VIOLENCE IN NURSING: PERCIEVED PREVALENCE AND IMPACT IN COMMUNITY HEALTH CLINICS IN CAPE TOWN

BY

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DEDICATIONS:

This dissertation are dedicated to my husband Nasief and our three sons, Rafeeq, Abdulghaaliq, and Gabeeburagmaan

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Operational definitions: Terms familiar to respondents

Terms	Definitions
Physical	Physical rough handle another nurse
Pushing	Physical pushing another nurse
Assault	All types of physical assault with no injuries
Sabotage	Physical sabotage of another nurses work
Injuries	Causing situations where another nurse may sustain injuries or wounds
Group Attack	Group of nurses ganged up to physical attack another nurse
Verbal Abuse	Using unkind and hurtful words
Shouting	Raising one's voice above acceptable levels of communication
Insinuations	indirect allusions or devious hints or devious suggestions about another nurse
Swearing	A curse or blaspheme against another nurse
Humiliations	To hurt or lower the dignity or pride of another nurse
Devalued	To reduce the value or worth of another nurse
Intimidation	To discourage, or silence through threats or blackmail
Discrimination	To single out a particular person for favour or disfavour
Isolation	To place apart or cause another nurse to be alone or to prevent interaction with another nurse
Marginalisation	To be placed on the sidelines or views and ideas considered irrelevant
Bullying	To hurt or persecute another nurse
Ignored	To fail or refuse to notice or disregard another nurse
Labelling	Giving derogatory names or maliciously qualifying another nurse
Innuendoes	An indirect or subtle malicious and defamatory reference or indicating criticisms or disapproval of another nurse
Gossiping	Conversation involving damaging or malicious information about another person
Stigmatisation	attaching negative qualities to another person's character of state of being
Name calling	Use of derogatory names to label another person
Manipulation	Ways that people skilfully control or influence others
Avoids contact	Ways that people employed to keep away from coming into close contact with or shun another person
Threats	Verbal declarations of intentions to inflict harm on another person
Professional nurse	College or university trained and registered with the south African nursing council
Enrolled nurse	Nursing school trained and enrolled with the south African nursing council
Auxiliary nurse	Nursing assistants trained and enrolled with the south African nursing council

Nurse learner	student nurses registered with the south African nursing council
Unit or facility manager	Professional nurse in charge of the clinic
Clinical nurse practitioner	SANC Regulations: Professional nurse with speciality in Community health and primary health
Violence	violation resulting in an emotional ramification in addition to physical injuries
Physical violence	All form of violence that result in bodily discomfort to the victim
Psychological violence	All forms of violence that cause distress to the victim
Vertical violence	All forms of violence perpetrated by either seniors nurses against junior nurses or by junior nurses against senior nurses
Horizontal violence	Violence between nurses of the same rank
Covert violence	Violence acts committed in secret
Overt violence	Violence acts committed openly or in public

LIST OF ABREVIATIONS AND TERMS

ANC: **A**frican **N**ational **C**ongress

CCMA: **C**ommission for **C**onciliation **M**ediation and **A**rbitration

CHC: **C**ommunity Health Clinics

CNP: **C**linical Nurse Practitioner

EC: **E**uropean Commission

EN: **E**nrolled Nurses

ILO: **I**nternational **L**abour **O**rganization

INC: **I**nternational **N**urses **C**ouncil

MASA: **M**edical **A**ssociation of **S**outh **A**frica

MRC: **M**edical **R**esearch **C**ouncil

PSI: **P**ublic **S**ervices **I**nternational

RDP: **R**econstruction and **D**evelopment **P**rogramme

RN: **R**egistered **N**urse

SACP: **S**outh **A**frican **C**ommunist **P**arty

SANC: **S**outh **A**frican **N**ursing **C**ounsel

SN: **S**tudent **N**urses

TB: **T**uberculosis

UM: **U**nit Managers

WHO: **W**orld **H**ealth **O**rganization

UCT: **U**niversity of **C**ape **T**own

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EXECUTIVE SUMMARY

Title: VIOLENCE IN NURSING: PREVALENCE AND IMPACT IN COMMUNITY HEALTH CLINICS IN CAPE TOWN

Introduction: The paper will be focusing on violence against nurses working in community health clinics in Cape Town. The study is a replication of Prof Doris Deedei Khalil's (principle researcher) larger studies on violence in all areas of nursing including general, paediatric and psychiatric nursing, midwifery and undergraduate nursing schools. **Aim and objectives**: to explore violence in nursing within community health care settings. Some of the objectives of the study examined the extent and frequency of violence against nursing staff in community health clinics. **Research design:** phenomenological approach was selected to capture experiences and views of nurses working in selected health centres. The sample group or research participants was drawn from seven sub-districts public funded clinics within the Cape Town Metropole Health District, namely Tygerberg, Mitchell's Plain and Klipfontein, Southern, Eastern, Western and Northern sub-districts. Categories of nurses that participated in the study were Professional Nurses (RN), Clinical Nurse Practitioners (CNP), Unit Mangers (UM), Registered Auxiliary Nurses, Enrolled Nurses (EN) and Student Nurses. Ethical approval to proceed with data collection and permission to access research sites was granted in 2008. **Methods of data collection**: data was collected from three sources, i.e. questionnaires, interviews and documents. Although phenomenological approach normally does not use questionnaires as a means of data collection because of the nature of the topic under study, confidentiality has to be assured to avoid the possibility of reprisals or intimidation. **Analysis:** computer software were utilised to capture information obtained from questionnaires and interviews. Questionnaires and interview responses were compared for similarities and differences. Only official document was made available for the study, therefore triangulation of data sources was possible. **Results:** The main types of violence were verbal abuse, and threats to assault. Significant number of respondents indicated that women attack nurses more often than gang members and patients' relatives. Nevertheless, perpetrators of violence against nurses varied among the sub-districts, e.g. Western sub-district clinics identified women whereas, Klipfontein identified patient relatives and Tygerberg identified gang members as regular perpetrators of violence against staff in their clinics. Results indicated that violent incidences occur on Mondays and Fridays in all the participating clinics. The highest number of violent incidences in Tygerberg clinics occurred on Mondays. On the other hand, threats to assault nurses were high in Western and Southern sub-districts clinics compared to the other sub-districts. **Conclusions:** violence against nurses in

most health clinics of the study is on the increase because of substance abuse and gang violence. Recruitment of additional staff could minimise the time patients have to wait to see a doctor. However, it is essential that some nurses working in these clinics be more compassionate and polite towards their patients. Recommendations: increase number of security personnel sub-districts with high frequency of attacks against nurses. Nurses should be encouraged to respect each other and minimise verbal abuses against each other. Nurses that violate patients should be dismissed from the profession.

Chapter 1: Introduction

1.1 Background

The South African media had been raising concerns about violence in country. Crime statistics of South Africa reflected the violent nature of South African society. In 2008/2009 there were 37.3 murders per hundred thousand compared to "global homicide rate" estimated at 7, 6 per hundred thousand with Aggravating robbery were 200-300 per 100 000 (Burger 2009:5). The most common crimes in the country were street robberies, bank robberies, cash in transit robberies and truck hijacking (Burger, 2009:7)). Schaefer and Lamm (1992:100) described sociological forces that could account for the rise in crime and violence in society. Similarly, Merton in Schaefer and Lamm (1992:98) described behaviours that could lead to violence in a given society, i.e. *innovation*, *ritualism, retreatist, rebellion*. Violence has become an everyday occurrence in South Africa since the post apartheid era (Mandela and Poggenpoel, 1993:692; Bowman et.al, 2009:300-313).

Therefore, to what extent does the violence in society affect health care professionals in particular nurses. This study sets out to explore the phenomenon of violence in nursing and forms part of a larger study on violence in nursing in Cape Town. The study will be examining violence in selected community health clinics in Cape Town.

1.2 Research Aim and Objectives

One main aim was identified to focus the study. This is supported with four objectives presented below.

1.2.1 Aims of the study

To explore violence in nursing within selected community health care clinics in Cape Town.

1.2.2 Objectives:

- To examine the extent of violence against nursing staff in community health care clinics
- To investigate the extent to which violence exists amongst nursing staff working in community health care clinics
- To explore nurses' response and attitude towards health care consumers as results of violence in the workplace
- To identify strategies in place to manage violence in community health clinics
- To make recommendations to manage violence in community health clinics

1.3 Conceptual model

The conceptual model presents sequence of events that could have resulted in violence in public sector community health clinics in Cape Town.

Stage 1: Apartheid segregation policies lead to → resentment and poverty among non-white population in the country → increased gang membership and crime (Dinan, 2004: 728; Silber and Geffen, 2009:36)

Stage 2:

Community violence → spill over to public health facilities→ personal security concerns → exodus of health care professionals from the country **(Wildschut and Mqolozana, 2008: 25)** → **shortage of skilled health care professionals** (Sosibo, 2006:1) →long waiting time at health facilities

Stage 3:

Shortage of nurses (Wildschut and Mqolozana,2008: 25) → delays in service provision and consumers' right to health care (Jubber, 2007:11; www.doh.gov.za/docs/misc/healthcharter) → health consumers' frustration → violence against nursing staff

Stage 4:

Violence from health care consumers' → low morale among nurses → short temper among nurses→ violence among nurses

Stage 5:

Consequences of stages 3 and 4 → violence by nurses against health care consumers' → disciplinary actions or exodus from the profession

Stage 6:

Consequences of stages 3-5 → adverse effects of nurses → absenteeism or sick leave requests

Stage 7:

Managing stages 3-6 ← continuous professional development, self defence training, counselling, and anger management for nurses

Stage 8:

Prosecution of health care consumers that violate nurses (Wildschut and Mqolozana 2008:55)

1.4 General Layout of dissertation

Chapter two will present literature review the political history of South Africa, history of health care provision and nursing in the country. It will also review incidences of violence involving nurses and types of violence. The chapter will explore levels of violence, e.g. violence against nurses, among nurses and by nurses against others. It will present information from the literature on global demographics of violence in nursing from developed and developing countries. Chapter three will outline methodology of the study including the selected research design, methods of data collection, the population, and criteria for selection of research participants. It will address ethical issues relating to the study, validity and reliability of data collection tools, and processes for data analysis. Chapter four presents results of data analysis of questionnaires and interviews. It also presents constraints and limitations during data collection and analysis. Chapter five presents discussions on key findings of the study, and chapter six outlines conclusions and proposed some recommendations for policy makers.

Chapter Two: Literature review

2.1 Introduction

This chapter presents literature reviewed on violence in society and in the workplace. It outlines factors leading to or some reasons for violence in South Africa. The chapter provides brief overview of political history of South African and possible ways that political history could have contributed to violence in the public health sector. A brief history of the health services and community nursing are provided also showing how the process of transformation can inadvertently cause factors that could give rise to violence. This chapter also reviews available literature as regards the incidence of violence in the health sector internationally, and examines the extent of research on violence in the health sector in South Africa. Finally, the chapter will present a conceptual model as to why violence exists in nursing.

2.2 Political History of South African

In 1948, the Nationalist Government came into power. Although the colonialist had already introduced segregation based on class, apartheid made race the bases of segregation (Orten 1988:300). Segregation of the races led to the formation of Bantustans or 'home lands' (Baldwin-Ragaven, de Gruchy and London 1999: 18). By creating 'independent black states' or 'home land', all black Africans were declared foreigners in the rest of South Africa and denied equal rights (Baldwin-Ragaven et al 1999: 20). Black Africans were further denied access to higher educational institutions, employment, housing, healthcare, and other such social services. Forced removal policies of the apartheid government dramatically increased the population within the Bantustans. Combined homeland population increased from 4, 739,855 in 1960 to 11 338 308 in 1980 resulting in 239% population increase (van Rensberg, Fourie and Pretorious 1992: 66). The creation of Bantustans in poverty-stricken areas generated social conditions conducive to violence (Baldwin-Ragaven, de Gruchy and London, 1999: 18). Consequently, non-whites were forced into poverty, and handicapped in their efforts to procure basic needs (Donald, Lazarus and Lolwana 2004: 123). Oppressed groups' rebelliousness to the status quo, lead to the formation of resistance organisations, e.g. African National Congress (ANC), and South African Communist Party (SACP).

