ support for critical incidents, and access to the employee assistance program for non-critical incidents that impact the nurse. In order to ensure that CISM follow-up is possible, Manitoba region forwards all WPOA-related ORs to the CISM office for follow-up with nursing staff-in addition to the follow- up provided by nursing directorate regional staff. The findings of this study identify the impacts of WPOA in a broader context than had previously been considered by FNIH managers. As the long term implications for ongoing engagement and retention of field staff are significant, this

study identified the need for support by managers as well as CISM for all incidents, regardless of the initial response of the nurse to the event.

Data trending

Until this study, there was no data available within FNIH that demonstrated the incidence and patterns of WPOA in Manitoba communities. This data will be useful in the development of educational initiatives, as well as staffing considerations for specific time periods. This study provides the first quantitative analysis of the OR data collected and will inform FNIH as to how WPOA incidents may be tracked and analysed by using the ORs and statistical software such as SPSS. With dedicated data entry until such time that an electronic system is implemented, staff at FNIH will be able to generate reports by community using the parameters established in this study, namely type of incident, and timing to provide valuable ongoing information related to community specific WPOA events, responses and nursing impacts.

The new knowledge generated by this will be of benefit to nurses in direct practice, administrators, educators and researchers as it provides insight into WPOA in an understudied area of nursing practice. Recommendations based on the data from this study are presented in the areas of nursing practice, nursing administration, education and research.

Recommendations

Nursing practice.

This study served to inform nurses of the types of situations they may face, and assists in identifying variables that can be considered in relation to personal and perpetrator characteristics, and where possible these can be recognized, avoided or

ameliorated by taking the appropriate actions. It identified patterns of when specific types of incidents occur and may serve to heighten nurses' awareness of potential circumstances which present, thus enhancing their own well-being and safety, as well as that of their co-workers. For nurses joining FNIH, this study identifies the need for appropriate preparation related to types of WPOA to which they may be exposed. For nurses currently employed, the study has identified the need for reinforcement of learning related to recognition of situation potential and appropriate actions for de-escalation or resolution of incidents. As these incidents may have negative personal, professional and employment impacts, the supports required post-event are also critical to assist staff to cope with the exposures. However, as under-reporting of incidents is likely, in many instances it is possible that necessary supports are not being provided as it is not known that they are required. The study reinforces the importance of reporting incidents which occur and the potential for reporting to influence action at the regional and national level. Community engagement in reducing and addressing WPOA incidents was evident from the notifications of incidents on the ORs. The aggregated data from the ORs submitted will provide information for discussion with community leadership and key stakeholders. It is recommended that the findings of this study be presented to field nursing staff to heighten awareness of the issues identified above, and allow for the introduction of change into the established and entrenched normalization of WPOA incidents in this practice setting.

Nursing policy and administration.

This study has demonstrated several areas in which policy and administrative modifications are required to enhance the safety and security of nurses working in FNIH nursing stations in Manitoba Region.

The OR policy and form is a critical element in understanding and responding to situations which occur in nursing stations. Central to this policy is the utilization of a common, and encompassing definition of workplace violence. The definition of WPOA developed for this study is recommended as the foundation for future policy and practice documents within FNIH as well as in broader health care settings. OR policy modification is required and needs to include a new definition and incident categorization, new data elements related to originator, perpetrator and community variables, the development and implementation of an electronic system for completion, submission and response to ORs, and an accountability structure that clearly identifies roles and responsibilities related to completion, response and analysis of incidents. It is recommended that the current OR form be modified, with health care practice and community issues separated from safety and security issues. The new safety and security OR form would include the definition of WPOA developed in this study, and encompass the categories of events utilized in the data analysis. A proposed safety and security OR form is presented in Appendix K.

In addition, it is recommended that education related to how to complete the OR form, as well as procedures and processes for reviewing and responding to ORs, be established within the FNIH structure. Expedient communication throughout the process is also important, ensuring that the data is transmitted to the regions in a timely manner,

and that the response of the manager is communicated back to the originator of the report. Optimally, this would be done using an electronic system via email or a web based system. In the current practice, feedback from the manager is to the NIC, and the originator may not be fully aware of the actions being considered or undertaken. It is recommended that this practice be modified so that while the NIC is aware, the originator also needs to be advised of any and all actions taken by management. This could be accomplished most effectively using an electronic system, however, until such time that an electronic system is in place, it is recommended that all reports involving WPOA be returned to the originator with management comments, and telephone or electronic communications be initiated within 48 hours of the report being received.

All data elements included in the revised OR form would be captured in a database which would allow for the data to be aggregated using various parameters such as, but not limited to, type of exposures, timing of incidents, parties involved, and perpetrator factors. The ability to separate information by community, tribal council, and, region will also be essential for communicating findings. It is recommended that on a quarterly basis, all ORs and responses are aggregated and reviewed by the Nurse Manager team to assess for best practices and establish common expectations for how to best respond and support nursing staff and communities when incidents do occur. Communication of these finding to NICs at the NIC forums on an annual basis would be an expectation. In addition, it would be expected that aggregate, community-specific data be shared with nursing staff and community leadership during site visits to the community by the Nurse Manager, in collaboration with the NIC. This information will be valuable for community level understanding of the extent of reported issues and

provide an opportunity for dialogue and development of strategies to address and resolve WPOA incidents. These discussions will also serve to improve field and regional level communication.

An additional forum to enhance the communication and relationship between field staff that has been overlooked to date is the NSAT sessions. Based on this study, it is recommended that Nurse Managers be involved in the NSAT sessions for a portion of the program to allow staff to communicate the issues that they have identified, and allow for first hand communication with the managers and regional security staff jointly. This also provides an opportunity for managers to identify how the ORs provide insight into the activities and issues impacting the community staff and thereby informing managers of the need for additional supports or resources.

This study has provided insight into the WPOA exposures encountered by nurses working in FNIH nursing stations and the responses of Nurse Managers to those incidents. The study has identified the need for administrators to create management expectations for responding to verbal and physical incidents involving all possible perpetrators, clients, families, community leadership, peers, colleagues and supervisors. The development of guidelines to assist managers to respond to situations consistently and allow for the appropriate people to be engaged is recommended. These guidelines are to include processes for the engagement of community leadership and/or community stakeholders as well as regional supports such as facilities, security and the employee assistance program or critical incident stress management program.

Of particular note are the findings related to political involvement and the impact these incidents have on nursing engagement and retention. This study identifies the need

to develop a consistent strategy for working with community leadership to recognize how these situations impact on the nursing workforce in communities. As Nurse Managers play a central role in assisting nurses in charge to develop and maintain effective working relationships with community leadership, this finding is critical for improving community level support to CHNs.

As incidents have the potential to impact staff on an ongoing basis, resulting in workplace injuries and time lost from work, it is also important for administrators to work collaboratively with labour relations experts including organizational human resources representatives and the union staff who may act on behalf of employees who experience a WPOA incident. Doing so will have positive benefits for both the well being of the employee and the organization with respect to staff retention and an effectively engaged and functional workforce.

Howard (2001) and Gallant-Roman (2008) suggest that administrators are responsible for creating a safe workplace from the point of hire onward. He indicates that the initial step is ensuring proper employee screening processes, a factor identified as a concern for nurses with respect to the security guards- that the organization needs WPOA-specific policies and procedures. Existing research indicated that training of employees, managers and all staff in the facilities is required, and that employee assistance programs must be in place (Gallant-Roman, 2008; Howard, 2001; Nachreiner et al., 2005). While FNIH has instituted an extensive review of the hiring processes for potential staff, WPOA policies, staff education and an employee assistance program, ongoing review and assessment are required to ensure relevance, currency and impact. In respect to this study, the hiring of security staff is central to nurses' perceptions of safety

during the "silent hours" of the facilities. It is recommended that this critical role be under the responsibility of FNIH for the hiring, training and supervision should communities not demonstrate the capacity to manage this essential service on an ongoing basis.

Administrators in Manitoba region will be provided with the findings of this study, and discussions held to consider the need for policy development and modification related to reporting of incidents and trending of data, hours of service, on call support, security services, and post incident follow-up, communication and support. As these findings impact national policy, the results of this study will also be presented to staff at the FNIH Office of Nursing Services and at an upcoming national Senior Managers Meeting which includes the Assistant Deputy Minister of FNIH, the Regional Directors of the 8 FNIH regions across Canada, and representatives from national corporate services, finance, human resources and strategic policy and planning branches.

Nursing education.

For educators at both the basic nursing program and employer levels, the study provides useful information about WPOA exposure in the delivery of care in a primary health care setting. While there has been much research published about the experiences of nurses and the training suggested for emergency departments, hospital wards, long-term care and community health settings (Arnetz & Arnetz, 2000; Beech, 2001; Beech & Leather, 2003; Farrell & Cubit, 2005; Hegney, Eley, Plank, Buikstra & Parker, 2006; Henderson, 2003; McKenna, Poole, Smith, Coverdale,& Gale, 2003; and Pozzi , 1998), there are limited studies which speak to the remote/isolated practice setting. This study validates that the experiences are similar, and that nurses who work in these roles benefit

from education tailored to all of the settings identified, as the population which the CHNs work with encompass the types of clients who would be cared for in any of these sites. At the same time the study identified factors that may be unique to rural/remote practice with First Nations people.

Existing research suggests that introduction of what constitutes WPOA should be introduced early in basic education programs and reinforced through out (Beech, 2001; Beech & Leather, 2003; Farrell & Salmon, 2009). It is recommended that the FNIH orientation include workplace- specific WPOA education and again through the employment of staff, consistent with studies suggesting that annual or biannual refreshers are of benefit. The orientation and ongoing education related to WPOA is to include content such as self- awareness with respect to how ones' own values and behaviours influence interactions, conducting a general risk assessment of a community and individual situations, assessing individual patient risk characteristics, perpetrator characteristics, situational factors, and physical safety (Farrell & Salmon, 2009; Gallant-Roman, 2008). Nurses must also be able to recognize escalating situations, employ de-escalation strategies and utilize effective communications (Adamson, Vincent, & Cundiff, 2009; Alexander et al., 2004; Gallant-Roman, 2008). Documentation of incidents, awareness of resources or supports including organizational policies, procedures and guidelines, as well as post incident debriefing are essential (Farrell & Cubit, 2005, Gallant-Roman, 2008;Peek-Asa, 2009). Specific to FNIH, education should include a component related to First Nations cultures and the impact of those cultures on accessing health services. Education must also identify how each worldview impacts interactions, how communities are organized in terms of formal and informal leadership

or reporting structures, who holds power in literal and figurative senses, and who the community stakeholders are in terms of who needs to be heard, understood and brought on board. Recognition of what incidents need to be reported, and the appropriate mechanisms to do so are also a critical part of the initial education required for staff. While this study focussed on nursing and health care providers, it is recommended that this training be available and offered to all staff engaged in providing health services including CHNs, other health care professionals, support staff and regional managers involved in nursing station operations and education to allow for common understandings and responses to be demonstrated (Peek-Asa et al., 2009).

Currently FNIH has a two-day NSAT program that provides a good foundation for practice, however based on the findings of the study, consideration should be given to its' updating and revision as it was last revised in 2006. As this study provides insight into FNIH specifically, it is recommended that the data be included in the revision of the NSAT program manual and discussions. In addition, the current national and international WPOA literature should be added to the stong historical information tht is present in the NSAT manual. In addition, enhancement of the discussion of ORs in the program, including how the data can be used to increase knowledge related to incidents in the workplace, is required. The impacts on policy, education and supports to nurses must be clearly identified to program participants. In the NSAT session, it is recommended that nurses be provided with time to complete a sample OR based on one of the scenarios or role plays discussed. As was previously recommended, NSAT sessions should also include an opportunity to meet with Nurse Managers who would be

able to present aggregate data that is region-specific and identify the approaches to respond and resolve the issues that had been reported.