Violence was viewed as a legitimate response resulting in more than thirty years of violence, reaching peaks during the Sharpeville Massacre in 1960, the Soweto uprisings in 1976 and the uprisings in 1985 and 1986 resulting in states of emergencies being declared (Baldwin-Ragaven et al, 1999: 21). Such long-term exposure to violent resistance led to a culture of violence, and

acclimatization to the use of violence, an allegation supported by the ANC's Reconstruction and Development Programme policy document argued that apartheid unleashed vicious wave of violence (ANC 1994). The spectrum of violence and poverty continuously haunt the people of South Africa (ANC 1994: 3). Violence became an automatic response among the non-white population of South Africa as conflict resolution strategy (Gilson et al 2004: Van Wyk et al 2006). A culture of violence became part of everyday life in South Africa (Silber and Geffen, 2009:34).

2.3 History of Health Provision in South Africa

The apartheid Department of Health (from 1948-1994) had health policies which were driven not by concern for the well-being of all South Africans but by ideologies of the state (Baldwin-Ragaven, de Gruchy and Londen 1999: 18). Segregation was implemented in education, health, welfare, transport and employment. Baldwin-Ragaven et al (1999: 18) further stated that the oppression created disparities of access to public health care services between whites and non-white population groups. Despite evidence of disparity, unnecessary revenue was spent in building separate entrances at outpatient clinics, separate wards in hospitals and special dormitory facilities for white nursing staff nearer to hospitals (Baldwin-Ragaven et al 1999: 37). Poverty in the black areas resulted in third world illnesses such as tuberculosis, malnutrition, diarrhoea, respiratory illnesses, measles and cholera with resultant high infant mortality rates (Baldwin-Ragaven et al 1999: 26-28; Van Rensberg, Fourie and Pretorious, 1992: 66). Subsequently, there was a dichotomy of illness, e.g. first world illness among the whites and third world illnesses amongst the blacks (Ehlers, 2000:134).

2.4 History of Community Nursing

Professionally training, statutory control, state registration and licensing of nurses in South Africa were started in the late 19th century (van Rensberg et al 1994: 45). The South African Nursing Council was created after the Nursing Act of 1944 was passed by Parliament. The Nursing Amendment Act of 1957 permitted black doctors to give orders to white nurses (Baldwin-Ragaven et al 1999:151). The Medical Association of South Africa (MASA) felt that the then government was justified in approving the amendment since exceptional cases may arose where a 'white nurse would be required to look after a black patient' (Baldwin-Ragaven et al 1999: 151). The recommendations at the Alma Ata Conference in 1978 (www.who.com) resulted in the implementation of primary health care approach in country (www.doh.gov.za/docs/misc/**healthCharter**). In 1992, the then Minister of Health declared that

primary health care must be implemented in order to make healthcare more available, accessible and affordable (Hatting, Dreyer and Roos 2004: 11). Community health clinics were then understaffed with overworked nurses, a situation still in existence at time of writing (Wildschut and Mqolozana, 2008: 25). However, Ehlers (2000) argued that more capital was spent in providing curative care since this is what most white South Africans needed.

The ANC government passed the Batho Pele policy document that aimed to improve public service delivery including health care (www.healthsytemstrust.gov.za). The White Paper on Transformation of the Health Services (www.dephealth.gov.za) was adopted in 1997 based on the Alma Ata declaration of 1976 (www.who.int/publications/almaata_declaration_en.pdf). The decentralizing of health care brought healthcare to all communities in the country (de Haan 2005: 18) as stipulated in the South African Health Charter. Tertiary institutions were situated way from areas with high rates of gang membership and violence, e.g. Elsiesriver, Manenberg, and Hanover Park (Steinman, 2003: 133). However, some community health centres were directly exposed to violence as they were built near to or within gang infested communities (Steinberg, 2003: 134; Steinman, 2003:133). The close proximity health care centres could have contributed to the exposure of health care workers to violence (Steinman, 2003:133; de Haan 2005: 19).

2.5 Violence involving Nurses

Macintosh (2006: 666) defined violence in the workplace as repeated unwanted psychological, physical, sexual abuse or harassment. Bowmen et al (2010:300) affirmed that workplace violence had been receiving increasingly global attention. According to Heinchberger (2009), Chappel and Di Martina (2006), Di Martino (2002) and Flannery (1996), workplace violence is a worldwide phenomenon. On the other hand, Ishmael (1999: xii) stated that harassment, bullying and violence in the workplace are not a new phenomena. Workplace violence had become widely researched academic topic with studies conducted by Morgens (2007: 161-172); Hutchinson, Vickers, Lutgen-Sandvik, Tracy and Alberts (2007: 837-862); Hoel and Beale (2006: 239-262); Jackson and Wilkers (2005: 331-336); Marais, Van Der Spuy and Rontch (2002: 9-12); and Boyd, (1995: 491-519). Stanley, Martin, Michel, Welton and Nemeth (2007:1247-1265) reported in their study findings that lateral violence, also identified by them as horizontal violence as a very serious problem.

According to Di Martino (2000:1), there was mounting evidence internationally that workplace violence involving nurses in the health sector was common. Kingma (2001: 130) and Di Martino (2000: 1) maintained that nurses were three times more likely to experience violence than other health related occupational groups. Nolan, Soares, Dallender, Thomsen and Arnetz (2001:419-426) found that violence in mental health institutions in England had not been adequately addressed. According to Nolan et al (1999: 934-941), previous research by Poster (1996) and Whittington (1994) underestimated the extent of the situation.

2.6 Definition and types of violence

Hoel and Rainer (1999:23) defined workplace violence in general as destructive behaviour towards another person and finds expression in the forms of physical assault, homicide, verbal abuse, bullying, mobbing, sexual harassment and acts leading to mental stress. Di Martino (2002: 11) defined violence as

> "*Incidents where staff is abused, threatened, or assaulted in circumstances related to their work, including to and from work, involving an explicit or implicit challenge to their safety, well-being or health"*.

This definition Di Martino (2002: 11) adapted from the European Commission on guidelines on prevention of violence at work (Wynne and Clarkin 1995: 4). Violence in the workplace and more specifically, in the context of health care and the nurse, manifested as physical and psychological violence (Ishmael 1999: 55). Physical violence includes physical assault, homicide and sexual harassment (Ishmael 1999: 55). Ishmael (1999) argued that physical violence had always been recognized but the existence of psychological violence had long been under-estimated. Di Martino (2002: 1) found that psychological violence in the health sector to be more common than physical violence. He argued that failure to recognize the occurrence of psychological violence could lead to under-estimation of the occurrence of violence (Di Martino 2002). The added dimensions within the health sector were gender violence and sexual harassment, especially as majority of nurses are females (Ehlers, 2006:133).

2.7 Levels of Violence

It is imperative that research into violence in the health sector should take cognisance of the fact that violence had not only been perpetrated against nurses and amongst nurses but also by nurses (Khalil 2010; Coyne 2002). A term such as horizontal violence had started to appear in

the literature, mainly referring to nurse-on-nurse violence (Khalil 2009; Woelfle and MaCaffrey, 2007: 123-131 and Mckenna, 2003: 12). Vertical violence among nurses occurred in both directions, i.e. violence by senior nurses against junior nurses and vice versa (Hoel and Cooper, 2000: 195-230). A survey of nursing staff in Australia revealed that 63.5% of respondents complained of aggression against them immediately prior to the survey, from patients, visitors, medical and other nursing colleagues (Farrel, Bobrowski and Babrowski, 2006: 778-787).

Hippeli (2009:186) found that violence among nurses had been evident since the mid-1960s. Stanley, Martin, Michel, Welton and Nemeth (2007:1247-1265) indicated that 65% of respondents frequently observed lateral violence amongst co-workers. Violence within same rank had been referred to as horizontal violence (Mladineo, 2006:44-6). Joley and Brykczynska (1995: 81) described the nursing profession as a type of hierarchy that exposed nurses to the possibility of either being a bully or being bullied. Cavanagh (1991: 1254-1260) research on bullying identified nurse managers as the main perpetrators within the health care environment. Lewis, (2006: 52-8) maintained that bullying amounted to an abuse of power making the recipient feel upset, humiliated, and vulnerable. Bullies tended to threaten junior nurses in order to assert their power, or to invoke fear and anxiety (Anderson and Parish, 2003:237-243). Un-reported bullying within the nursing profession could have resulted in the exodus of nurses from the profession (Khalil 2009; Woelfle and MaCaffrey, 2007: 123-131 and Mckenna, 2003: 12; McKenna, Smith, Poole and Coverdale, 2003: 56-63).

Violence by nurses manifested at various areas of care intervention. Khalil (2009) conducted a study in Cape Town, and found that nurses tend to label patients as either ‘good’ or ‘difficult’. Good patients were awarded with kindness and tender loving care, whilst difficult patients were completely ignored or nursing interventions were deliberately delayed (Khalil: 2009). Khalil (2009) study found nurses were rude and shouted at patients, whilst minority of nurses discriminated against patients because of their skin colour (Khalil2009). Jewkes, Abrahams and Mvo (1998:1781-1795), conducted one hundred and three in depth interviews with patients and maternity staff, finding that many of the patients had experienced violence from nurses in the form of verbal and physical abuse. Lucas and Stevenson (2005: 195-203) also documented abuse of psychiatric patients. One hundred and twenty one cases of poor patient care were reported to the South African Nursing Counsel (www.**sanc**.co.za). Reports of nursing malpractice which is on the increase, does not distinguish between intentional negligence and

violence as opposed to unintentional negligence (Giordino, 2003: 3). Despite these reports, search of the literature failed to yield articles that had studied violence in community healthcare setting specifically involving nurses.

2.8 Global Demographics of Violence in Nursing

Research papers such as Ali, (2008: 179), Wells and Bowers (2002: 230-240) and (McKenna, Poole, Smith, Coverdale and Gale, 2003: 56-63) were reviewed which indicated that violence in the health sector is a global phenomena. Stanley, Martin, Michel, Welton and Nemeth (2007:1247-1265) Indicated in their study conducted in South Carolina, America that lateral violence, also identified as horizontal violence, as a phenomena that undermines the nursing administrators efforts to diligently recruit and retain nurses. Experiences of violence in the nursing profession vary, depending on whether at commencement of the profession or prior to retirement or throughout the nursing career (McKenna, Poole, Smith, Coverdale and Gale, 2003: 56-63). Types of violence and management of violence differ from country to country (Wells and Bowers 2002: 230-240, Bronner, Chava and Ehrenfel (2003: 637-644, Lee (2001: 3-8).

A survey of nursing staff in Australia revealed that sixty three and half percent of respondents complained of aggression against them immediately prior to the survey, from patients, visitors, medical and other nursing colleagues (Farrel, Bobrowski and Babrowski, 2006: 778-787). Wells and Bowers (2002: 230-240) showed that little is known about the scale of the problem for general nurses working in general hospitals in the United Kingdom. Rumpersaud (2008:132) found that Canadian emergency department nurses experienced mental, physical abuse from patients and patients' families. Bronner, Chava and Ehrenfel (2003: 637-644) survey of Israeli nurses and student nurses, indicated that at least 90% of them had experienced sexual harassment. Wells and Bowers (2002: 230-240), found similar findings in their United Kingdom study. Luck, et al (2007) found emergency department nurses made judgement about the meaning of violent events based on three factors, i.e. mitigating circumstances, personalization of the violence, and reasons for the violence.