To ensure that WPOA does not become viewed as "part of the job" or normalized by staff, it will be necessary to provide ongoing reinforcement of the expectations for reporting incidents and the processes being established to respond. It is recommended that a "refresher" NSAT module be developed and delivered to nurses who have previously participated in the 2-day program. It is proposed that this could be done via distance education using telehealth, teleconferences or webinars, or onsite by Nurse Managers when doing the review of community specific aggregated OR data. For example quarterly or semi-annual reviews of ORs could be done and a teleconference or videoconference with the Nurse Manager and regional security staff could be undertaken to discuss one or two major issues and brainstorm about management and staff protection.

Educators also have a role to play in the development and delivery of community based education related to WPOA. The study identified the types of WPOA to which CHNs are exposed, and the patterns at which they occur. Development of resources for leadership and stakeholder groups including local policing agents, service agencies and other community program staff is required. This is important as the data identified that community and regional actions and notifications included these stakeholder groups. Having a consistent understanding of what WPOA is, and how to best respond to staff and communities is critical. Community level awareness and understanding of implications to health service delivery is essential to generate support and action to be taken to reduce WPOA incidents. Engagement of community leadership and

stakeholders can be achieved by having regular communications with nursing staff, with the NIC as the primary contact at the nursing station level. As previously suggested, quarterly or semi-annual meetings with regional managers, security and education team members are recommended, which will assist in the development of effective and supportive working relationships.

Issues for future nursing research.

This study provided insight into the phenomena of WPOA in FNIH Manitoba Region communities. Based on the findings and implications for nursing practice, administration and education, the need for further research into this subject have been identified. Suggestions for further study are presented below.

With the development of a new safety and security OR form, future studies which will build on the baseline data presented are possible. It is recommended that an intervention study be conducted with the implementation of the new OR form. This study would include an education component for all staff at the field and regional levels with respect to how to complete the form and the process for submission and feedback related to responses from regional management. Data analysis would be conducted using the variables identified in this study, namely type of incident, perpetrator gender, time periods, use of intoxicants or other substances, as well as variables that were not possible to explore in this study including report originator data such as gender, age, employment type, employer and community related data including geographic isolation, community size, and support services available. The study design would also include the ability to conduct interviews, focus groups or questionnaires based on incident criteria to gather further retails about the event, individuals involved and community factors which may be

present. The report originator(s) would be contacted for additional information related to perpetrator and community variables that may not have been recorded such as pay periods, weather, traumatic community events specialty clinic schedules, planned activities or events, access to intoxicants, road access to larger centres. Information related to the health care provider involved would also be captured and may include experience in nursing, and specifically northern nursing, education, type of employment- be it full time, part time, or itinerant with an agency and staff complement of permanent versus itinerant CHNs at the time of the incident. This data would be of benefit as it would allow for reporting biases to be considered as well as the impact of continuity on community interactions with health care staff. Additionally, the potential to reproduce the proposed study over a period of time would provide the opportunity to assess what, if any, impact policy, practice administrative and education initiatives have on WPOA exposures and responses.

As it would be possible to pair OR data with interviews of nurses completing the reports, it would allow the researcher to gather rich data, which may provide valuable insights into nurses' experiences of WPOA and the impact that it has on other professional and personal lives. Interview questions which included exploration of impact on job satisfaction, productivity and intent to leave the organization would be of benefit to the employer. This information would also be of benefit to the larger nursing community as it could inform other employers of the cost to individuals and organizations when WPOA incidents occur. This would provide the opportunity to determine how nursing staff cope with and resolve issues when incidents do occur. As CHNs working in FNIH nursing stations provide services to the community at large, and

contact with perpetrators and their families is likely to occur, a future study would provide the opportunity to determine what strategies nurses use to separate the interaction that occurred from future interactions.

As FNIH currently delivers a two-day NSAT program, an intervention study that explores reporting patterns and community level nursing responses to incidents pre- and post-program attendance would be of benefit to assess the program for its effectiveness. This would be a two-part study which utilizes the OR data submitted, as well as a pre and post NSAT questionnaire which will be conducted at three months after hire, and three, six, and twelve months after attending the NSAT program. As the initial part of this study, in the pre-intervention phase, questions related to how nurses define WPOA and the criteria they utilize in determining what to report would be explored. This is important as it has implications for organizational knowledge related to the extent of the issue as well as the ability of the organization to respond as well as what content would be required in the education related to WPOA for the intervention. The post-NSAT questionnaire would explore what nurses communicate about their experiences and reporting practices on a self-reported, retrospective basis. The OR data would be used to correlate the actual reporting done by the individual nurse. This study would assist in demonstrating if there are changes in awareness and reporting of incidents, as well as if those changes are sustained over time. The findings of this particular study may also demonstrate areas in which enhancement or modification of the NSAT program is required.

As this study has also provided recommendations for policy introduction or modification, as well as education, an evaluation of these interventions would also be an

opportunity for research relative to the impact of these changes. Hills (2008), identifies this issue as it was found that comprehensive post-policy change and education program evaluations are limited. As some studies have found increased WPOA incidents are reported after changes are introduced, further study is required to determine why this is the case (Arnetz& Arnetz (2000); Beech, 2008; Nachreiner et al.,2005). While it is anticipated that it may be due to increased recognition of what constitutes a WPOA incident and the significance of reporting, it is also possible that the program creates an increased or decreased sense of confidence which may impact how the nurse interacts with others. As the OR data is submitted on an ongoing basis, it would be possible to collect and analyze this information on an annual basis, doing the in-depth exploration with the interviews or questionnaires on a specified basis such as one month per seasonal period. This data could be compared over time, to determine if the interventions instituted were demonstrating any impact on reported incidents and management responses to WPOA.

The study of WPOA in FNIH Manitoba Region nursing stations has identified the importance of community support, and the impact that interactions with community leadership have on nursing engagement and retention. As WPOA reduction is grounded in effective relationships and creating a healthy workplace culture, it is imperative that a good understanding of the community within which the workplace is situated is developed. A participatory action research study which would involve nursing, but be led by community stakeholders would provide critical new knowledge about how best to work collaboratively to enhance the health of communities while working in remote and isolated locations with limited on-site professional capacity and resources. Exploration

of community perceptions related to accessing care at the nursing station would be explored, the variables which create communication opportunities or challenges related to differing expectations for services on the part of community members, or health care providers. The current study revealed that involvement of community political leaders in clinical situations impacts the ability of the community health nurse to feel she is being recognized for her professional skills and the study being proposed would explore how community leadership views their role and responsibilities in attempting to gain access to services when community issues or concerns arise. Engaging community leadership, elders and other stakeholders in the development of a participatory action research study would provide insight into how to most effectively work with communities to address WPOA.

This study identified additional knowledge gaps related to WPOA in remote and isolated communities which would warrant future exploration. As was identified, there was insufficient information related to the nursing demographic and the question of whether or not age and experience of the nurse affects WPOA exposure and response is of importance to FNIH. To build on this question could be the exploration of generational impacts which influence response and expectations for manager support. With respect to community-specific circumstances, questions such as, does community size impact rates of WPOA, and are these incidents related to staff variables such as number of nurses onsite relative to patient volumes seen, or perpetrator variables related to mental health, substance use, or social determinants of health, are yet to be explored.

Conclusion

The findings of this study were discussed within the context of existing national and international health care literature however it was identified that limited information specific to this practice setting has been published to date. Commonalities with other health care settings were identified and issues specific to remote and isolated practice highlighted. The limitations of using an administrative tool as the data source were reviewed.

This study generated an encompassing definition of workplace and occupational aggression which will assist in identifying the range of exposures faced by nurses in health care settings. The data available in the FNIH ORs for the period of January 1 and December 31, 2008 demonstrated that CHNs working in FNIH nursing stations in Manitoba Region were exposed to both verbal and physical WPOA incidents. While limitations related to the data available prevented an in-depth exploration of the phenomena, based on the re-categorization of the available information, new knowledge related to types, patterns, perpetrators and concurrent use of intoxicants/substances by perpetrators of WPOA incidents was generated. This study demonstrated that the smaller communities reported WPOA incidents more frequently than larger communities, and leads to the need for further exploration of the reasons for why this may occur. Patterns of seasonal, day of week and shift verbal and physical WPOA incidents were identified, although statistical significance was demonstrated only for the physical WPOA incidents by shift. Further study of these findings is also required as the variables related to why these patterns presented could not be ascertained with the available data. This study demonstrated that perpetrator gender was different for the verbal versus physical WPOA

incidents, a finding which had not been previously noted in other studies. Themes related to impact on staff and service delivery to communities were identified. Unique to nursing station settings was the involvement of community leadership in accessing health care services or treatment decisions. Nurses identified on ORs that this caused distress and had implications for continuing service delivery in that particular community. The importance of community engagement in creating a healthy working relationship for delivery of health services is an area for further exploration identified by this study. Management responses to the ORs submitted were found to be inconsistent, and identified the need for the development of standardized approaches to support and address incidents. The study also identified gaps with respect to managers preparation to deal with incidents, the need for education for the management team and the need for an improved OR communication process within the region, to community staff, and to community leadership.

Implications for nursing in the broader context, as well as for nursing practice, administration, education and research related to WPOA were identified. As WPOA has significant implications for nurses, communities, the organization and the clients served, further knowledge to support all parties concerned is required and future research activities proposed.

Appendix A

FNIH Occurrence Reporting Form (side 1)

Health Canada / Santé Canada — Canada

CONFIDENTIAL – Protected B — **APPENDIX B**

FIRST NATIONS AND INUIT HEALTH BRANCH OCCURRENCE REPORT

Identification: Date of Occurrence: _____ Time: _____ Tel: _____ Province/Region: **Manitoba**

Zone/Health Authority: _____ Report Sent: d/m/y_____ Fax No: **204-984-0101**

HCP Involved: check (✓) all that apply: ☐CHN ☐ CHR ☐ HCC ☐ Doctor ☐ Dentist ☐ NADAAP ☐ Mental Health ☐ Other _____

Names of HCP Involved:_____

If Client involved: Age(s): Community:

Description of Occurrence check (✓)all that apply

-1-Security Violation	-2-Self Harm	-3-Community	-4-Process Issues	-6-Substance Use Related
A				
☐ Violence/Assault/ Threats to Nurse ☐ Threats to Other HCP in Community ☐ Security Guard Issues ☐ Policing Issues ☐ Theft ☐Damage to Property ☐ Other _____	☐ Suicidal Ideation Recurrent: ___ ☐ Attempted Suicide No° of Attempts:__ ☐ Completed Suicide ☐ Self Destructive Behaviours ☐ Other_____	☐ Vehicular ☐ Death ☐ Environmental ☐ CDC Outbreak ☐ Political issues ☐ Violence to client ☐ Other _____	☐ Medical Evacuation ☐ On-Call /receiving ☐ Workforce ☐ Other _____ **-5-Nursing Practice** ☐ Policy ☐ Scope of Practice ☐ Intervention ☐ Medication ☐ Good Catch/Near Miss ☐ Other _____	☐ Alcohol ☐ Narcotic and controlled substance ☐ Solvents ☐ Drugs OTC / illicit ☐ Unknown ☐ Other :_____

Brief description of occurrence:

How does the occurrence affect the abilty to deliver health services:

Actions taken by Nurse (CHN) or other health care personnel check (✓) all that apply

Consultation	Intervention	Notification		
☐ Physician ☐ CHN☐ NIC ☐ Mental Health Services ☐ Child Care Services ☐ Police ☐ Community Program Staff _____ ☐ Other _____	☐ Medical Evacuation by: ☐ Land ☐ Air to: _____ ☐ Observation _____ hrs ☐ Discharged to:_____ ☐ Accompanied by: _____ Date:_____ Time:_____	☐ ZNO / manager ☐ Facilities / Maintenance ☐ Regional Security Manager ☐ Other_____ _____ _____	☐ Health Director ☐ Chief / Councilor _____ ☐ Other _____ _____ _____	☐ CISM ☐ Coroner ☐ Police ☐ EHO ☐ Other _____ _____

Follow-up required at community level:

Prepared by(Print name) :	Signature:	Date:

Actions taken by Management

Zone/Area /Health Authority		**Date Received:**

B

Forwarded: ☐ Regional Director ☐ CISM ☐ Facilities ☐ Regional Security ☐ Health Director ☐ Chief ☐ Coroner ☐ Police ☐ EHO ☐ Other

Signature:	Title	Date:
Region- RNO/Manager/Director	**Date Received:**	

C

Forwarded: ☐ Regional Director ☐ Facilities ☐ Regional or Corporate Security ☐ Health Director ☐ Chief ☐ CISM ☐ Coroner ☐ Police ☐ EHO ☐ ONS ☐ Other

Signature:	Title	Date:
Completed Report Forwarded to Source of Occurrence		Date:

D

Signature:	Fax:	Date:

Appendix A

FNIH Occurrence Reporting Form side 2

APPENDIX B

Health Canada / Santé Canada — Canada

CONFIDENTIAL

FIRST NATIONS AND INUIT HEALTH BRANCH OCCURRENCE REPORT

Page 2 optional if more room needed to describe Occurrence and Implications for nurses

Identification: Date of occurrence:_____ Time: _____ Tel: _____

Province/region: _____ Zone/area/health authority: _____ Community: _____

Report sent: d/m/y_____ Faxed to No._____

Description of Occurrence cont...

How does the occurrence affect the ability to deliver health services:

Prepared by (print name):	**Signature:**	**Date:**

Appendix A

FNIH Occurrence Reporting Form (definitions)

APPENDIX B

Compliances: The Following occurrences will be mandatorily completed by FNIHB health personnel or transferred health authorities/societies when an occurrence takes place. Occurrences include but are not limited to the following:

1.0 Security Violation

- 1.1 Violence/Assault/Threats Against Nurse: refers to physical assault, stabbing, rape etc.
- 1.2 Threats to Health Care personnel: verbal abuse, harassment, etc.
- 1.3 Security Guard Issues: does not follow post order or regulations, does not report for duty etc
- 1.4 Policing Issues: police did not respond to call, slow to respond to calls, insufficient presence in community etc.
- 1.5 Theft: of government, personal property, break-in, etc
- 1.6 Damage to Property: damage or destruction directed toward equipment in the health facility, health facility building(s), the nurses' residences and/or personnel property, FNIHB or equivalent vehicles,
- 1.7 Other: any occurrences affecting reduction or changes in pattern of service deemed significant by staff.

2.0 Self Harm:

- 2.1 Suicidal ideation: "cry for help" (i.e. communicating intention to commit suicide, etc)
  Recurrent suicidal ideation: this refers to repeated suicidal ideation and should be checked ✓ if ideation is recurrent
- 2.2 Attempted Suicide: identify total number of actual attempts (i.e. medication overdose)
- 2.3 Completed Suicide: intentionally killing oneself
- 2.4 Self Destructive Behaviours: violence toward self (i.e. inflictions to physical body)
- 2.5 Other: any occurrences affecting reduction or changes in pattern of service deemed significant by staff.

3.0 Community

- 3.1 Vehicular: any type of motor vehicle accident (MVA) e.g. ATV, snow mobile, boat, plane, etc.
- 3.2 Death: expected/unexpected death (drowning, terminal illness, etc), occurrence.
- 3.3 Environmental: such as toxic spills, chemical exposure, natural disasters such as floods and forest fires
- 3.4 CDC Outbreak: communicable diseases outbreak
- 3.5 Political issues: any political occurrences affecting reduction or changes of services
- 3.6 Violence to client: individual violence from one to another, physical assault, spousal / child abuse, rape, etc.
- 3.7 Other: any occurrences affecting reduction or changes in pattern of service deemed significant by staff (i.e. gang related violence in the community) not covered above.

4.0 Process Issues

- 4.1 Medical Evacuation: any occurrences /procedures related to the medical evacuation of a client
- 4.2 On-call Facility: any professional/process issues related to the on-call facility (e.g. availability for telephone consultations)
- 4.3 Workforce: any workforce issues (i.e. staff shortage)
- 4.4 Other: any occurrences affecting reduction or changes in pattern of service deemed significant by staff (e.g. failure of equipment) not covered above.

5.0 Nursing Practice

- 5.1 Policy: any occurrences or variances from current policy or standards.
- 5.2 Scope of Practice: occurrences related to RN competencies or skills required to health care services in FN & I clients, (clinical assessment, health protection, prevention and promotion)
- 5.3 Intervention: care delivery, referral, consultation, language, culture, client safety issues, communication
- 5.4 Medication: any occurrence or variances from current standards of administration, documentation, dispensing, known allergy, drug, count, intravenous infusion, medication order related.
- 5.5 Good Catch (near miss or close call): a situation or event that could have occurred, but did not because of chance or interception (i.e. dispensed wrong medication, but caught before it being administered to the client)
- 5.6 Other: any occurrences or variances in nursing practice not covered by the above.

6.0 Substance Use Related

- 6.1 Substance use Related: occurrences related to the ingestion/inhalation of alcohol or use of recreational, over the counter (OTC) and / or controlled drugs (e.g. controlled substances, solvents such as gas, glue, white-out liquid paper, etc), or "illicit" use of drugs (e.g. steroids). Refer to the Policy and Procedures on Controlled Drugs and Substances in FNIHB Health Care Facilities for missing counts, lost or stolen controlled drugs and substances.

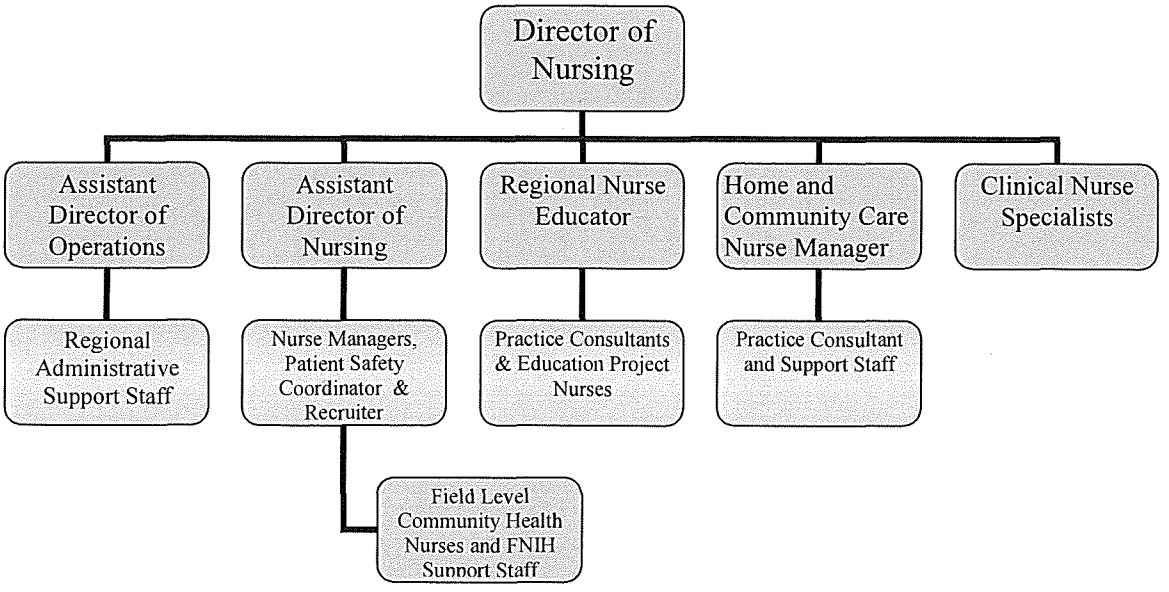
Abbreviations:

CHN – Community Health Nurse	CS – Health Canada, Corporate Security	ATV – all-terrain vehicle
RNO Regional Nursing Officer	EHO – Environmental Health Officer	NIC – Nurse-in-Charge
CHR – Community Health Representative	RSM – Regional Security Manager	ZNO – Zone Nursing Officer or manager
HCC – Home and Community Care	HCP – Health Care Personnel	DON – Director of Nursing
OTC – over-the-counter	CISM – Critical Incident Stress Management	

NADAAP– Native Alcohol, Drugs and Addictions Program

Appendix B

Manitoba Region Nursing Directorate Organizational Chart



Appendix C

List of FNIH Nursing Stations with Populations

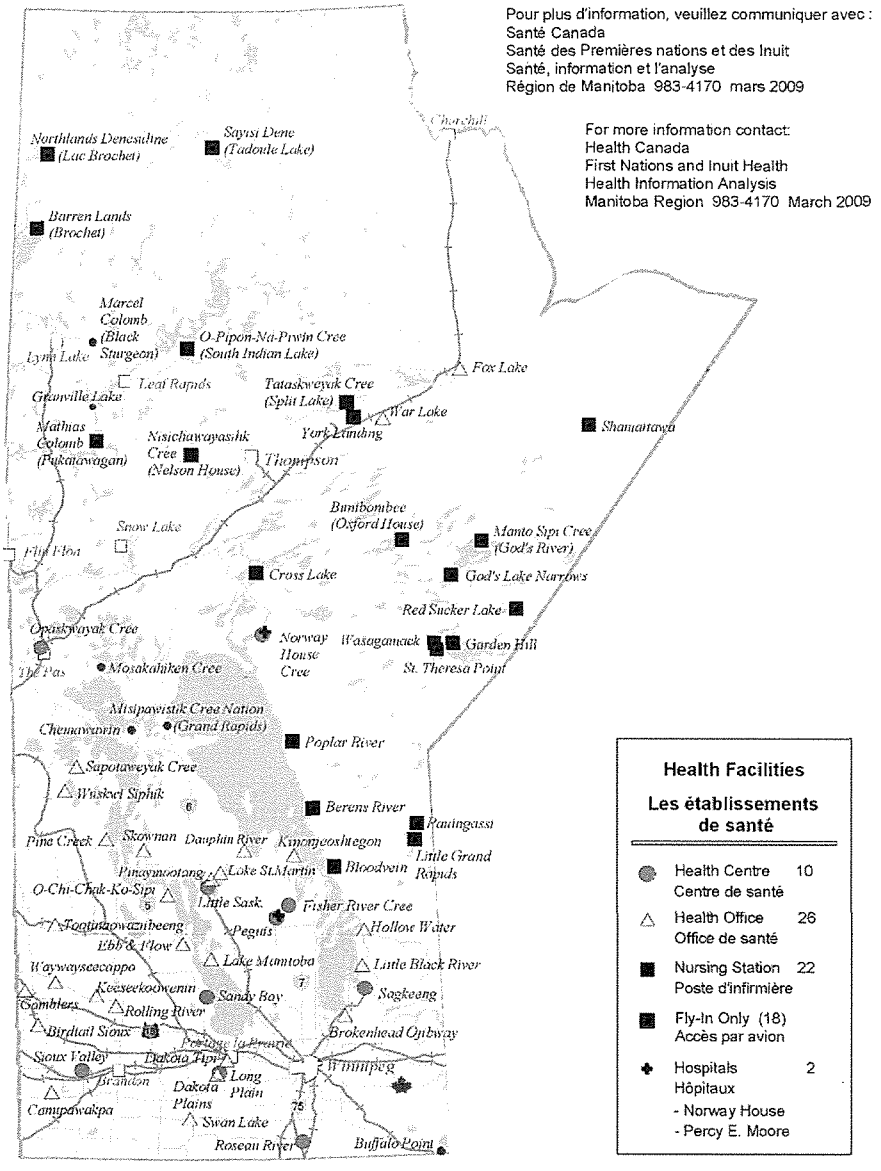
FNIH Manitoba Nursing Stations	Population (2008)
Bloodvein Nursing Station	890
Brochet Nursing Station	478
Cross Lake Nursing Station	4869
Garden Hill Nursing Station	3529
God's Lake Narrows Nursing Station	1369
God's River Nursing Station	579
Lac Brochet Nursing Station	794
Little Grand Rapids Nursing Station	1079
Nelson House Nursing Station	2795
Oxford House Nursing Station	2130
Pauingassi Nursing Station	529
Poplar River Nursing Station	1107
Pukatawagan Nursing Station	2232
Red Sucker Lake Nursing Station	801
Shamattawa Nursing Station	1243
South Indian Lake Nursing Station	798
Split Lake Nursing Station	2217
St. Theresa Point Nursing Station	3033
Tadoule Lake Nursing Station	345
Wasagamack Nursing Station	1514
York Landing Nursing Station	456