Lee (2001: 3-8) study amongst nurses in their first year of practice in mental health settings in New Zealand, revealed that nurses experienced verbal threats, verbal sexual harassment and physical intimidations. Kwok, Law, Ng, Cheung, Fung, Kwok, Tong, Yen, and Leung (2006: 6-9)

found that Hong Kong nurses experienced verbal abuses, bullying, and sexual harassment. Farrell, Bobrowski and Bobrowski (2006: 778-787) indicated that Australian nurses experienced high levels of verbal and physical abuse from patients/clients or their visitors, medical and nursing colleagues. Knigma (2001:129-130) extensive research in the UK indicated that 95% of nurse respondents knew of at least one nurse that had been physically assaulted during the previous year. Knigma (2001:129-130) further found that 95% of nurses indicated having been bullied and 75% of nurses had been subjected to sexual harassment at work. Knigma (2001:129-130) study further identified main perpetrators of violence against nurses as patients and their relatives.

Dubcan, Hyndman, Estabrooks, Hesketh, Humphrey, Wong, Acorn and Giovannetti (2001: 57-78) surveyed 8780 nurses practising in 210 hospitals in the Canadian provinces of Alberta and British Columbia found evidence of violence against nurses. Celik and Celik, (2007: 359-366), and Oztunc (2006: 360-365) found that in Turkey, 91% of the nurses were verbally abused and 33% were physically abused. Zuraikat, (2008:143) found increased violent attacks against nurses and doctors in Jordan. Nurses in Kuwait were also experiencing violence in the work place (Adip, Alshtti, El –Gerges, Al- Raqem, 2002: 469-78). Shoghi and Heidari (2008:184-191) indicated that 87.4% Iranian nurses that participated in their study had experienced verbal abuse. Verbal abuse by health care consumers is the largest form of abuse against nurses found in Cape Town (Khalil, 2009:207-217). Khalil (2009a:133) showed that midwives in two large maternity hospitals in Cape Town faced violence from health care consumers on daily bases.

A survey conducted by Steinman (2003: 21) in the Greater Johannesburg Metropolitan region found that sixty three percent of respondents experienced some form of violence, but the survey included all allied and administration staff as well. Marais, Van der Spuy and Rontsch (2002: 45) found that 50% of health care workers had experienced some form of violence from consumers at various health care facilities in Cape Town. Jewkes, Abrahams and Mvo (1998:1781-1795), in depth interviews with patients and maternity staff, found that many of the patients reported to have been verbally and physically abused by nurses. Lucas and Stevenson (2005: 195-203) also documented nurses' abuse of psychiatric patients. Anderson and Parish (2003: 237-43) found that gender and history of violence were significantly associated with workplace violence. Anderson and Parish (2003: 237-43) recommend training programmes for violence prevention.

Anderson and Parish (2003: 237-43) strengthened the findings of Di Martino (2002: 14) that there were cultural difference in perception and understanding of violence.

2.9 Summary

Relevant literature was reviewed in this chapter to provide a historical background to violence in nursing in South Africa, and to assess current research nationally and internationally. Historically Bantustans were created which resulted in poverty in the black community. This also had an impact on health care and violence in nursing. International research has shown that violence is indeed an international phenomenon, requiring more research to address the problem. Psychological violence was generally underestimated, resulting in an under-estimation of violence in general. Violence in the literature was described as occurring both vertically and horizontally. The problem of violence is also to be found in the South African context, although available research is limited, especially pertaining to community health nursing.

Chapter 3: Methodology

3.1 Introduction

The chapter will describe the research design, population and criteria for selection of participants and community clinics. It will also outline methods of data collection and processes of analysis. The chapter presents ethical considerations, validity and reliability of data collection tools, and constraints and limitations during the research process.

3.2 Research Design

Qualitative research methodology was selected to shed light on the extent that violence exist in selected community health clinics in Cape Town. Qualitative researches design study experiences and views of individuals or groups over time (Huberman and Miles 1985:77; Denzin and Linclon 1998:38). One of the advantages of qualitative research is to understand a given human life experiences in their entirety, rather than focusing on specific concepts (Brink 2002: Pilot and Hungler 2003). The other advantage is that qualitative research has few preconceived ideas but stresses the importance of people's interpretations of events and circumstances, rather than researchers' interpretations. Furthermore, qualitative research does not attempt to control the context of the research, but rather attempts to capture that context in its entirety (Brink 2002:13).

Out of the list of qualitative research designs, phenomenology is selected to focus the study. Heidegger the phenomenologist believes that the person is a self within a body which is known as being embodied. Husserl, another phenomenologist, believed that although self and the world are mutually shaping, it is possible to bracket oneself from one's beliefs to see the world first hand in a naïve manner, although he does not disagree that bracketing is not possible. Husserl explained that phenomenon is the world of experience and phenomena can only occur when a person experienced the phenomenon (Burns and Grove, 2007: 55). Taminiaux (2008: 33) argued that Husserl view was that the worth of phenomenology intuition was to show that the concrete life of consciousness is an absolute existence to which the appearance of all beings is referred.

According to Polit and Beck (2006: 285), phenomenological approaches examine the lived-experiences of individual, group of peoples, social problems experienced during interaction and examine the nature of the experience. Some of the advantages of a phenomenological design are that it concentrates on the participants experiences rather than objects or subjects (Brink 2002:119). Phenomenology also enables participants to describe their experiences and meanings that the experiences hold for them (Brink 2002:119). On the other hand, some of the disadvantages of phenomenology are that researchers are required to immerse themselves in large volumes of data collected in order to be able to analyse and interpret information contained (Denzin and Lincoln 1998:42).

3.2.1 Population and samples

The study population consist of all nurses working in 119 community health clinics located within the Cape Town Metro pole Health Area. Non-probability sampling technique would be employed to select community health clinics and nurses to participate in the study (Burns and Groove 2009; 429). Justification for the use of non-probability sampling was that nurses that are willing to participate in the study would be the only ones to be included in the sample group. Categories of nurse to be included in the study are registered Nurses (RN) or Professional Nurses; Clinical Nurse Practitioners (CNP); Unit Mangers (UM); Auxiliary Nurses, Enrolled Nurses (EN) and Student Nurses (SN). Permission for access to the nurses in clinics was sought from the Director of Metropole Health Services (Appendix E). Criteria for selection of clinics and participants are outlined below.

3.3 Criteria for selection of participants and clinics

3.3.1. Inclusion criteria

- Participants for the study were nurses working in the selected clinics.
- Nurses licensed by the South African Nursing Council to practice during the period of data collection.
- The nursing population included all categories of nurses specified above.
- Both male and female nurses are included in the study

3.3.2. Exclusion criteria

- Non-nursing health care professionals
- Nurses not licensed to practice.
- Patients
- Doctors, medical students and administrator

3.3.3 Selection of community clinics

There are 119 community health clinics within the Metropole Health Area (www. http://www.capetown.gov.za/en/CityHealth). The Metropole area is further divided into sub-districts. Clinics were selected from a variety of sub-districts. Non-probability sampling was utilised in selecting clinics willing to participate in the study. Of the numbers of clinics approached to participate, only 28 expressed interest in the study. Clinics that agreed to participate in the study were 5 clinics in the Tygerberg sub-district, 3 clinics in Mitchells Plain, 7 clinics in Klipfontein, 5 clinics in the Southern sub-district, 2 clinics in Eastern, 4 clinics in the Western, and 2 clinics in the Northern sub districts.

3.4 Methods of Data Collection

Three data collection methods would be employed in collecting information on the phenomenon under study, i.e. questionnaires, interviews, and official documents review. One of the benefits of a questionnaires as a data collation tool is that it allows respondents to articulate their personal experiences without fear of being identified (Polit and Peck 2006: 285; Burns and Grove 2009:208). Interview also allows respondents to articulate their experiences and views (Brink 2002:156; Burns and Grove 2009:298). Official documents would enable the researcher to validate information provided in both questionnaires and interview responses (Mouton 2006:198). The main disadvantages of the selected tools are that questionnaires could be time consuming and respondents may not provide information to all questions (Mouton 2006:198). Similarly, documents are official legal papers and permission may not be granted because of confidentiality.

3.4.1 Confidential Questionnaires

Phenomenological approach normally does not use questionnaires as means of data collection (Denzin and Lincoln 1998: 63). However, due to the sensitive nature of the topic under study, confidentiality had to be assured to avoid the possibility of reprisals or intimidations of participants. Questions contained in the questionnaires were modified from that of Prof. Khalil's initial study (Appendix F). The modified version comprised of combinations of open and close-ended questions that would elicit responses to information required to determine extent of violence within the selected community health centres. The advantages of open-ended questions allow respondents to answer in their own words (Brink 2002: 212). Close ended questions allowed the respondents to choose from response options, e.g. age, gender and race (Brink 2002: 206). It is estimated that the length of time for completing questionnaire to be between 20 to 25 minutes. The researcher would distribute the questionnaires to each participating health clinic. Rationale for personal delivery was to ensure that the questionnaires arrived at the designated clinics. Participants would be required to deposit completed questionnaires in a designated and clearly labelled box in each of the participating clinics. The researcher would visit each clinic daily over a period of one week to empty the box.

3.4.1 Interviews

Mouton (2006:197) outlined practical advantages of interviews. Brink (2002: 158) and Mouton (2006:197) stated that interviews are useful in obtaining respondents' articulated opinions or views on a given situation. In this study, only key informants would be interviewed regarding types and levels of violence within community health centres in the Metropole Area Health Authority. Complete privacy will be ensured throughout this process (Brink 2003; Mouton 2006). The interviewees will not be known to each other. The interviews will be conducted in the privacy of the respective unit nursing manager's office. Informal interview questions will focus only on the five key objectives of the study, i.e. violence against nurses; violence among nurses; violence by nurses; effects of violence on nurses; and management of violence. Interviews will be audio recorded with the consent of each participant for 15-30 minutes.

3.4.3 Official Documents Review:

Efforts will be made to review as many official documents as would be made available to the researcher. The rationale for reviewing official documents is to determine number of indicated incidences of violence and identify number of indicated absence of nursing staff in each clinic

(Marshall and Rossmann 1995: 85). Types of document expected to be reviewed are policies documents; guidelines and directives for management of violence; records of sick leave, absenteeism, and information on any reported incidences of violence (Denzin and Lincoln 1998: 63).

3.5 Strategies for data analyses

Data analyses would be undertaken throughout data collection phase of the study (Melnyk and Fine-Overholt 2005, 146). Two sets of analytical processes would be undertaken, i.e. compilation of numbers of responses to questions (quantitative data), verbal and written responses (qualitative data). Written comments to open-ended questions would be used to capture on SPSS software. For questionnaire analysis, responses will be grouped per question. In the case of the interviews, responses will be transcribed, send back to participants for verification (Miles and Huberman 1994:209; Denzin and Lincoln, 1998: 137) and then loaded on to the software for analysis. Responses to each question will then be examined for similarities of differences of experiences within and between clinics. Some of the written comments will be used as quotations to describe nurses' experiences (Denzin and Lincoln, 1998: 137; Holloway and Wheeler 1996: 78; Miles and Huberman 1994: 209).

'STATISTICA-7' computer software will be used to analyse responses to closed-ended questions contained in the questionnaire. Basic descriptive statistical analysis, e.g. frequency distribution and percentages will be calculated to examine incidences within and amongst participating clinics. However because of the University's stipulated word limit for the academic degree that the study is required to meet, tables of data analysis is attached as Appendix G. Once both quantitative and qualitative data analysis is completed, comparative analysis of responses from questionnaires and interviews will be undertaken to identify similarities and difference of responses from participating clinics (Gibbs 2007: 123; Mays and Pope 2000: 234; Miles and Huberman 1994: 198).

3.6 Validity and reliability

The results would be reliable and valid because the questionnaire as a data collection tool had been utilised different countries and nursing care settings. For example, N Myburgh (2007) used the same tool to examine violence by nurses against patients in midwifery. Similarly de Villiers (2008 unpublished UCT) examined violence among student nurses, and Kebuang (2008 – in

progress UCT) examined violence in nursing in Botswana (Bloor in Miller 1997: 38; Maxwell 1992: 145; Stauss, Anseln and Corbin 1990: 203). Ethical approval to conduct national and international studies using the questionnaires confirmed validity and reliability of the instrument.