Appendix D

Map of Communities

Manitoba First Nations Communities and Health Facilities

Les communautés des Premières nations et les établissements de santé au Manitoba



Appendix E:

Emergency Departments Studies

Author(s)	Method	Sample	Response rate	Results
Catlette (2005)	Qualitative interview with demographic form and interview guide (USA)	Nursing Convenience sample; with criteria; self selected, n=8 from 2 sites; all must have exposure to WPV	n/a	2 themes emerged: inadequate safety measures and vulnerability; Verbal aggression most common from families, physical violence commonly related to mental health diagnosis or intoxication.
Levin, Beauchamp Hewitt, & Misner (1998)	Descriptive study with four focus groups (USA)	Nursing State ENA assisted process, n=22 from 15 sites	n/a	Themes: RN attitude and behavior most significant, size, age, gender less important. Security and admin support critical. Lack of management recognition, mixed responses to reporting and insufficient nurse preparation for WPV. Societal changes, types of patient, facility location and psych or intoxicated patients and families viewed as most threatening. Physicians also a source of violence
Ryan & Maguire (2006)	Cross sectional survey, SAVE questionnaire, 1/12 retrospective reporting (Ireland)	Nursing 2 sites, n=80 sent thru internal mail system with return in same manner with pre-addressed envelope	46%; n=37	Patients are the principle source of aggression/ violence in ERs but multiple perpetrators have been identified. Staff identified in verbal aggression, threats, humiliation, proactive and passive aggressive behavior and splitting behaviors
Crilly, Chaboyer, & Creedy (2004)	Descriptive, longitudinal cohort design. (Australia)	Nurses employed in Emergency department; n=108 for inclusion criteria	66%, n=71	Patient initiated violence only 70% of RNs reported violence in preceding 5/12; Being sworn at and being pushed were the most common. Precipitating factors included wait times, intoxication and mental health illness. Underreporting/ insufficient supports identified.

Appendix F
Psychiatric/ Mental Health Units or Facilities Studies

Author(s)	Method	Sample	Response rate	Results
Bensley, Nelson, Kaufman, Silverstein, Kalat, & Walker Shields (1997)	Survey Questionnaire, review of hospital assault reports and Workers Compensation claims (USA)	Ward staff n= 262, with 10 page questionnaires distributed on individual wards Hospital records of assaults (237) Workers Compensation claims (141 accepted)	N=147, 56% RN-64% LPN-51% MHT-51% from 3 units	Survey data suggest significant underreporting (5:1) of assaults; relationships between aggressiveness and diagnosis of organic brain disease Recognition of nonfatal occupational violence in psych facilities seen as necessary for staff safety with working conditions/ isolation as important variables.
Duxbury & Whittington (2005)	Survey design with follow-up interviews	Convenience sample of patients (n=82) and nurses (n=80) from 3 mental health wards	Patients n=80, nurses n=80	Perspectives on causation varied between the two groups, Both staff and patients believed that environmental factors were contributory and could be modified. Staff interaction styles with patients were identified as a significant stimulus for aggression.
Kindy, Peterson & Parkhurst (2005)	Qualitative descriptive study with demographic data collection and interview questions (USA)	N=10 nurses who self selected from an advertisement or were referred by other study participants	n/a	Nurses use a multitude of tools to manage the safety risks inherent in working in unpredictable environments. Negative encounters with administrators, physicians and colleagues resulted in feelings of self blame and punishment which led to impacts in their personal lives.
Lawoko, Soares, Nolan (2004)	Survey with demographic data collection conducted in 13 districts in England& Sweden	Questionnaire with reminders sent to all possible participants with union and human resources support Sweden: n=1554, England n=800	Sweden: RN n=745 (68%) MD n=306 (66%) England RN n=301 (45%) MD n=74 (60%)	Mental health staff was exposed to high levels of violence. Nurses were exposed to more violence than MDs; with male nurses the group most exposed to violence. Health care structure and working with multiple ethnic groups/language barriers were suggested as contributing to increased assaults in the British system. Support for staff exposed to violence was identified as necessary to prevent demoralization and frustration. Physical work environment and contact requirements were also found to contribute to violence.

Privitera, Weisman, Cerulli, Tu & Groman (2005)	Survey with demographic data collection in one location and one department (university setting), (USA)	Survey provided to all staff in the Department of Psychiatry (clinical and non-clinical) by the hospital mailing services with self addressed return envelope N=742	N=380, 80% female, 69% clinical	Threats and assaults identified as a common occurrence in the psych setting and appear to be increasing. Experience found to be beneficial in reducing risk. Risk to support staff in clinical areas was identified which is an area that had not been previously recognized. Communication identified as a critical area for improvement in the potential reduction of aggressive acts. The need for improved post assault protocols and supports was also identified relative to the individual and organizational impact these events may have.
Flannery, Fisher, Walker, Littlewood & Spillane (2001)	Retrospective study tracking assaults committed by patients with psych diagnosis following hospital discharge	Observation of identified patients with schizophrenia or affective disorders	Male n=14 Female n=18	The most abusive patient profile was consistent with previous inpatient studies. Assaults decreased over time and were significantly reduced by 9/12 suggesting an adjustment period is required for the patients to transition into the new setting. The judicial system was not used in dealing with the perpetrators with rehospitalization occurring for the most aggressive patients. Departmental authorities suggest that underreporting may be an issue in the study as anecdotal information suggests higher numbers than were observed. Staff education identified as a requirement for being able to recognize risk and respond to situations which may occur.

Appendix G

Occurrence Report Inclusion Criteria Flow Chart

Preliminary review:

All Occurrence Reports submitted January 2008- December 31, 2008
ORs from predetermined categories included for screening

Categories:
- security violations;
- community;
- process issues;
- nursing practice and
- substance use related

Secondary Review of ORs meeting inclusion categories

ORs meeting initial screening criteria reviewed. WPOA definition applied to all incidents using headings as determined by individual submitting report, and principal investigator review of incident description

Final OR Inclusion: Review and Recoding.

ORs from secondary reviewed to ensure relevance to WPOA potential.
Descriptions reviewed and recoded to specific WPOA incident type as warranted

Incident type categories:
- unspecified aggression
- verbal aggression
- verbal threat
- verbal threat related to practice
- verbal threat related to political involvement
- physical threat
- physical violence

Appendix H

Letter to First Nations and Inuit Health Requesting Access to the 2008 Occurrence Reports for Manitoba Region

Wendy Ducharme

2010-02-26

Jim Wolfe
Regional Director,
First Nations and Inuit Health-Manitoba
300-391 York Avenue
Winnipeg, MB
R3C 4W1

Dear Mr. Wolfe

I am currently pursing a Masters in Nursing at the University of Manitoba, Faculty of Nursing. As we have previously discussed, workplace and occupational aggression is an area in which very little objective data has been published related to remote and isolated nursing station practice settings.

In consultation with my thesis advisor and committee, I have developed a proposal in which the Occurrence Reports submitted by nurses in FNIH nursing stations would be utilized to provide insight into this issue in Manitoba region. It is recognized that this data is limited in the depth of exploration possible; however it would provide the ability to do some qualitative and quantitative descriptive analysis related to the prevalence ant types of exposures to workplace and occupational aggression that FNIH staff face.

My thesis would explore the following research questions:

1. What were the reported incidence, prevalence and pattern of WPOA in FNIH Manitoba Region nursing stations during the 12 month period from January 1, 2008 to December 31, 2008 as documented by nurses on Occurrence Reports?
    a. On a monthly basis, how many incidents of WPOA were reported within Manitoba region?
    b. What are the types of WPOA to which nurses have been exposed?
2. What types of actions, if any, were taken to respond to the reported incidents of WPOA?
    a. How frequently were community level actions taken to address the reported WPOA incident?
    b. How frequently were regional level actions taken to address the reported WPOA incident?

.../2

This study will be of significance to FNIH as it will increase the knowledge of WPOA exposures and responses to the incidents which will potentially impact the conditions of the existing nursing workforce, as well as have potential implications for recruitment of new staff. Specifically, it will assist FNIH in identifying the reported incidence and types of WPOA as well as identify any patterns which are present. The responses to the incidents will be analyzed and actions taken to address situations will be identified. Analysis of any patterns will be conducted and recommendations made for staff protection and management of WPOA incidents. A method to categorize the occurrence reporting data will be created, and will be useful for the timely and ongoing analysis of reports submitted. Recommendations for policy, protocol and practice modifications may also be made based on the data analysis and findings.

As this information may be seen as potentially harmful to specific communities which may demonstrate increased numbers of reported incidents with respect to recruitment and retention, there will be no identification of individual communities. Prior to my reviewing the occurrence reports, a research assistant who is not familiar with FNIH will code all communities based on tribal council affiliation and population ranges. As there may also be a concern with respect to my knowledge of individual staff members and their involvement in these reports, the research assistant will also remove all names of individuals completing the reports and provide only the gender, if known. As an employee of FNIH as well as a student, I am very cognizant of the importance of separating my employment status and access to information from the academic and research requirements of the university. The proposal will be reviewed by the University of Manitoba Education/Nursing Research Ethics Board prior to any data collection occurring.

I am hereby requesting access to all occurrence reports submitted to the FNIH Nursing Directorate Regional Office between the period of January 1, 2008 and December 31, 2008 inclusive. If this access is granted, I will make the necessary arrangements to have the original documents copied for use in this study. No original documents will be retained by the research assistant after copying is complete. The occurrence report copies will be maintained by the researcher in a locked cabinet. Computer files and storage devices will be encrypted and password protected. Copies of Occurrence Reports will be maintained for a period of 3 years at which time the hard copy and all related data files will be destroyed.

Upon completion of the study, a copy of the thesis findings and recommendations will be provided to you for your review. The results of the study and any recommendations generated will be shared with yourself and any staff that you feel it would benefit. I would also plan to share the findings of the study with the broader nursing community in the format of journal articles, poster presentations and or educational sessions as the opportunities present.

I look forward to your response. Should you have any questions, or if you would like to review the complete proposal, please do not hesitate to contact me at 983-3174 or 864-2790.

Respectfully,

Wendy Ducharme
Masters of Nursing student

Appendix I

Response from First Nations and Inuit Health Regarding Access to the 2008 Occurrence Reports for Manitoba Region

Health Canada / Santé Canada

First Nations and Inuit Health
300-391- York Avenue
Winnipeg, Manitoba,
R3C 4W1

Your file *Votre référence*

2010-03-16 *Our file* *Notre référence*

University of Manitoba Research Ethics Board
Fort Garry Campus
CTC Building, 208-194 Dafoe Road
Winnipeg, Manitoba
R3T 2N2

Re: Masters In Nursing Thesis of Wendy (Hawrychuk) Ducharme

Research Board members:

This letter is being written in support of the research being proposed for the thesis of Wendy (Hawrychk) Ducharme, MN student at the University of Manitoba, Faculty of Graduate Studies-Nursing.

Please accept this letter of support for the study titled: Workplace and Occupational Aggression in First Nations and Inuit Health Nursing Stations in Manitoba Region: Prevalence and Types of Incidents. Ms. Ducharme and the relevant members of her thesis committee will be granted access to the occurrence reporting data for the period of January 1, 2008- December 31, 2008 for the collection of information for this study. It is required that the data be used only for the purposes stated in the research proposal, and that the anonymity of individuals and communities be protected in the process and the communication of any and all findings.

It is expected that this research will provide valuable insight into the working conditions of nurses in the nursing station settings and will be of benefit to the organization. Should you require anything further, please contact my office at (204) 983-4199.

Sincerely

Jim Wolfe,
Regional Director

Canada

page 9

Appendix J

University of Manitoba Ethics Approval

UNIVERSITY OF MANITOBA | Ethics
Office of the Vice-President (Research)

CTC Building
208 - 194 Dafoe Road
Winnipeg, MB R3T 2N2
Fax (204) 269-7173
www.umanitoba.ca/research

APPROVAL CERTIFICATE

June 10, 2010

TO: **Wendy Ducharme** Dauna Crooks
Principal Investigator

FROM: **Lorna Guse, Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2010:047**
"Workplace and Occupational Aggression in First Nations and Inuit Health Nursing Stations in Manitoba Region: Prevalence and Types of Incidents"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- **if you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to Eveline Saurette in the Office of Research Services, (e-mail eveline_saurette@umanitoba.ca, or fax 261-0325), including the Sponsor name, before your account can be opened.**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/ors/ethics/ors_ethics_human_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**

Appendix K:
Proposed First Nations and Inuit Health Safety and Security Occurrence Report

First Nations and Inuit Health Safety and Security Occurrence Report (side 1 completed at community level)

Please complete all areas by placing an "x" in all relevant boxes. Where "other/specify" is indicated, please provide a brief description.

Community Name:

Current Accessibility
☐ Fly–in only ☐ All year road access ☐ Winter road in use

Incident Information:

Date of Incident: Year/month/day	**Time of Incident:** (24 hour clock)	**Location of Incident** ☐ Health facility (specify area): _____ ☐ Residence (specify area): _____ ☐ Other (specify area): _____ ☐ Telephone call

Incident Description (check all that apply)

Verbal WPOA Incident

☐ verbal aggression (general)
☐ verbal threat
☐ verbal threat- practice related
☐ verbal threat-political involvement
☐ discriminatory remarks
☐ sexually inappropriate remarks
☐ offensive profanity

Physical WPOA Incident

☐ physical threat
☐ uncontrolled physical movements/flailing
☐ intentional expelling of body fluids
☐ physical violence
  ☐ scratching/pinching
  ☐ slapping/hitting
  ☐punching
  ☐ pushing
  ☐ kicking
  ☐ restraining

Incident description and Activities underway when incident occurred:
☐ while awaiting care
☐ during exam/treatment
☐ at completion of exam/treatment
☐ while under observation/awaiting transfer
☐ at discharge
☐ unrelated to patient care
☐ other (describe) :

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Aggressor Information: ☐ not applicable

The aggressor was a:
☐ male ☐ female
☐ patient
☐ family member/friend of a patient
☐ person not receiving care (describe):
_____
☐ health care provider (describe)
_____
☐ support staff/community program staff (describe):
_____

Aggressor age: ☐ less than 18 ☐ 19-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60-69 ☐ over 70

Other Aggressor Information:
☐ mental illness
☐ senile/dementia
☐ developmentally delayed/cognitive impairment
☐ alcohol/solvents/other intoxicants
☐ narcotics/controlled substances
☐ street drugs
☐ other?

Security Services	**Policing Services**	**Property Damage**	**Theft**
☐ no show for scheduled shift ☐ left facility unsecured ☐ did not respond/inadequate response ☐ other : _____	RCMP in community ☐ yes ☐ no band constables ☐ yes ☐ no ☐ did not respond/inadequate response ☐ other : _____	government asset: ☐ yes ☐ no personal asset: ☐ yes ☐ no Describe: _____ ____	government asset: ☐ yes ☐ no personal asset: ☐ yes ☐ no Describe: _____ ____

Incident Description/Actions Taken at community level to respond:
_____
_____
_____
_____
see additional sheet: ☐ yes ☐ no

Report Originator Information		Notifications/Engagement related to incident	
Name:		Community	Regional
☐ RN ☐ LPN ☐ MD ☐ Other HCP: _____ ☐ Support staff: _____	☐ FNIH employee ☐ Band employee ☐ Contract employee ☐ Other: _____	☐ Security ☐ Band Constable/RCMP ☐ Health Director ☐ Chief/ Councillors ☐ Other: _____	☐ Nurse Manager ☐ Regional Security Manager ☐ Facilities/Maintenance ☐ Chief/ Councillors ☐ Other: _____

First Nations and Inuit Health Safety and Security Occurrence Report (side 2- completed at regional office)

Nurse Manager Comments	
Discussed with report originator: ☐ yes ☐ no Date:	**Discussed with NIC:** ☐ yes ☐ no Date:
Additional data obtained:	
Internal engagement required: ☐ yes ☐ no ☐ Assistant Director of Nursing ☐ Assistant Director of Operations ☐ Director of Nursing ☐ Regional Security Manager ☐ Facilities/Maintenance ☐ CISM ☐ Regional Director ☐ Environmental Health ☐ Other: _____	**External Engagement required:** ☐ yes ☐ no ☐ Security ☐ Band Constable/RCMP ☐ Health Director ☐ Chief/ Councillors ☐ Regional Health Authority ☐ Contracted organization ☐ PWGSC ☐ Other: _____
Comments/Recommendations:	
Nurse Manager Signature	**Date:**
Other Nursing directorate comments:	
Other Regional comments:	
Report returned to originator with comments by:	**Date:**

First Nations and Inuit Health Safety and Security Occurrence Report (definitions and descriptions)

Date of Incident: refers to when the incident occurred, not time of reporting
Location of Incident: refers to the place where incident occurred
Activities underway when incident occurred: refers to what interactions were happening at the time of the incident

Incident Description (all descriptors which reflect any aspect of the incident are to be checked off)
WPOA: any and all acts occurring within the workplace context, perpetrated by persons internal or external to the health care team resulting in physical, psychological or emotional harm to an individual.

Verbal WPOA Incident
☐ verbal aggression (general) : refers to non-specific utterances /words/sounds that are seen as aggressive
☐ verbal threat: refers to utterances/ words/sounds that are seen as a threat to the safety or security of the report originator or others
☐ verbal threat- practice related: refers to utterances/ words indicating that actions related to employer/regulatory authority would occur
☐ verbal threat-political involvement : refers to utterances/ words indicating that actions related to community leadership engagement would occur
☐ discriminatory remarks : refers to utterances/ words related to age, race, gender, sexual orientation or other
☐ sexually inappropriate remarks : refers to utterances/ words that are sexually suggestive/offensive/ inappropriate
☐ offensive profanity : refers to utterances/ words of profanity that are offensive to the report originator or others present

Physical WPOA Incident
☐ physical threat: refers to body language or movement that are seen as threatening or could lead to harm
☐ uncontrolled physical movements/flailing refers to body language or movement that could lead to harm (intended or not)
☐ intentional expelling of body fluids: refers to actions resulting in forceful ejection of body fluids which may lead to exposure of others
☐ physical violence: refers to direct or indirect physical contact with report originator or others by another party_ specification required
☐ scratching/pinching/ ☐ slapping/hitting/ ☐punching/ ☐ pushing/ ☐ kicking/ ☐ restraining

Security Services
☐ no show for scheduled shift: no security staff arrive for scheduled shift (within 15 minutes of start time)
☐ left facility unsecured: security staff left site before end of shift/during shift without notification to RN with or without doors being secured, comment required if keys or locks an issue
☐ did not respond/inadequate response; incident or concern raised: no response , or security unable to manage incident
☐ other : _describe_____

Policing Services/ Property Damage/Theft: identify all that apply to the incident and community situation.
☐ RCMP in community (permanent services in community)
☐ band constables ☐ yes ☐ no
☐ did not respond/inadequate response
☐ other : _____

Property Damage
☐ government asset: ☐ yes ☐ no
☐ personal asset: ☐ yes ☐ no
Describe: _____

Theft
☐ government asset: ☐ yes ☐ no
☐ personal asset: ☐ yes ☐ no
Describe:
_____

Community Notifications **: identify who has been contacted at the community level**

☐ Security
☐ Band Constable/RCMP
☐ Health Director
☐ Chief/ Councillors
☐ Other: _____

Regional Notifications**: identify who you believe should be informed at the regional level/ involved by the NM**
☐ Nurse Manager
☐ Regional Security Manager
☐ Facilities/Maintenance
☐ Chief/ Councillors
☐ Other: _____

Aggressor Information: ☐ not applicable

The aggressor was a: (if multiple aggressors, check all that apply
☐ male ☐ female
☐ patient
☐ family member/friend of a patient
☐ person not receiving care (describe): _____
☐ health care provider (describe) _____
☐ support staff/community program staff (describe): _____

Aggressor age: check the best category, if multiple individuals involved, check all that apply
☐ less than 18 ☐ 19-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60-69 ☐ over 70

Other Aggressor Information: refers to the impression of the report originator at the time of the incident, does not require chart review or confirmation of substance use by diagnostics
☐ mental illness
☐ senile/dementia
☐ developmentally delayed/cognitive impairment
☐ alcohol/solvents/other intoxicants
☐ narcotics/controlled substances
☐ street drugs
☐ other?

Reference List

Adamson, M.A., Vincent, A.A., & Cundiff, J. (2009). Common ground, not a battle ground; Violence prevention at a detoxification facility. *Journal of Psychological Nursing online, 47,* 32-35.

Alexander, C., House, D., & Fraser, J. (2004) Occupational violence in an Australian healthcare setting: Implications for managers. *Journal of Healthcare Management 49*, 377-390.

Anderson, C. (2002). Past victim, future victim? *Nursing Management, 33,* 26-31

Anderson, C. (2002). Workplace violence: are some nurses more vulnerable?. *Issues in Mental Health Nursing*, *23*(4), 351-366. Retrieved from CINAHL database.

Anderson, C. (2006). Training efforts to reduce reports of workplace violence in a community healthcare facility. *Journal of Professional Nursing*, *22*(5), 289-295. Retrieved from CINAHL database.

Anderson, C. (2001). Defining the severity of workplace violent events among medical and non-medical samples" A pilot study. *Gastroenterology Nursing, 24* (5), 225-230.

Arnetz, J., & Arnetz, B. (2000). Implementation and evaluation of a practical intervention programme for dealing with violence towards healthcare workers. *Journal of Advanced Nursing*, *31*(3), 668-680. Retrieved from CINAHL database.

Arnetz, J., & Arnetz, B. (2001). Violence towards healthcare staff and possible effects on the quality of patient care. *Social Science & Medicine*, *52*(3), 417-427. Retrieved from CINAHL database.

Association of Registered Nurses of Newfoundland and Labrador. (2010). Workplace Violence and Prevention Policy. St. John's NL.: Author.

Awadalla, C.,& Roughton, J. (1998). Workplace violence prevention: The new safety focus. *Professional Safety, 43*(12), 31-35.

Badger, F. & Mullen, B. (2004). Aggressive and violent incidents: perceptions of training support among staff caring for older people and people with head injury. *Journal of Clinical Nursing, 13*(4), 526-533.