3.6.1 Trustworthiness and Credibility

The results is reliable and valid and there is consistency in measuring the extent of violence across different sectors in the health fraternity since the same questionnaire has been used for the larger study performed by Prof. Khalil (2006), This questionnaire has been used in two previous studies conducted by two MSC students from University of Cape Town and Stellenbosch University (Ryan and Bernard 2003b: 89; Mays and Pope 2000: 51; Miles and Huberman 1994: 245). The researcher is a qualified nursing practitioner with twenty years experience in various fields of nursing including critical care, primary health care, undergraduate training and midwifery. The researcher had undergone advanced research methods training and could be relied on to produce unbiased and credible results. Furthermore, the research supervisor would be reviewing content of questionnaire and interview response including all the analysis of data to ensure that there is no bias information and that the content reflect actual information collected (Ryan and Bernard (2003b: 89; Mays and Pope 2000: 51; Miles and Huberman 1994: 245).

3.6.2 Transferability and Dependability

The data accumulated in this study reflects the demographics of the Western Cape. Results from this study may be transferable to other areas provided the demographics are similar as evident by findings of De Villiers in 2008, and Myburg in 2007 (Ryan and Bernard 2003b: 89; Mays and Pope (2000: 51; Miles and Huberman 1994: 245). Di Martino (2002:5) has demonstrated differences in the incidence of violence in various countries, observing differences between third world and first world countries.

3.7 Ethical consideration

The researcher will follow ethical guidelines stipulated in the Helsinki Declaration of 2008 (http://www.wma.net/en/30publications/10policies/b3/17c.pdf), and participants rights enshrined in the Constitution of the Republic of South Africa (1996). These ethical guidelines include among others respect for individual's autonomy, privacy, confidentiality, right to withdraw, and no harm to persons participating in a research study (Melnyk and Overholt, 2005, 294; RSA Bill of

Rights 1996). Written informed consent would be obtained from each participant (Appendix D). Each participant would be allocated unique identity to ensure confidentiality. Records of their names, clinics based would be kept in a safe place and only accessible to the researcher and supervisor. Ethical clearance to conduct the study was granted by both the Faculty of Health Sciences Human Ethics Committee (Ref no.410/2004; Appendices B and C) and the Cape Town Metropole Area Health Authority (Appendix A).

3.7.1 Autonomy and informed consent:

Autonomy is the right of participants to withdraw from the study at any time during the process if they so wish (Burns & Grove 2009: 196; Huberman and Miles 1985:85; RSA Bill of Rights 1996). Participants would be assured that if they decided to withdraw, they would not be penalised (Mouton. 2006: 244). They would be assured that their decision to withdraw would only be known to the principle researcher (Appendix D). The Constitution of the Republic of South Africa (1996) had stipulated that no persons living or residing in the country should be coerced into participating in a research study (Act 108 of RSA: 1996). Similarly, the Helsinki Declaration of 2008 urged voluntary participation in research studies (http://www.wma.net/en/30publications/10policies/b3/17c.pdf). Polit and Beck (2006, 93) argued that informed consent forces the researchers to give participants adequate information about the study. Polit and Beck (2006:93) further argued that participants' knowledge of the focus of the study would enable them to voluntarily consent to participate in the study. All participants were issued with a letter informing them of the aims and objectives of the study in addition to a consent form for their signature indicating their willingness to participate (Appendix D).

3.7.2 Beneficence and Nonmaleficence:

Beneficence is to ensure the well-being of research participants (Brink 2002:40; Helsinki Declaration 2008). Another beneficence component of the study is that it would contribute to nursing knowledge of violence within community health clinics and effects on nurses. Findings from the study would be published in national and international nursing journals to add to the body of nursing knowledge that exist on the phenomenon. Furthermore, the study may stimulate further research on other areas of violence and its effects on the nursing profession. Nonmaleficence is not to cause any harm to persons participating in a research (Helsinki Declaration 2008). Each clinic and participants would be brief on the purpose, potential benefits, risks, and time commitment expected of them during the data collection phase of the study.

3.7.3 Privacy and Confidentiality

A further requirement of the Helsinki declaration (2008) is to ensure confidentiality of information collected during the research process. Every precaution will therefore be taken in this study to protect research subjects' confidentiality (http://www.wma.net/en/30publications/10policies/b3/17c.pdf). All efforts will be made to protect participants' identities so that information provided could not be linked to a specific clinic or individual nurse (Polit and Beck.2006, 497). To protect the identity of participating clinics, alphabetical letters and numbers will be used in the presentation of results, e.g. K1 to represent clinic one in Klipfontein sub-district. Similarly, participants will be referred to by their respective nursing ranks, e.g. professional nurse or enrolled nurse.

3.7.4 Risks and Benefits

To the best knowledge of the researcher, there would be no risk to participants. However, relating one's experiences of violence may cause distress to some respondents (Burns and Grove 2009:221; Silverman 2001:78; Miles and Huberman 1994: 255). Trauma counselling is available for nurses in the health authority and distress nurses would be advised to utilise the service (Polit and Beck.2006, 102). Some benefits of the study would be that sharing experiences of violence in their working environment would be a form of catharsis and nurses would feel that their plights in the community clinics are being acknowledged (Burns and Grove 2009:221; Silverman 2001:78).

3.7.5 Summary

Qualitative research methodology was adopted to capture the entire context of the research, recording experiences of individuals over a period of time. Phenomenological approach was used, describing violence as living experiences of individuals. All categories of licensed nurses in the primary health care setting were used as the study population. Interviews and questionnaires and official documents review were the main method of data collection. Qualitative analysis and basic quantitative analysis such as frequency distribution and calculation of percentages will be performed using 'STATISTICA-7' software. The utilization of the questionnaire used in other local and international studies ensures the trustworthiness, credibility, transferability and dependability of the data. Ethical principles will be adhered to in this study, with due regard to autonomy, informed consent, beneficence, nonmaleficence, privacy, confidentiality and ensuring that benefits outweighs the risks.

Chapter 4: Results

4.1 Introduction

This chapter presents the results obtained from data analysis of questionnaires and interview responses from twenty-eight clinics in the Western Cape Metro pole Health Area Authority. The chapter presents results on demographic distribution of various categories of nurses, types and frequency of violence, and perpetrators of violence against nurses. It also outlines results of levels of violence among nurses and categories of nurses with propensity to revert to specific behaviour patterns against other nurses. Results of types of violence perpetrated by nurses against health care consumers, the effects of violence on nurses and management of violence are presented. Finally, some constraints and limitations during the data collection and analysis are outlined.

4.2 Demographic information

One hundred and fifty (150) questionnaires were distributed of which eighty-five (85) were returned achieving a response rate of 54%. Seven (7) sub-districts within the Cape Town Metropole Health Area Authority participated in the study, i.e. Tygerberg, Mitchells Plain, Klipfontein, Southern, Eastern, Western and Northern sub districts (Table 4.2a). Tygerberg provided the highest response rate, Mitchells Plain the second largest response rate, and the lowest response rate was from the Northern sub-district (Table 4.2a).

Table 4.2a: Response rates from the seven sub-districts

Sub district	Total number of nurses	Total Respondents
Eastern	25	6(24%)
Klipfontein	30	17(57%)
Mitchells plain	30	19(63%)
Northern	6	3(50%)
Southern	15	7(47%)
Tygerberg	50	27(54%)
Western	15	6(40%)
Total	171	85

4.2.1 Years of nursing experience

Sixty-seven respondents (n=67; 78.8%) had been working as nurses for over 10 years, and eighteen respondents (n=18: 21.2%) had less than ten years experience. All participating sub-

districts clinics had large proportion of experienced nurses, whilst Southern sub-district had equivalent numbers of experienced and inexperienced nursing staff (Table 4.2b and Chart 4.3a).

Eighty respondents (n=80; 94%) agreed with the aims of the study. Other indicated that they would like studies to be conducted on the following areas:

> "Emotional and verbal abuse by clients" (Klipfontein- Clinic S4)
>
> "Violence against staff to and from their workplace" (Tygerberg – clinic T3)
>
> "Exploitation of staff, and attitudes of clients towards nursing staff" (Southern – clinic S3)
>
> "Violence against nurse by other non-nursing employees" (Tygerberg – clinic T1)
>
> "Violence by managers" (Tygerberg –Clinic T1)

4.2.2 Violence in nursing

Over half of the nurses (n=50; 58.8%) that participated in the study agreed that there is violence in nursing (Table 4.3a; Chart 4.3b). among the participating clinics, Mitchell's Plain (n=12; 75 %); Southern (n=4; 67%); and Klipfontein (n=11; 61%) nurses agreed that there is violence in nursing. Some respondents elaborated on their selections of response, e.g. nurses working in Tygerberg, Mitchells plain, and Klipfontein clinics indicated that,

> "Clients come to the clinic with personal problems and fight with the staff" (Clinic T2, Tygerberg)
>
> "Nurses being attacked by client verbally, emotionally and sometimes physically on a regular basis in CHC" (Clinic T1, Tygerberg)
>
> "Patients become aggressive and violent almost on a daily basis. Mostly verbally, yet at times physically" (clinic M1, Mitchells plain)
>
> "Nurses are being abused not verbally but physically as well, this I say due to my own experience". (Clinic M3, Mitchells plain)
>
> "Patients do not want to wait, when they come to a clinic they expect to be seen immediately. When they are sitting longer they expected they start being rude". (Clinic M1, Mitchells plain)

"In our facility we have endless abuse from the clients and sometimes from the community outside." (Clinic K2, Klipfontein)

4.3 Violence against nurses

4.3.1 Violence by health care consumers against nurses

In response to the question regarding groups of health care consumers that violate nurses, women (n=69; 81%) were identified as the main perpetrators in all participating health centres i.e. for the participating clinics (Table 4.3b). Other perpetrators of violence against community health nurses were gang members (n=51; 60%), and patient relatives (n=50; 58.9%), men (n=45; 52.9%) and men (n=45; 52.9%) and drug abusers (Chart 4.3c). However, perpetrators varied among the sub-districts, e.g. Tygerberg indicated gang members (Chart 4.3h) as the major perpetrators whilst Klipfontein identified patient relatives (Chart4.3k). All other sub-districts identified women as main perpetrators (Charts 4.3c – 4.3k). In all the participating clinics, violent incidences against nurses occurred mostly on Mondays (Chart 4.3m). Fridays were identified as second day during the week that violence incidences occur in the clinics (Chart 4.3n). Fifty respondents (n=50; 58.8%) indicated all categories of nurses are exposed to violence in community health clinics (Table 4.3p). Eighty three (n=83; 98%) indicted that specific groups of nurses were not necessarily targeted for violent attacks (Tables 4.3p and 4.3q). Eighty five (n=85) respondents provided information on incidences that they had witnessed. Verbal abuse (n=67; 78.8%) were identified as the most frequent form of violence witnessed (Chart 4.3q). nurses working in Western sub-district clinics witnessed the most frequent incidences of verbal abuse (Chart 4.3q). Ninety two percent of the respondents (n=79; 92.9%) from all participating clinics have received reports of verbal abuse from other nurses (Chart 4.3r and Table 4.3k).

Table 4.2b: years of nursing experience in all participating sub-districts

Length	Western	Northern	Southern	Eastern	Tygerberg	Mitchells	Klipfontein	Total
≥ 10	5(83.3%)	3(100%)	3(50%)	6(100%)	24(80%)	11(68.8%)	15(83.3%)	67(78.8%)
≤ 10	1(16.7%)	0	3(50%)	0	6(20%)	5(31.2%)	3(16.7%)	18(21.2%)
Total	6	3	6	6	30	16	18	85

Table 4.3a: Nurses views on violence in clinical areas

Violence	Western	Northern	Southern	Eastern	Tygerberg	Mitchells Plain	Klipfontein	Total
Yes	3(50%)	1(33.3%)	4(66.7%)	2(33.3%)	17(56.7%)	12(75%)	11(61.1%)	50(58.8%)
Not sure	1(16.7%)	1(33.3%)	1(16.7%)	0	1(3.3%)	0	3(16.7%)	7(8.3%)
No	2(33.3%)	1(33.3%)	1(16.7%)	4(66.6%)	12(40%)	4(25%)0	4(22.2%)	8(9.4%)
Total	6	3	6	6	30	16	18	85

Table 4.3b: Perpetrators of Violence against Nurses

Perpetrators	Western	Northern	Southern	Eastern	Tygerberg	Mitchells Plain	Klipfontein	Total
Women	6(100%)	2(66.7%)	6 (100%)	6(100%)	20(66.7%)	15(93.8%)	14(77.8%)	69 (81%)
Gang	2(33.3%)	1(33.3%)	4 (66.7%)	4(66.7%)	22(73.3%)	6(37.5%)	12(66.7%)	51 (60%)
Patient relatives	2(33.3%)	1(33.3%)	5 (83.3%)	5(83.3%)	14(46.7%)	8(50%)	15(83.3%)	50 (58.8%)
Men	3(50%)	2(66.7%)	4 (66.7%)	3(50%)	18(60%)	6(37.5%)	9(50%)	45 (52.9%)
Drug addicts	3(50%)	1(33.3%)	2 (33.3%)	1(16.7%)	16(53.3%)	8(50%)	11(61.1%)	42 (49.4%)
Adolescent	3(50%)	1(33.3%)	4 (66.7%)	1(16.7%)	12(40%)	6(37.5%)	5(27.8%)	32 (37.7%)
Psychiatric	2(33.3%)	1(33.3%)	1 (16.7%)	2(33.3%)	15(50%)	6(37.5%)	4(22.2%)	31 (36.5%)
Adolescent	1(16.7%)	1(33.3%)	3 (50%)	0	10(33.3%)	6(37.5%)	3(16.7%)	24 (28.2%)
Doctors	1(16.7%)	0	0	0	4(13.3%)	1(6.3%)	3(16.7%)	9 (10.6%)
Children	0	0	2 (33.3%)	0	0	1(6.3%)	4(22.2%)	7 (8.3%)
Homeless	1(16.7%)	0	0	0	2(6.7%)	1(6.3%)	2(11.1%)	6 (7.1%)

Table 4.3c different types of nurses affected by violence in the clinical areas

Groups	Western	Northern	Southern	Eastern	Tygerberg	Mitchell plain	Klipfontein
All Types	6(100%)	2(67%)	4(67%)	4(67%)	13(43%)	10(63%)	11(61%)
Coloureds	4(67%)	3(100%)	1(17%)	2(33%)	13(43%)	5(31%)	12(67%)
Blacks	4(67%)	3(100%)	1(17%)	2(33%)	13(43%)	5(31%)	9(50%)
Afrikaans	4(67%)	3(100%)	0	1(17%)	8(27%)	0	9(50%)
Whites	2(33%)	3(100%)	0	1(17%)	2(7%)	1(6%)	0

Seventy-eight respondents (n=78; 91.8%) indicated that they had shared their experiences of violence with other colleagues. Thirty respondents (n=30; 35.3%) indicated more than ten nurses working in community clinics in the Metro pole discussed their violent experiences with them, whilst forty-eight nurses (n=48; 56.5%) indicated less than ten nurses (Charts 4.3r and 4.3s; Table 4.3m). Seventy-three respondents (n=73; 86%) indicated that they had personally experienced verbal abuses and threats from health care consumers (Table 4.3n and Chart 4.3s). On the other hand, Western and Southern indicated threats and physical violence against nurses (Chart 4.3s). On the other hand, Mitchells Plain indicated that nurses were targeted because of their racial background (Chart 4.3t). Sixty–five respondents (n=65; 76.5%) indicated that violence against nurses is on the increase (Chart 4.3 u).

During interviews with the four informants, maintained that verbal abuses were the main form of violence directed against nurses in most of the clinics. Only one informant had experienced actual physical assault. All four informants had experienced and witnessed violence against nurses. Some of their comments were,

> *"I have witnessed lots of violence, mostly verbal abuse. Lots of dissatisfaction of long waiting times, when are we going to be helped, and the long waiting times is the core of all the abuse, verbal abuse against the staff, there are too few nurses and waiting times are much too long" (Senior nurse-manager - K4).*

> *"I have witnessed lots of violence, mostly verbal abuse" (senior nurse-manager - K1)*

> *"Verbal abuse I have experienced. Violence against nurse were very obvious in the clinic A person came to me and assaulted me and said he will come back to kill me" (senior nurse-manager - W2)*

> *"Mainly verbal abuse, yes definitely" (senior nurse-manager - M3)*

Chart 4.3a: Years of nursing experience

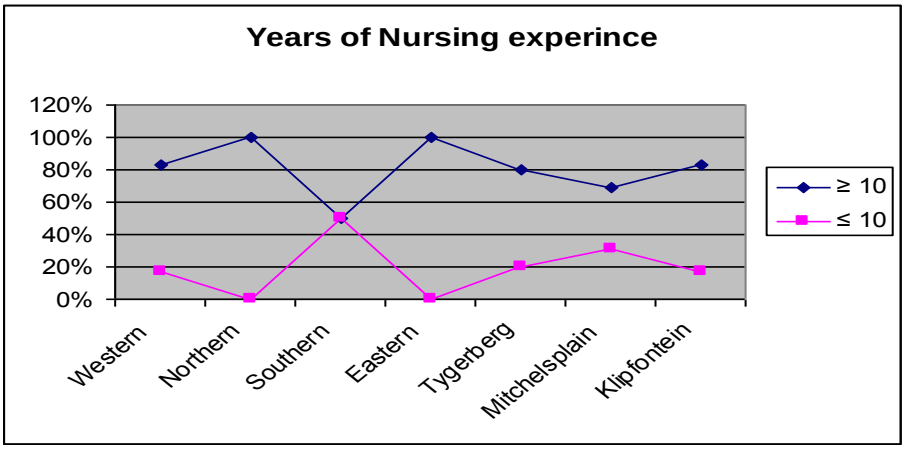


Chart 4.3b: Views on violence within sub-district clinics

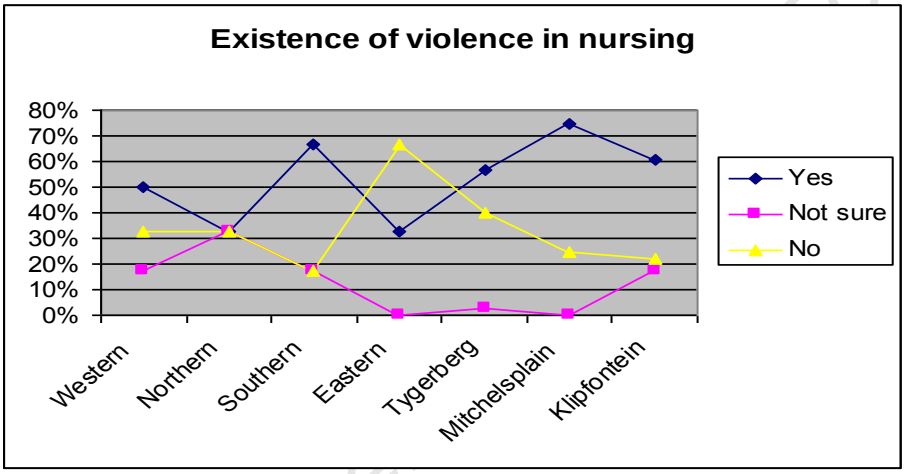


Chart 4.3c: Perpetrators of violence against nurses in all participating clinics

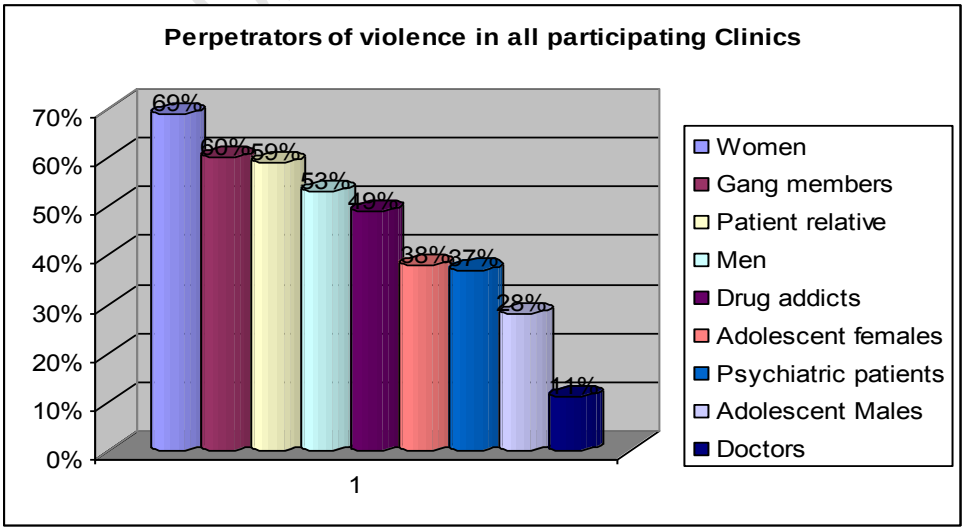


Chart 4.3d: Perpetrators of violence against nurses at Western sub-district clinics

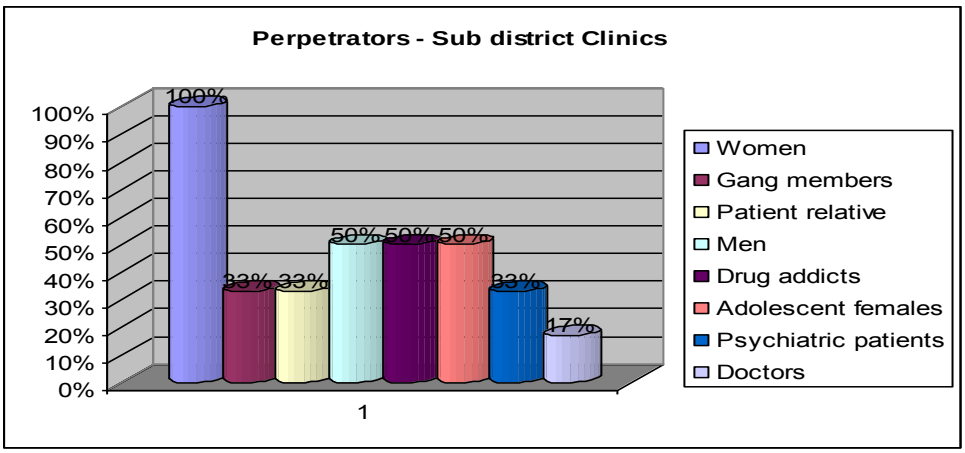


Chart 4.3e: Perpetrators of violence against nurses at Northern sub-district clinics

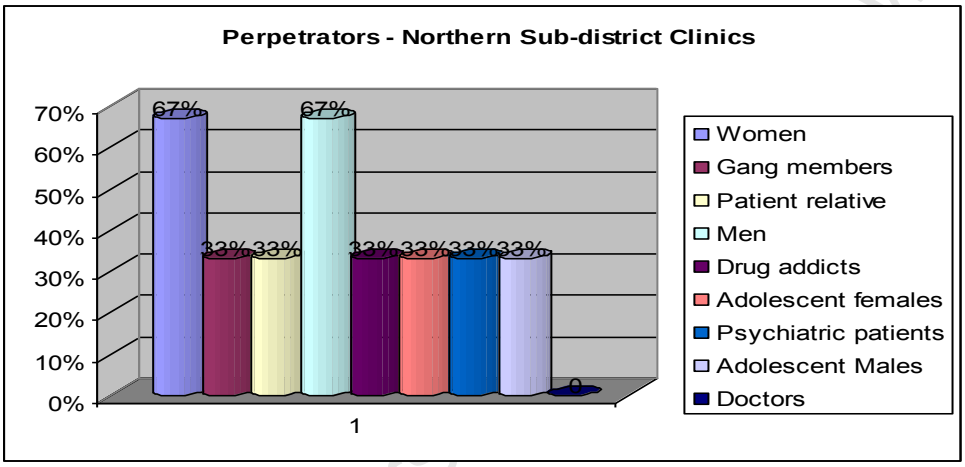


Chart 4.3f: Perpetrators of violence against nurses at Southern sub-district clinics