Barling, J., Rogers, A., & Kelloway, E. (2001). Behind closed doors: In-home workers' experience of sexual harassment and workplace violence. *Journal of Occupational Health Psychology, 6*(3), 255-269.

Barron, R. & Neumann, J. (1996). Workplace violence and workplace aggression: Evidence on their relative frequency and potential causes. *Aggressive Behaviour, 22*, 161-173.

Barron, R.A. & Neumann, J.H., (1998). Workplace aggression- the iceberg beneath the tip of workplace violence: evidence on its forms, frequency and targets. *Public Administration Quarterly, 21*(4), 446-464.

Beech, B. (2001). Sign of the times or the shape of things to come? A 3-day unit of instruction on 'aggression and violence in health settings for all students during pre-registration nurse training. *Accident & Emergency Nursing*, *9*(3), 204-211. Retrieved from CINAHL database.

Beech, B. (2008). Aggression prevention training for student nurses: differential responses to training and the interaction between theory and practice. *Nurse Education in Practice*, *8*(2), 94-102. Retrieved from CINAHL database.

Beech, B. & Leather, P. (2003). Issues and innovations in nursing education: Evaluating a management of aggression unit for student nurses. *Journal of Advanced Nursing, 44,* 603-612.

Beech, B., & Leather, P. (2003). Evaluating a management of aggression unit for student nurses. *Journal of Advanced Nursing*, *44*(6), 603-612. Retrieved from CINAHL database.

Bensley, L., Nelson, N.,Kaufman, J., Silverstien, B., Kalat, J, & Walker Shields, J. (1997). Injuries due to assaults on psychiatric hospital employees in Washington state. American *Journal of Industrial Medicine, 31,* 92-99.

Bryant, M., & Wolfram-Cox, J. (2003). The telling of violence organizational change and atrocity tales. *Journal of Organizational Change Management, 16*(5), 567-583.

Brzozowski, J., Taylor-Butts, A. & Johnson, S. (2006). Victimization and offending among the Aboriginal population in Canada. *Juristat, 26*(3), 1-31.

Budd, J, Arvey, R., & Lawlwss, P. (1996). Correlates and consequences of workplace violence. *Journal of Occupational Health Psychology, 1*(2), 197-210.

Burnes, B. & Pope, R. (2007). Negative behaviour in the workplace- a study of two primary car trusts in the NHS. *International Journal of Public Sector Management, 20*(4), 285-303.

Bussing, A. & Hoge, T. (2004). Aggression and violence against home care workers. *Journal of Occupational Health Psychology, 9*(3), 206-219.

Cameron, L. (1998). Verbal abuse: a proactive approach. *Nursing Management*, *29*(8), 34-36. Retrieved from CINAHL database.

Canadian Nurses Association. (2008). *Position Statement-Ethical practice- The code of ethics for registered nurses.* Retrieved from http://www.cna-aiic.ca/CNA/documents/pdf/publications/PS95_Code_of_Ethics_2008_e.pdf

Canadian Nurses Association and Canadian Federation of Nurses Unions. (2008). *Joint Position Statement-Workplace violence.* Retrieved from http://www.cna-aiic.ca/CNA/documents/pdf/publications/JPS95_Workplace_Violence_e.pdf

Carmel, H. & Hunter, M. (1989). Staff injuries from inpatient violence. *Hospital Community Psychiatry, 40*, 41-46.

Catlette, M. (2005). A descriptive study of the perceptions of workplace violence and safety strategies of nurses working in level I trauma centers. *JEN: Journal of Emergency Nursing*, *31*(6), 519. Retrieved from CINAHL database.

Chaboyer, W., Najman, J. & Dunn, S. (2001). Cohesion among nurses: a comparison of bedside vs. charge nurses' perceptions in Australian hospitals. *Journal of Advanced Nursing, 35*(4), 526-532.

Chapman, R., & Styles, I. (2006). An epidemic of abuse and violence: nurse on the front line. *Accident & Emergency Nursing*, *14*(4), 245-249. Retrieved from CINAHL database.

College of Nurses of Ontario. (1999). *Abuse of nurses: A Guide to Prevention and Management.* Toronto, ON: Author.

College of Registered Nurses of British Columbia. (2007). *Practice Standard- Duty to provide care.* Vancouver, BC: Author.

College of Registered Nurses of Nova Scotia. (2008) *No more violence: moving towards a violence free workplace in health care.* Halifax, NS: Author

College of Registered Nurses of Nova Scotia. (2007). *Position Statement- Violence in the workplace.* Halifax, NS: Author.

Commission de la santé et de la sécurité du travail du Québec (Occupational Health and Safety Commission). (2010). *An act respecting occupational health and safety.* Montréal PQ: Retrieved from http://www.csst.qc.ca/portail/fr/

Cooper, C. & Swanson, N., (2002). *Workplace Violence in the Health Sector: State of the Art.* International Labour Office, Geneva. Retrieved from http://www.icn.ch/state.pdf.

Corneil, W. & Kirwan, S. (1994). *Preliminary results study of post-traumatic stress among Medical Services Branch nurses in Manitoba region.* Medical Services Branch. Ottawa: Queen's Printer.

Cortina, L., Magley, V., Hunter Williams, J. & Day Langhout, R. (2001). Incivility in the workplace: incidence and impact. *Journal of Occupational Health Psychology, 6*(1), 64-80.

Crilly, J., Chaboyer, W., & Creedy, D. (2004). Violence towards emergency department nurses by patients. *Accident & Emergency Nursing, 12*(2), 67-73. Retrieved from CINAHL database.

de Leseleuc, S. (2004). *Criminal victimization in the workplace.* Ottawa, ON; Statistics Canada.

DelBel, J. (2003). Conflict management special, part 1. Deescalating workplace aggression. *Nursing Management, 34*(9), 30-34. Retrieved from CINAHL database.

Denton, M. Zeytinoglu, I. and Webb, S. (2000). 'Work-related violence and the OHS of home health care workers'. *The Journal of Occupational Health and Safety – Australia and New Zealand, 16*(5), 419-427.

di Martino, V. (2003). *Relationship between work stress and workplace violence in the health sector.* Geneva

Dietz, J., Robinson, S., Folger, R., Baron, R., & Schultz, M. (2003). The impact of community violence and an organizations' procedural justice climate on workplace aggression. *Academy of Management Journal, 48*(3), 317-326.

Distasio, C. (1999). Workplace violence: part I. Violent patients -- how to cope. *Maryland Nurse, 1*(1), 12-13. Retrieved from CINAHL database.

Distasio, C. (2000). Workplace violence: part II: documentation and reporting -- how to paint the picture. Future articles will address employer responsibilities relative to violence in the health care workplace, and employee/co-worker violence. *Maryland Nurse, 1*(2), 12. Retrieved from CINAHL database.

Distasio, C. (2000). Workplace violence: part III: employee/co-worker violence. *Maryland Nurse, 2*(2), 11. Retrieved from CINAHL database.

Distasio, C. (2000). Workplace violence: part IV: employer responsibilities. *Maryland Nurse, 3*(2), 11. Retrieved from CINAHL database.

Dowd, T. & Johnson, S. (1995). Remote area nurses- on the cutting edge. *Collegian, 2*(1), 36-40.

Duncan, L. & Rod, G. (2007). Workplace bullying in the public sector: understanding the racial dimension. *Public Administration, 85,* 641.

Duncan, S., Estabrooks, C., & Reimer, M. (2000). Violence against nurses. High rates of workplace violence against nurses: findings of the Alberta Nurse Survey. *Alberta RN, 56*(2), 13-14. Retrieved from CINAHL database.

Duncan, S., Hyndman, K., Estabrooks, C., Hesketh, K., Humphrey, C., Wong, J., Acorn, S.,... Giovannetti, P. (2001). Nurses' experience of violence in Alberta and British Columbia hospitals. *Canadian Journal of Nursing Research, 32*(4), 57-78.

Dupree, K. & Barling, J. (2006). Predicting and preventing supervisory workplace aggression. *Journal of Occupational Health Psychology, 11*(1), 13-26.

Duxbury, J. & Whittington, R. (2005). Causes and management of patient aggression and violence: staff and patient perspectives. *Journal of Advanced Nursing, 50*(5), 469-478.

Eley R., Buikdtra, E., Plank, A., Hegney, D. & Parker, V.(2007). Tenure, mobility and retention of nurses in Queensland, Australia: 2001 and 2004. *Journal of Nursing Management, 15,* 285-293.

Eley, R., Hegney, D., Buikstra, E., Fallon, T., Plank, A., & Parker, V. (2007). Aged care nursing in Queensland - the nurses' view. *Journal of Clinical Nursing, 16*(5), 860-872. Retrieved from CINAHL database.

Elliott, P. (1997). Violence in health care: what Nurse Managers need to know. *Nursing Management, 28*(12), 38-42. Retrieved from CINAHL database.

Elo, S. & Kyngas, H. (2007). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107-115. Retrieved from CINAHL database.

Farrell, G. (1997). Aggression in clinical settings: nurses' views. *Journal of Advanced Nursing, 25,* 501-508.

Farrell, G., (1999). Aggression in clinical settings: nurses' views- a follow-up study. *Journal of Advanced Nursing, 29*(3), 532-541.

Farrell, G. (2001). From tall poppies to squashed weeds: why don't nurses pull together more? *Journal of Advanced Nursing*, *35*(1), 26-33. Retrieved from CINAHL database.

Farrell, G., Bobrowski, C., & Bobrowski, P. (2006). Scoping workplace aggression in nursing: findings from an Australian study. *Journal of Advanced Nursing, 55,* 778-787.

Farrell, G., & Cubit, K. (2005). Nurses under threat: a comparison of content of 28 aggression management programs. *International Journal of Mental Health Nursing*, *14*(1), 44-53. Retrieved from CINAHL database.

Farrell, G., & Salmon, P. (2009). Challenging behaviour: an action plan for education and training. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, *34*(1), 110-118. Retrieved from CINAHL database.

Fernandes, C., Bouthillette, F., Raboud, J., Bullock, L., Moore, C., Christenson, J., ...Way, M. (1999). Violence in the emergency department: a survey of health care workers. *CMAJ: Canadian Medical Association Journal*, *161*(10), 1245-1248. Retrieved from CINAHL database.

Ferns, T. (2005). Terminology, stereotypes and aggressive dynamics in the accident and emergency department. *Accident & Emergency Nursing*, *13*(4), 238-246. Retrieved from CINAHL database.

First Nations and Inuit Health Branch. (2005). *Unusual Occurrences and Reporting.* Health and Safety Policy number 5.15. Ottawa, ON. First Nations and Inuit Health Branch.

First Nations and Inuit Health Branch. (2006). 2005 *First Nations and Inuit Health Nursing Workforce Survey.* Ottawa, ON. First Nations and Inuit Health Branch.

Fisher, J., Bradshaw, J. Currie, B, Klotz, J., Robins, P., ReidSearle, K., & Smith, J. (1996). Violence and remote area nursing. *Australian Journal of Rural Health, 4*, 190-199.

Flannery Jr. R., Fisher W.'Walker A., Littlewood K., Spillane M. (2001). Nonviolent psychiatric inpatients and subsequent assaults on community patients and staff. *Psychiatric Quarterly, 72*(1), 19-27.

Forrester, K, (2002). Aggression and assault against nurses in the workplace: practice and legal issues. *Journal of Law and Medicine, 9*(4), 386-91.

Gacki- Smith, J., Juarex, A., Boyet, L., Homeyer, C., Robinson, L. & McLean, S. (2009). Violence against nurses working in US emergency departments. *Journal of Nursing Administration, 39* (7-8), 340-349.

Gallant-Roman, M. (2008). Strategies and tools to reduce workplace violence. *AAOHN Journal*, *56*(11), 449-454. Retrieved from CINAHL database.