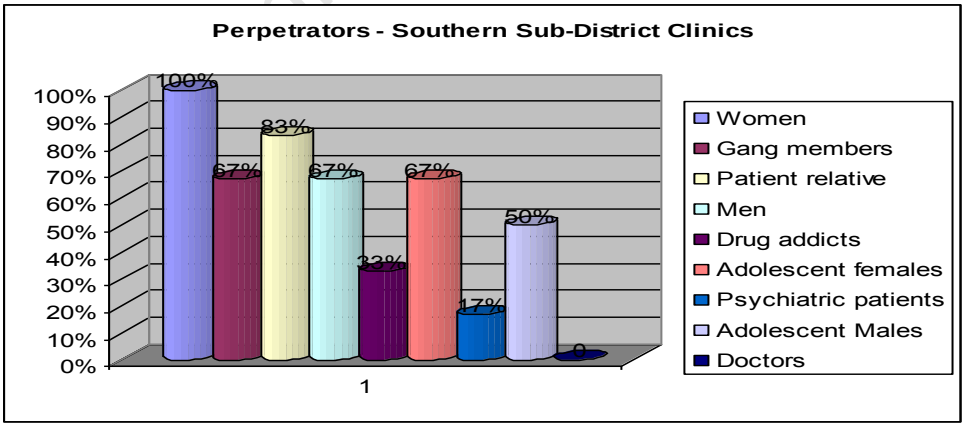


Chart 4.3g: Perpetrators of violence against nurses at Eastern sub-district clinics

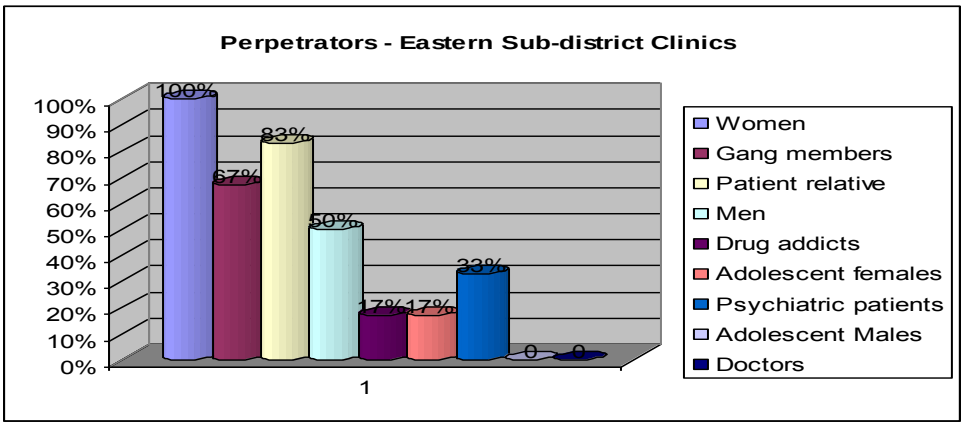


Chart 4.3h: Perpetrators of violence against nurses at Tygerberg sub-district clinics

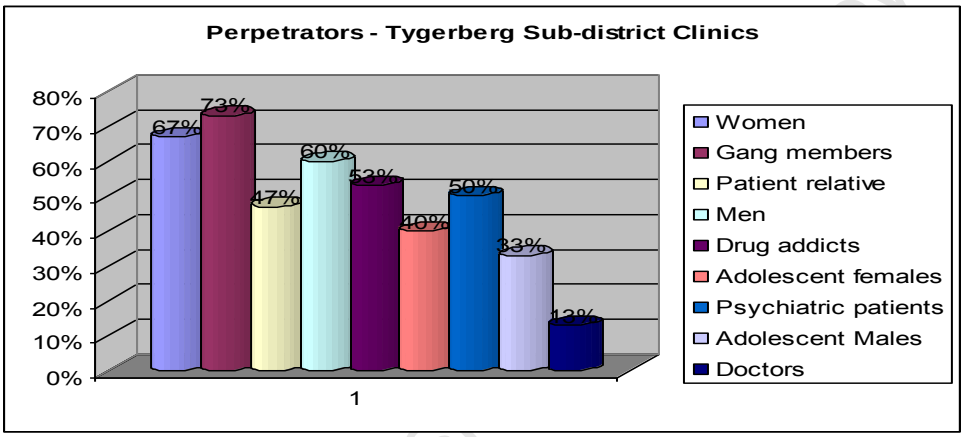


Chart 4.3j: Perpetrators of violence against nurses at Mitchells Plain sub-district clinics

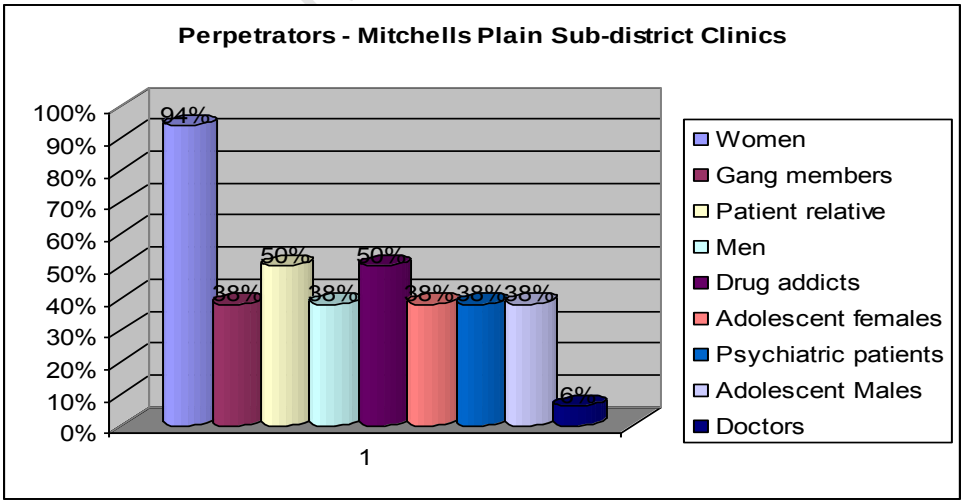


Chart 4.3k: Perpetrators of violence against nurses at Klipfontein sub-district clinics

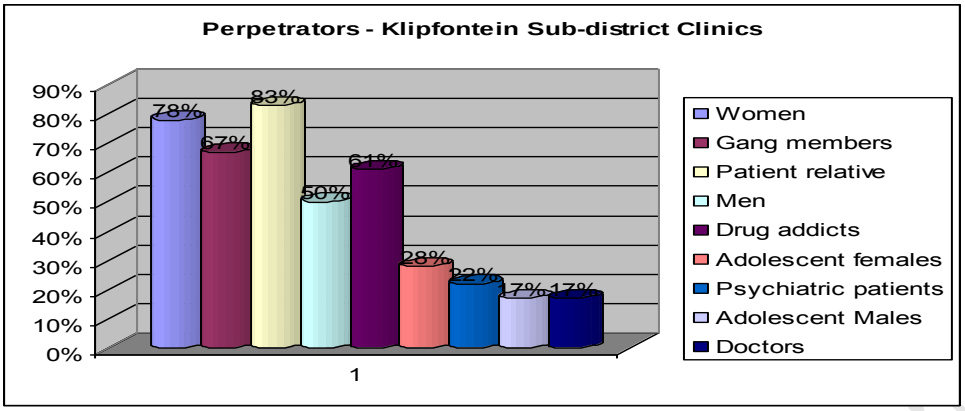


Chart 4.3m: Rates of violent incidences on Mondays

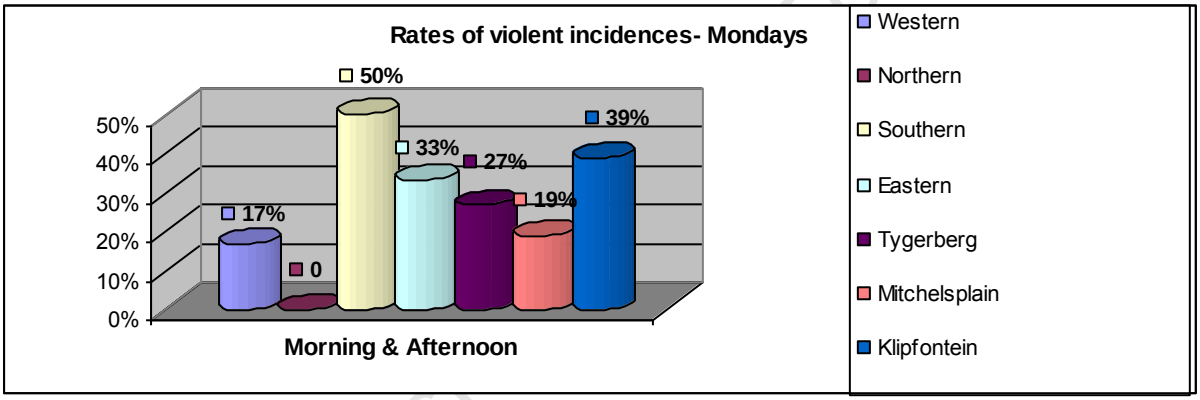


Chart 4.3n: Rates of violent incidences on Friday afternoons

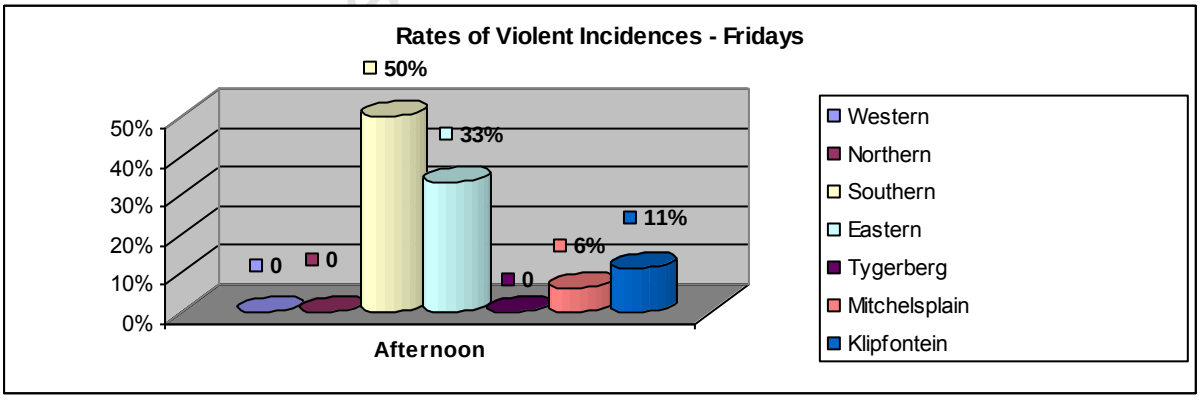


Chart 4.3p: Summary of incidences in all participating clinics

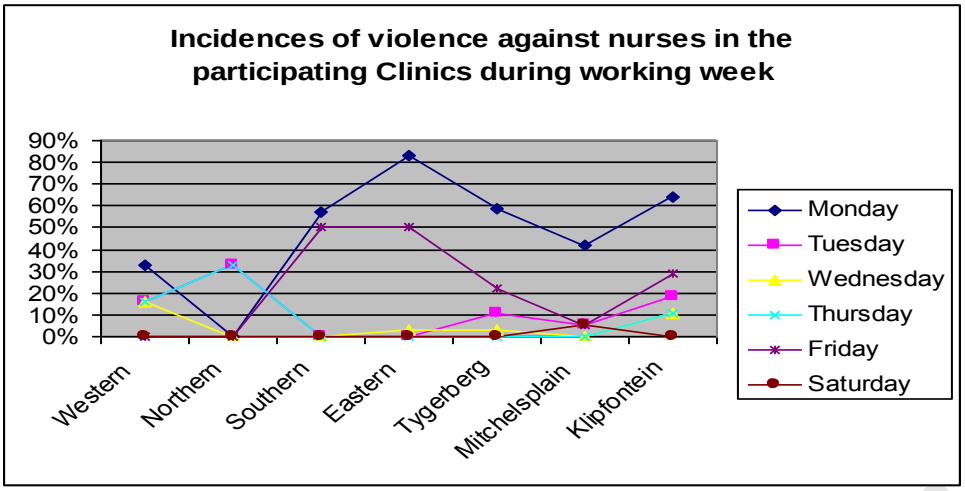


Chart 4.3q: Types of observed violence against nurses

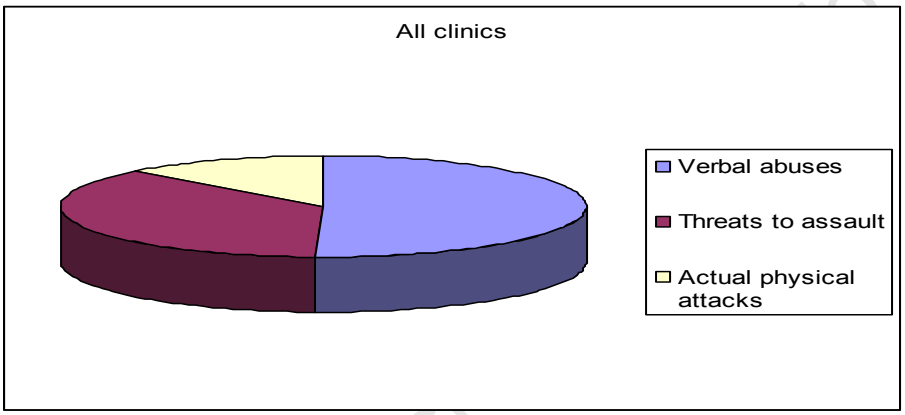


Chart 4.3r: Types and rates of violent incidences indicated by other nurses

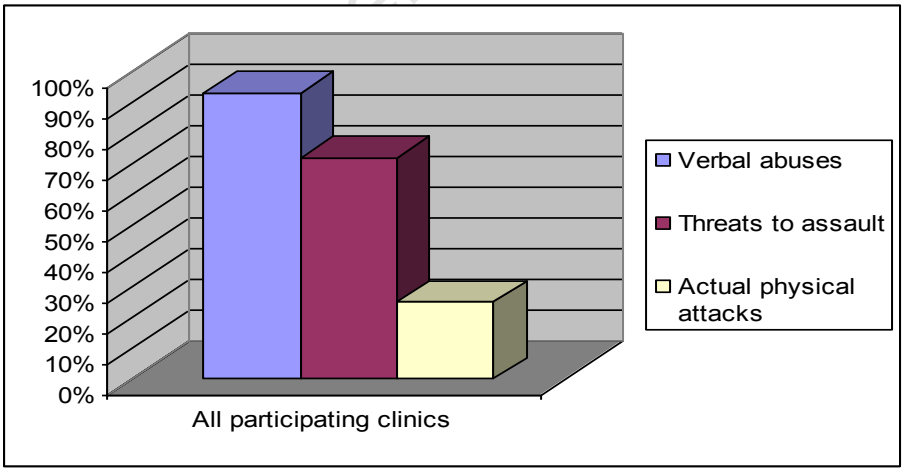


Chart 4.3s: Nurses personal experiences of violence in participating sub-district Clinics

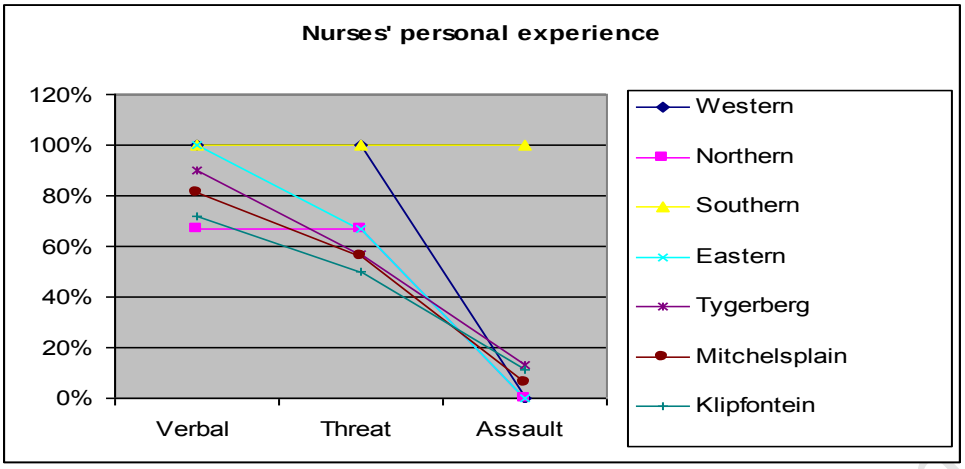


Chart 4.3t: Ethnicity, cultural and religious background of nurses frequently violated by health care consumers

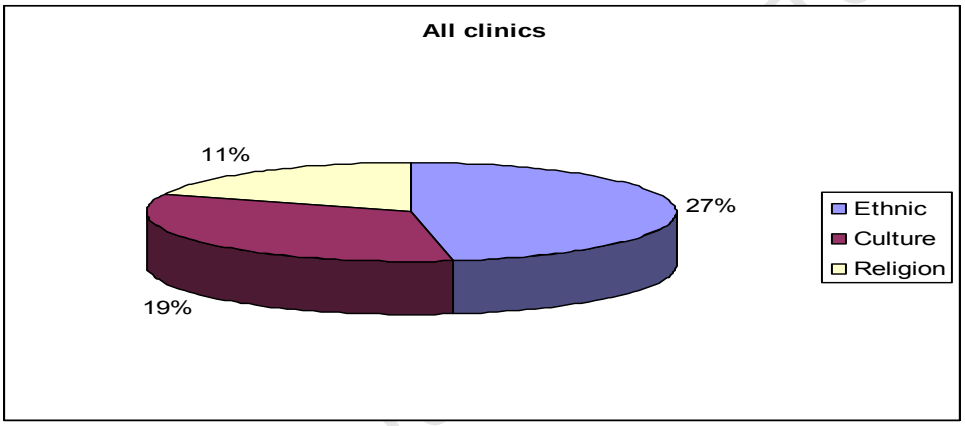
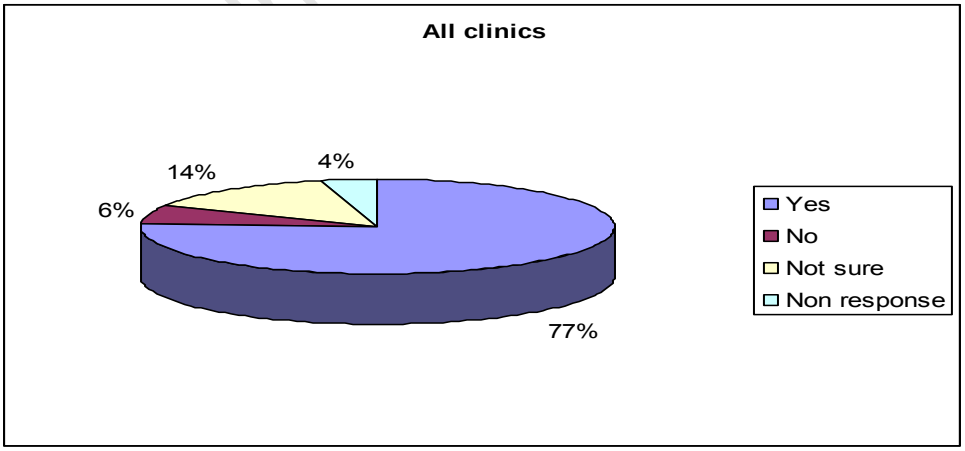


Chart 4.3u: Views on increase in violence against nurses in community clinics.



4.4 Violence amongst nurses

This section will present results on violence amongst nurses. The section will also present findings on the frequency of violence at different levels, i.e. physical, psychological, vertical, horizontal, covert and overt. The last section will set out categories of nurses with propensity to revert to violent behaviours against other nurses.

4.4.1 Violence among Nurses exist

Forty-nine respondents (n=49; 57.6%) agreed that there is violence amongst nurses whilst Tygerberg (n=9; 30%) disagree (Chart 4.4a and Table 4.4a). physical, psychological, vertical, horizontal, covert and overt (Charts 4.4b and 4.4c). Psychological violence (n=44; 51.8%) was selected as the most frequent form of violence among nurses. The second most frequent form of violence among nurses was vertical violence (n=41; 48.2%). On the other hand physical violence (n=14; 16.5%) was the least form of violence among nurses (Chart 4.4b).

Western indicated horizontal violence as the most frequent form of violence among nurses working in the clinics (Chart 4.4d). Psychological violence was common amongst nurses working in the northern, eastern and Mitchells Plains (Charts 4.4e-4.4g). Vertical violence was more common amongst nurses working in southern and Tygerberg (Charts 4.4h and 4.4j) whereas in both psychological and vertical violence exist amongst nurses working in the Klipfontein clinics (Chart 4.4k).

Respondents were asked to rate the frequency of occurrence of various types of violence on a scale of 1-10, with 1 being least frequent and 10 most frequent. Results were grouped into 1-5 as representing less frequent occurrences, and 6-10 as more frequent occurrence (Table 4.4b). Forty-six (n=46; 54.1%) respondents indicated verbal abuse as the most frequent type of violence among nurses. Shouting (n=36; 47.4%) was the second and insinuations (n=33; 38.8%) the third negative behaviour among nurses. Verbal abuse is the most common in all the sub-districts, but were indicated to be more prevalent among nurses working in the Northern (n=2; 66.7%), Western (n=4; 66.7%) and Mitchells Plain (n=10; 62.5%). Shouting is most frequent common among nurses in Mitchells Plain (n=7; 43.8%) and Western (n=3; 50%) whilst insinuations prevalent in the Tygerberg (n=16; 53.3%).

During interview with key informants, respondents identified personality differences as possible cause of the violence among nurses. Some had witnessed nurses shouting at each other. Other comments are listed below,

"Differences amongst personalities are the causes of friction amongst the staff" (K1)

"No not really, maybe just a verbal disagreement" (K4)

"Occasionally I have witnessed nurses screaming at each other. On a few occasions nurses has used fowl language but not in front of clients, this happens in the staff room" (M3).

"Not on the property, but you always hear, hear say especially when they went out together, not on counsel property per say. The black nurses will fight amongst each other verbally but will never tell on each other. The abuse is more verbal, attitude and physical. Verbal abuse is very prominent in meetings." (W2).