Gary, N. (2007). The Challenge of Workplace Bullying. *Employment Relations Today, 34,* 43.

Gerberich, S., Church, T., McGovern, P., Hansen, H., Nachreiner, N., Geisser, M.,...Watt, D. (2004). An epidemiological study of the magnitude and consequences of work related violence: the Minnesota nurses study. *Occupational*

and Environmental Medicine 61(6), 495-503. Retrieved from http://oem.bmjjournals.com/cgi/content/full/61/6/495

Glass, N. (2003). Studying women nurse academics: exposing workplace violence in Australia" part 1. *Contemporary Nurse,* 14(2), 180-186.

Glass, N. (2003). Studying women nurse academics: exposing workplace violence in Australia" part 2. *Contemporary Nurse, 14*(2), 187-195.

Glomb, T. (2002). Workplace anger and aggression: informing conceptual models with data from specific encounters. *Journal of Occupational Health Psychology, 7*(1), 20-36.

Griffin, R. & Lopez, Y. (2005). Bad behaviour in organizations: a review and typology for future research. *Journal of Management,(31),* 6, 988-1005. Retrieved from http://jom.sagepub.com

Health Canada. (2001) *A Policy on Prevention and Resolution of Harassment in the Workplace.* Ottawa: Health Canada

Health Canada. (2005) *A Statistical Profile on the Health of First Nations in Canada for the year 2000.* Ottawa: Health Canada

Health Canada. (2005) *First Nations and Inuit Health Branch Facilities Safety and Security Policy.* Ottawa: Health Canada

Health Canada. (2006) *Guidelines on the Prevention of Violence in the Workplace.* Ottawa: ON; Author

Health Canada. (2007) *Departmental Security Policy 10.10 Protection of Employees.* Ottawa: Health Canada

Health Canada. (2007) *Departmental Security Policy 10.11 Physical Security.* Ottawa: Health Canada

Health Canada. (2009) *Values and Ethics Code for the Public Service.* Ottawa: Health Canada

Hegney, D., Eley, R., Plank, A., Buikstra, E., & Parker, V. (2006). Workforce issues in nursing in Queensland: 2001 and 2004. *Journal of Clinical Nursing, 15,* 1521-1530.

Hegney, D., Eley, R., Plank, A., Buikstra, E., & Parker, V. (2006). Workplace violence in Queensland, Australia: the results of a comparative study. *International Journal of Nursing Practice*, *12*(4), 220-231. Retrieved from CINAHL database.

Hegney, D., Plank, A., & Parker, V. (2003). Workplace violence in nursing in Queensland, Australia: a self-reported study. *International Journal of Nursing Practice*, *9*(4), 261-268. Retrieved from CINAHL database.

Henderson, A. (2003). Nurses and workplace violence: Nurses experiences of verbal and physical abuse at work. *Nursing Leadership, 16*(4), 82-98.

Henry, J. & Ginn, G. (2002). Violence prevention in health care organizations within a total quality management framework. *The Journal of Nursing Administration, 12*(9), 479-486.

Hershcovis, M. Turner, N., Barling, J., Arnold, K., Dupree, K., Inness, M., ,...Sivangthan, N. (2007). Predicting workplace aggression: a meta-analysis. *Journal of Applied Psychology, 92*(1) 228-238.

Hesketh, K., Duncan, S., Eastabrooks, C., Reimer, M., Giovannetti, P., Hyndman, K., Acorn, D. (2003). Workplace violence in Alberta and British Columbia hospitals. *Health Policy, 63*, 311-321.

Hills, D. (2008). Relationships between aggression management training, perceived self-efficacy and rural general hospital nurses' experiences of patient aggression. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 31*(1), 20-31. Retrieved from CINAHL database.

Hilsop, E. & Melby, V. (2003). The lived experience of violence in accident and emergency. *Accident and Emergency Nursing, 11,* 5-11.

Hoel, H., Sparks, S., & Cooper, C. (2001). *The cost of violence/stress at work and the benefits of a violence-free working environment.* International Labour Organization. Retrieved http://www.ilo.org/public/english/protection/safework/whpwb/econo/ costs.pdf.

Howard, J. (2001). Workplace violence in organizations: an exploratory study of organizational prevention techniques. *Employee Responsibilities and Rights Journal, 13*(2), 57-75.

Hutton, S. (2006). Workplace incivility: state of the science. *The Journal of Nursing Administration, 36*(1), 22-28.

International Council of Nurses. (2006). *Position Statement- Abuse and Violence against nursing personnel.* Retrieved from http://www.icn.ch/images/stories/documents/publications/position_statements/C01_Abuse_Violence_Nsg_Personnel.pdf

International Council of Nurses. (2006). *Position Statement- Occupational health and safety for nurses.* Retrieved from http://www.icn.ch/images/stories/documents/publications/position_statements/C08_Occupational_Health_Safety.pdf

International Labour Office, International Council of Nurses, World Health Organisation, Public Services International. (2002). *Framework guidelines for addressing workplace violence in the health sector.* Geneva: Author

Irwin, A. (2006). The nurse's role in the management of aggression. *Journal of Psychiatric & Mental Health Nursing, 13*(3), 309-318. Retrieved from CINAHL database.

Jackson, D., Clare, J., & Mannix, J. (2002). Who would want to be a nurse? Violence in the workplace -- a factor in recruitment and retention. *Journal of Nursing Management, 10*(1), 13-20. Retrieved from CINAHL database.

Jackson, D., Firtko, A., & Edenborough, M. (2007). Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review. *Journal of Advanced Nursing, 60*(1), 1-9. Retrieved from CINAHL database.

Jansen, G., Dassen, T., & Jebbink, G. (2005). Staff attitudes towards aggression in health care: a review of the literature. *Journal of Psychiatric & Mental Health Nursing, 12*(1), 3-13. Retrieved from CINAHL database.

Jockin, V., Arvey, R. & McGue, M. (2001). Perceived victimization moderates self – repots of workplace aggression and conflict. *Journal of Applied Psychology, 86*(6), 1262-1269.

Keeley, B. (2002). Could your patient -- or colleague -- become violent? Workplace violence is on the rise, but you can learn to anticipate and defuse potentially dangerous situations. *Nursing*, *32*(12), 32cc1. Retrieved from CINAHL database.

Keely, B. (2002). Recognition and prevention of hospital violence. *Dimensions of Critical Care Nursing*, *21*(6), 236-241. Retrieved from CINAHL database.

Kennedy, D., Homant, R. & Homant, M. (2004). Perception of injustice as a predictor of support for workplace aggression. *Journal of Business and Psychology, 18*(3), 323- 335.

Kindy, D., Petersen, S., & Parkhurst, D. (2005). Perilous work: nurses' experiences in psychiatric units with high risks of assault. *Archives of Psychiatric Nursing*, *19*(4), 169-175. Retrieved from CINAHL database.

King L.A. & McInerney P.A. (2006). Hospital workplace experiences of registered nurses that have contributed to their resignation in the Durban metropolitan area. *Curationis 29*(4), 70-81.

Kingma, M. (2001). Guest editorial. Workplace violence in the health sector: a problem of epidemic proportion. *International Nursing Review*, *48*(3), 129-130. Retrieved from CINAHL database.

Lanza, M. L., Kayne, H. L., Hicks, C. & Milner, J. (1994). Environmental characteristics related to patient assault. *Issues in Mental Health Nursing, 15*(3):319-35.

Lawoko, S., Soares, J., & Nolan, P. (2004). Violence towards psychiatric staff: a comparison of gender, job and environmental characteristics in England and Sweden. *Work & Stress*, *18*(1), 39-55. Retrieved from CINAHL database.

Leck, J. (2005). Violence in the Canadian Workplace. *Journal of American Academy of Business, Cambridge, 7,* 308.

Lee, K., Ashton, M. C., & Shin, K. H. (2005). Personality correlates of workplace anti-social behavior. *Applied Psychology: An International Review, 54,* 81-98.

Lee, S., Gerberich, S., Waller, L., Anderson, A., & McGovern, P. (1999). Work-related assault injuries among nurses. *Epidemiology,10*(6), 685-691.

Levin, P., Beauchamp Hewitt, J. & Misner, S. (1998) Insights of nurses about assaults in hospital based emergency departments. *Journal of Nursing Scholarship, 30*(3), 249-254.

Lewis, S., & Blumenreich, P. (1993). Defusing the violent patient. *RN, 56*(12), 24-30.

Lim, S. & Cortina, L. (2005). Interpersonal mistreatment in the workplace: the interface and impact of general incivility and sexual harassment. *Journal of Applied Psychology, 90,* 483.

Liss, G. &. McCaskell, L. (1994). Violence in the workplace. *Canadian Medical Association Journal, 151*(9), 1243-1246.

Little, L. (1999). Risk factors for assaults on nursing staff: childhood abuse and education level. *Journal of Nursing Administration, 29*(12), 22-29.

Longo, J. (2007). Horizontal violence among nursing students. *Archives of Psychiatric Nursing, 21*(3), 177-178.

MacIntosh, J. (2005). Experiences of workplace bullying in a rural area. *Issues in Mental Health Nursing, 26,* 893-910.

Maguire, J. & Ryan, D. (2007). Aggression and violence in mental health services: categorizing the experiences of Irish nurses. *Journal of Psychiatric & Mental Health Nursing, 14,* 120-127.

Manning, S. M. (2005). Injury among direct health care staff. *Professional Safety, 50,* 31-40.

Martin, D. (1997). *An ethnographic study examining quality of worklife issues of outpost nurses in northern Manitoba.* Unpublished master's thesis, University of Manitoba, Winnipeg, Manitoba, Canada.

Martinko MJ, Grundlach MJ, Douglas SC. (2002). Toward an integrity theory of counterproductive workplace behaviour: A causal reasoning perspective. *Int. J. Select.*

Assess. 10:36-50

Martin, T. & Daffern, M. (2006). Clinician perceptions of personal safety and confidence to manage inpatient aggression in a forensic psychiatric setting. *Journal of Psychiatric & Mental Health Nursing, 13,* 90-99.

Martin, W. (2008). Is your hospital safe? Disruptive behavior and workplace bullying. *Hospital Topics*, *86*(3), 21-28. Retrieved from CINAHL database.

Martin, M., Douglas, S., & Harvey, P. (2006). Understanding and managing workplace aggression. *Organizational Dynamics, 35,* 117.

May, D., & Brubbs, L. (2002). The extent, nature, and precipitating factors of nurse assault among three groups of registered nurses in a regional medical center. *JEN: Journal of Emergency Nursing*, *28*(1), 11. Retrieved from CINAHL database.

Mayhew, C. & Chappell, D. (2007). Workplace violence risk for health care workers. *Journal of Occupational Health and Safety, Australia and New Zealand, 23,* 153.

Mayhew, C., McCarthy, P., Chappell, D., Quinlan, M., Barker, M. & Sheehan, M. (2004). Measuring the extent of impact from occupational violence and bullying on traumatised workers. *Employee Rights and Responsibilities Journal, 16*(3), 117-134.

McKenna, B., Poole, S., Smith, N., Coverdale, J., & Gale, C. (2003). A survey of threats and violent behaviour by patients against registered nurses in their first year of practice. *International Journal of Mental Health Nursing, 12*(1), 56-63. Retrieved from CINAHL database.

McKenna, B., Smith, N., Poole, S., & Coverdale, J. (2003). Horizontal violence: experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing, 42*(1), 90-96. Retrieved from CINAHL database.

Menckel, E., & Viitasara, E. (2002). Threats and violence in Swedish care and welfare -- magnitude of the problem and impact on municipal personnel. *Scandinavian Journal of Caring Sciences, 16*(4), 376-385. Retrieved from CINAHL database.

Merecz, D., Rymaszewska, J., Moscicka, A., Kiejna, A. & Jarosz-Nowak (2006). Violence at the workplace- a questionnaire survey of nurses. *European Psychiatry, 21*, 442-450.

Mossman, D. (1995). Violence prediction, workplace violence and the mental health expert. *Consulting Psychology Journal: Practice and Research, 47*(4), 223-233.

Mullen, E. A. (1997). Workplace Violence: Cause for Concern or the Construction of a New Category of Fear. *Journal of Industrial Relations,* 39(1), 21-32.

Nachreiner, N., Hansen, H., Okano, A., Gerberich, S., Ryan, A., McGovern, P., ...**Watt, G.** (2007). Difference in work-related violence by nurse license type. *Journal of Professional Nursing*, *23*(5), 290-300. Retrieved from CINAHL database.

Nachreiner, N., Gereberich, G., McGovern, P., Church, T., Hansen, H., Geisser, M. & Ryan, A. (2005). Relation between policies and work related assault: Minnesota nurses study. *Occupational Environmental Medicine, 62,* 675-681. retrieved from http:///www.oem.bmjjournals.com

National Joint Council (2010). Occupational Health and Safety Directive. Ottawa, ON: Author. Retrieved from http://www.njc-cnm.gc.ca/directive/index.php?did=7&lang=eng

Neuman, J. & Barron, R. (1998). Workplace violence and workplace aggression: Evidence concerning specific forms, potential causes, and preferred targets. *Journal of Management, 24,* 391.

Nolan, P., Dallender, J., Soares, J., Thomsen, S., & Arnetz, B. (1999). Violence in mental health care: the experiences of mental health nurses and psychiatrists. *Journal of Advanced Nursing*, *30*(4), 934-941. Retrieved from CINAHL database.

Nolan, P., Soares, J., Dallender, J., Thomsen, S., & Arnetz, B. (2001). A comparative study of the experiences of violence of English and Swedish mental health nurses. *International Journal of Nursing Studies*, *38*(4), 419-426. Retrieved from CINAHL database.

Nurses Association of New Brunswick.(2008). *Position Statement- Violence in the workplace*. Saint John, NB: Author

Occupational Health and Safety Branch Department of Government Services. (2009). *Occupational health and safety act.* Mount Pearl NL: Retrieved from http://www.gs.gov.nl.ca/ohs/

Occupational Health and Safety Branch Ministry of Labour.(2009). *Occupational health and safety act.* Toronto, ON: Retrieved from .

Occupational Health & Safety Division Nova Scotia Labour and Workforce Development (2009). *Occupational health and safety act.* Halifax, NS: Retrieved from http://www.gov.ns.ca/lwd/ohs/

Occupational Health and Safety Division Saskatchewan Ministry of Advanced Education, Employment and Labour (1993). *The occupational health and safety act.* Regina SK:Retrieved from http://www.labour.gov.sk.ca

Occupational Health and Safety Division Workers' Compensation Board (2009). *Occupational health and safety act.* Charlottetown PE : Retrieved from http://www.wcb.pe.ca

Occupational Health and Safety: Labour Program: Human Resources and Skills Development Canada (n.d.). Canada labour code part 2. Ottawa, ON: Retrieved from http://laws.justice.gc.ca/PDF/Statute/L/L-2.pdf

Ostry, A. S., Tomlin, K. M., Cvitkovich, Y., Ratner, P. A., Park, I., Tate, R.,& Yassi, A. (2004). Choosing a model of care for alternate level care patients: Caregivers' perspectives with respect to staff injury. *Canadian Journal of Nursing Research, 36*(1),142-157.

Owen, C., Tarantello, C., Jones, M., & Tennant, C. (1998). Violence and aggression in psychiatric units. *Psychiatric Services, 49*(11), 1452-1457.

Paton, N. (2005). Staff behaving badly. *Occupational Health, 57*(5), 17-19. Retrieved from CINAHL database.

Paul RJ, Townsend JB 1998. Violence in the workplace--a review with recommendations. *Employee Rights and Responsibilities Journal. 11*, 1-14

Pawlin, S. (2008). Reporting violence. *Emergency Nurse, 16*(4), 16-21. Retrieved from CINAHL database.

Peek-Asa, C., Casteel, C., Allareddy, V., Nocera, M., Goldmacher, S., OHagan, E.,...Harrison, R. (2009). Workplace violence prevention programs in psychiatric units and facilities. *Archives of Psychiatric Nursing, 23*(2), 166-176. Retrieved from CINAHL database.

Polit, D. & Beck, C. (2004). Nursing Research. Principles and Methods (7th ed.) London: Sage Publications Ltd.

Pozzi, C. (1998). Exposure of prehospital providers to violence and abuse. *Journal of Emergency Nursing 24*(4), 320-323.

Presley, D., Robinson, G., 2002. Violence in the emergency department. *Nursing Clinics of North America 37*(1), 161–169.

Privitera, M., Weisman, R., Cerulli, C., Tu, X., & Groman, A. (2005). Violence toward mental health staff and safety in the work environment. *Occupational Medicine, 55*, 480-486.

Quick, G. (1999). *Horizontal aggression among Manitoba general duty staff/registered nurses, a descriptive study.* Retrieved from `http://hdl.handle.net/1993/1669`

Randle, J. (2003). Changes in self-esteem during a 3-year pre-registration diploma in higher education (nursing) programme. *Journal of Clinical Nursing, 12*, 142-143.

Randle, J. (2003). Bullying in the nursing profession. *Journal of Advanced Nursing, 43*(4), 395-401.

Registered Nursing Association of Nova Scotia. (1996). Violence in the Workplace: A resource Guide. Halifax, NS: Author.

Rippon, T. (2000). Aggression and violence in health care professions. *Journal of Advanced Nursing, 31*(2), 452-460. Retrieved from CINAHL database.

Rogers, K., & Kelloway, K. (1997). Violence at work: personal and organizational outcomes. *Journal of Occupational Health Psychology, 2*(1), 63-71.

Ryan, D. & Maguire, J. (2006). Aggression and violence: a problem in Irish Accident and Emergency departments? *Journal of Nursing Management, 14,* 106-115.

SAFE Manitoba. (2010). *The workplace safety and health act.* Winnipeg, MB: Retrieved from http://www.safemanitoba.com/

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health, 23,* 334-340.

Schat, A. & Kelloway, K. (2000). Effects of perceived control on the outcomes of workplace aggression and violence. *Journal of Occupational and Health Psychology, 5*(3), 386-402.

Schat, A. & Kelloway, K. (2003). Reducing the adverse consequences of workplace aggression and violence: the buffering effects of organizational support. *Journal of Occupational and Health Psychology, 8*(2), 110-122.

Shields, M. & Wilkins, K. (2006). *Findings from the 2005 National Survey of the Work and Health of Nurses.* Ottawa, ON: Health Canada and Canadian Institute for Health Information.

Skillen D. L. (1995), "Nurses' Work Hazards in Public Health Units" in Issues in Women's Occupational Health, Messing K. et al. (Eds.), pp. 150-173.

Sofield, L. & Salmond, S. W. (2003). Workplace violence: a focus on verbal abuse and intent to leave the organization. *Orthopaedic Nursing, 22,* 274-283.

Spokes, K., Bond, K., Lowe, T., Jones, J., Illingworth, P., Brimblecombe, N., & Wellman, N. (2002). HOVIS -- the Hertfordshire/Oxfordshire violent incident study. *Journal of Psychiatric & Mental Health Nursing*, *9*(2), 199-209. Retrieved from CINAHL database.

Susan, M. S. (2007). An integrative framework of workplace stress and aggression. *The Business Review, Cambridge, 8,* 223.

The Canadian Centre for Occupational Health and Safety (CCOHS) 2008. Violence in the workplace http://www.ccohs.ca/oshanswers/psychosocial/violence.html

Thomas, C. (2010). Teaching nursing students and newly registered nurses strategies to deal with violent behaviors in the professional practice environment. *Journal of Continuing Education in Nursing*, *41*(7), 299-310. doi:10.3928/00220124-20100701-06.

Thomas, S. P. (2003). Anger: the mismanaged emotion. *Medsurg Nursing, 12,* 103-110.

Thomas, S., & Burk, R. (2009). Junior nursing students' experiences of vertical violence during clinical rotations. *Nursing Outlook*, *57*(4), 226-231. Retrieved from CINAHL database.

Tolhurst, H., Baker, L., Murray, G., Bell, P., Sutton, A., & Dean, S. (2003). Rural general practitioner experience of work-related violence in Australia. *Australian Journal of Rural Health*, *11*(5), 231-236. Retrieved from CINAHL database.

Tolhurst, H., Talbot, J., Baker, L., Bell, P., Murray, G., Sutton, A., & Dean, S. (2003). Rural general practitioner apprehension about work related violence in Australia. *Australian Journal of Rural Health, 11*(5), 237-241. Retrieved from CINAHL database.

Viitasara, E., & Menckel, E. (2002). Developing a framework for identifying individual and organizational risk factors for the prevention of violence in the health-care sector. *Work, 19*(2), 117-123. Retrieved from CINAHL database.

Viitasara, E., Sverke, M. & Menckel, E. (2003). Multiple risk factors for violence to seven occupational groups in the Swedish caring sector. *Relations Industrielles, 58,* 202.

Walsh, B. & Clark, E. (2003). Post-trauma symptoms in health workers following physical and verbal aggression. *Work and Stress, 17*(2), 170-181.

Whitly, G. G., Jacobson, G. A., & Gawrys, M. T. (1996). The impact of violence in the health care setting upon nursing education. *Journal of Nursing Education, 35*, 211-218.

Whittington, R. (1997). Violence to nurses: prevalence and risk factors. *Nursing Standard, 12*(5), 49-56.

Whittington, R., Shuttleworth, S., & Hill, L. (1996). Violence to staff in a general hospital setting. *Journal of Advanced Nursing, 24*(2), 326-333. Retrieved from CINAHL database.

Whittington, R., & Wykes, T. (1996). Aversive stimulation by staff and violence by psychiatric patients. *British Journal of Clinical Psychology, 35*, 11-20.

Wiley, K. (2007). 2007 Nebraska Nurses Survey results. Making a world of difference: workplace violence and nursing. *Nebraska Nurse*, *40*(4), 14-19. Retrieved from CINAHL database.

Wilkins, K. & Mackenzie, S. (2007). Work Injuries. *Health Reports (18)*, 3, 1-18. Statistics Canada, Ottawa, ON.

Workers' Compensation Board of the Northwest Territories and Nunavut.(2006). *Consolidation of safety act.* Retrieved from http://www.wcb.nt.ca/

Workplace Health and Safety: Alberta Employment and Immigration. (2006). *Occupational health and safety act. R*etrieved from http://employment.alberta.ca/SFW/53.html

WorkSafeBC. (2009). *Workers compensation act: occupational health and safety regulation.* Retrieved from http://www.worksafebc.com/

WorkSafeNB. (1994*). Workplace Health, Safety and Compensation Commission Act.* Retrieved from http://www.worksafenb.ca/

World Health Organization. (2002). World report on violence and health. Krug, E., Dahlburg, L., Mercy, J., Zwi, A. & Lazano, R. (Eds). Geneva: Author.

Yassi, A. (1994). Assault and abuse of health care workers in a large teaching hospital. *Canadian Medical Association Journal, 151*(9), 1273-1279.

Yassi, A., Gilbert, M., Cvitkovich, Y. (2005). Trends in injuries, illnesses, and policies in Canadian health care workplaces. *Canadian Journal of Public Health*, *96*(5), 333-339.

Yukon Workers' Compensation, Health and Safety Board: Occupational Health and Safety Branch. (2002). *Occupational health and safety act.* Retrieved from http://wcb.yk.ca