Chart 4.4a: Views on the existence of violence by nurses against other nurses

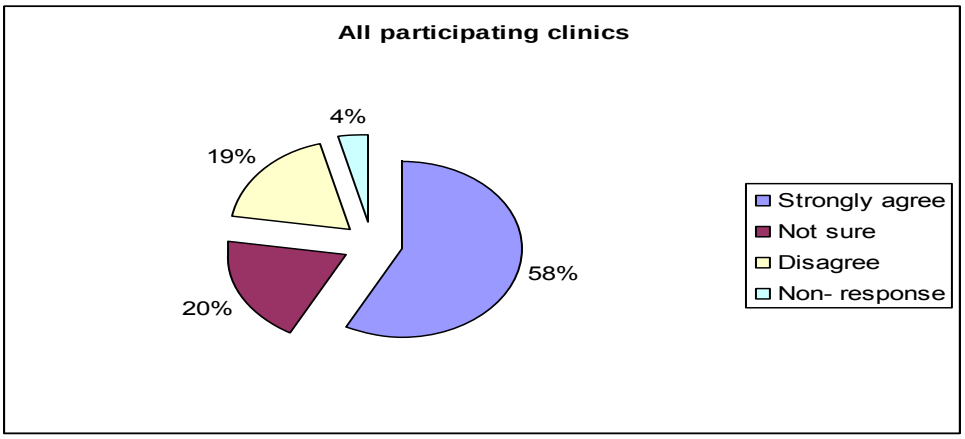


Chart 4.4b: Reported frequency of violence amongst nurses in the participating clinics

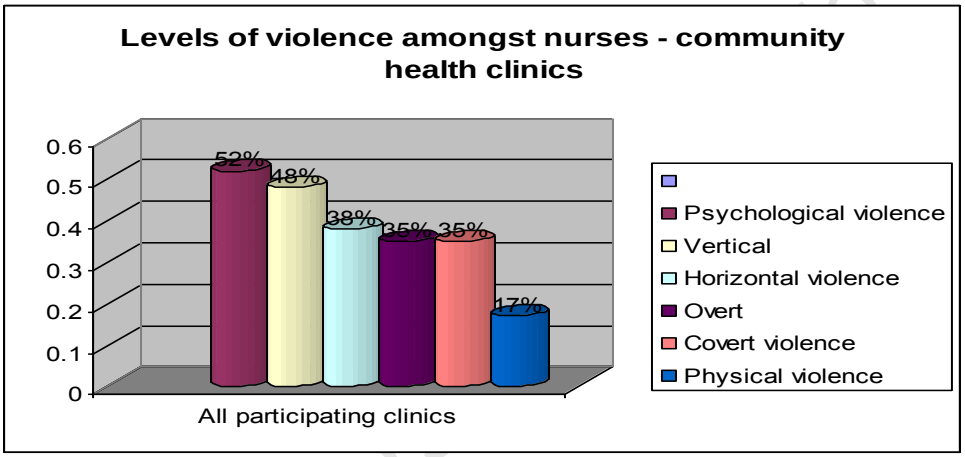


Chart 4.4c: Types of violence among nurses in participating clinics

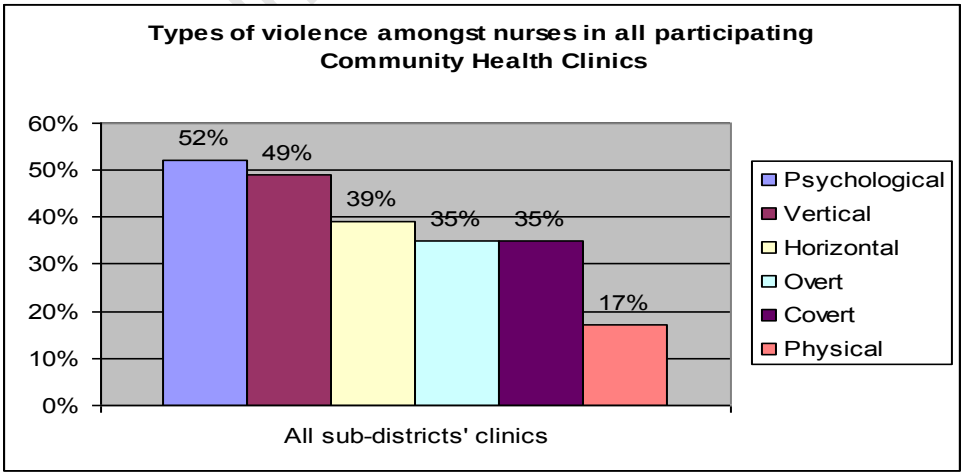


Chart 4.4d: Types of violence amongst Nurses in Western sub-district clinics

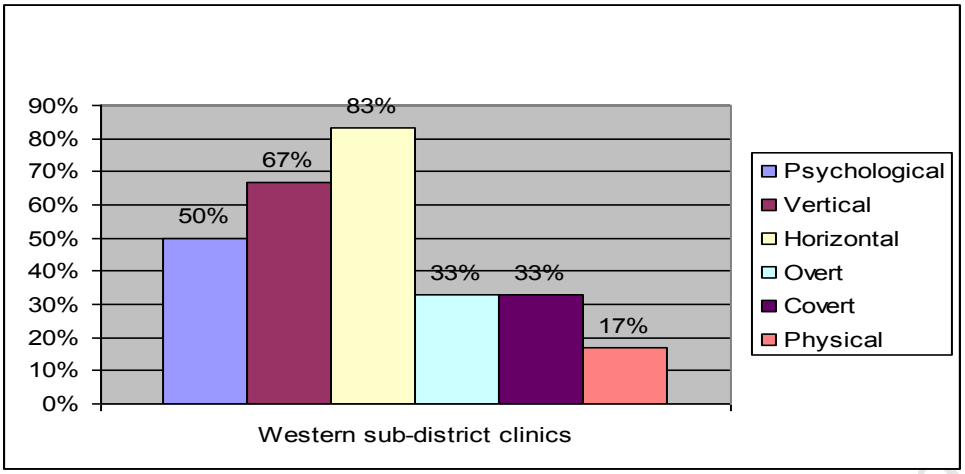


Chart 4.4e: Types of violence amongst Nurses in Northern sub-district clinics

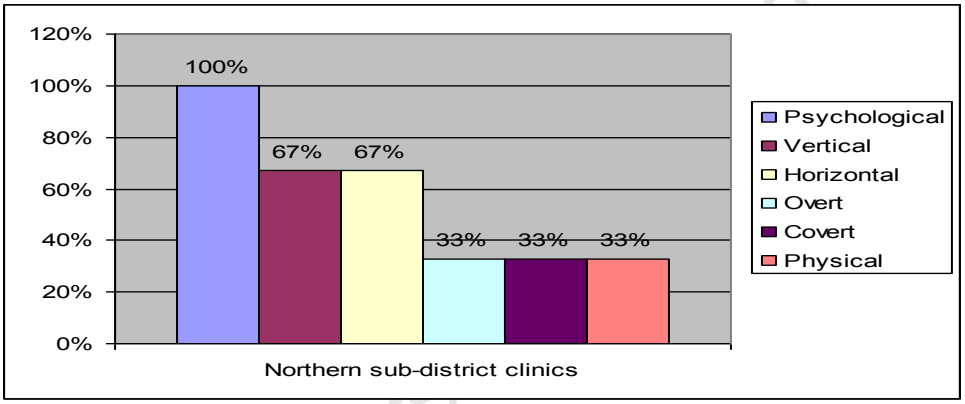


Chart 4.4f: Types of violence amongst Nurses in Eastern sub-district clinics

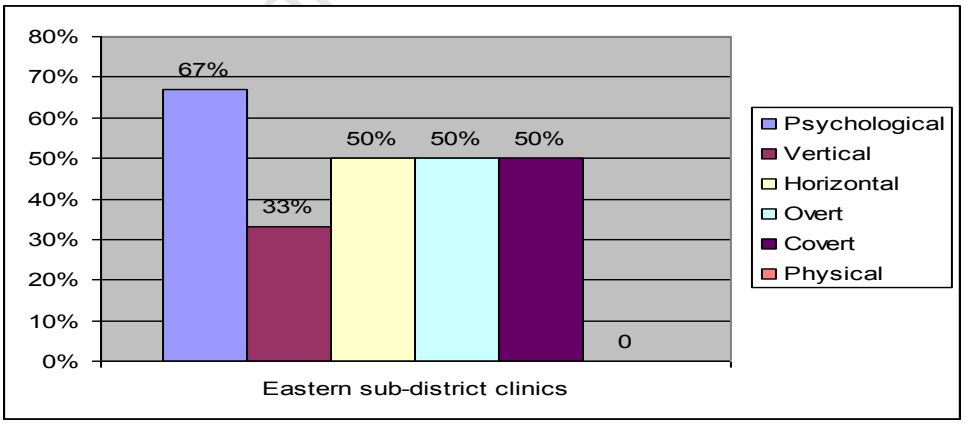


Chart 4.4g: Types of violence amongst Nurses in Mitchells Plain sub-district clinics

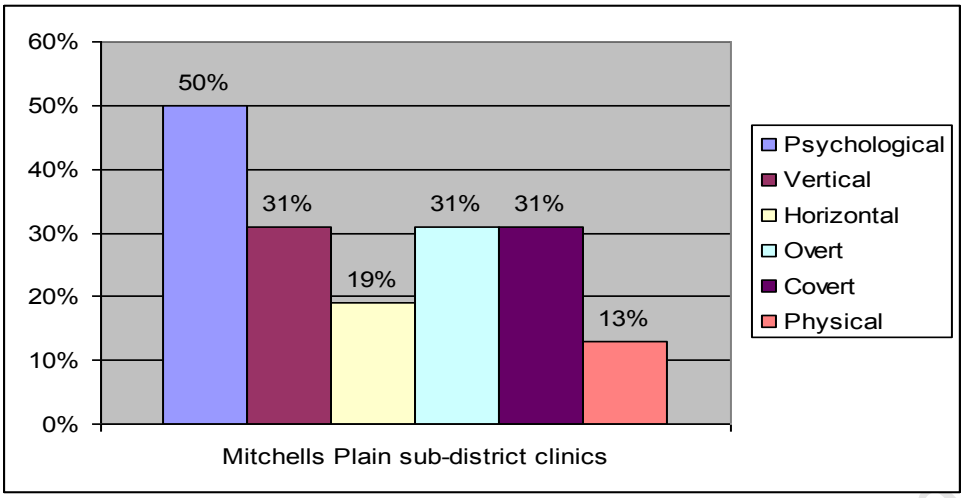


Chart 4.4h: Types of violence amongst Nurses in Southern sub-district clinics

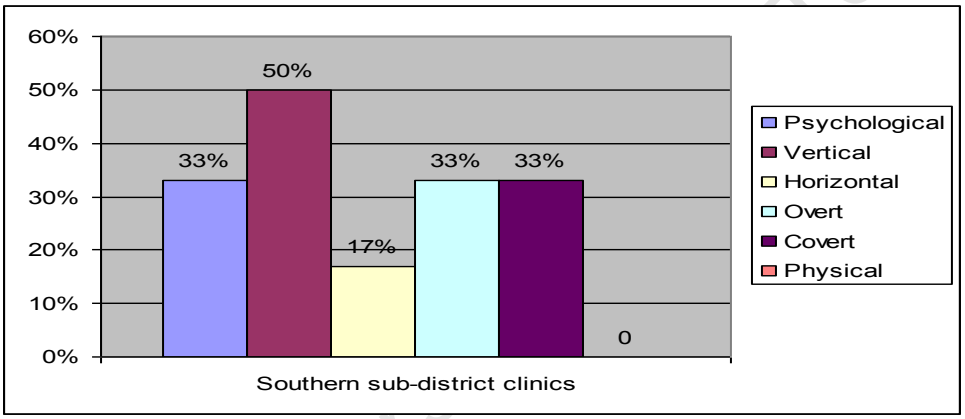


Chart 4.4j: Types of violence amongst Nurses in Tygerberg sub-district clinics

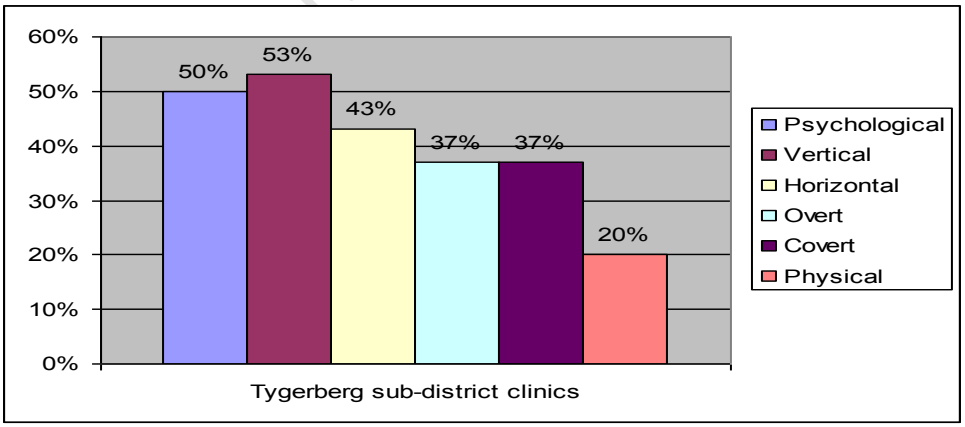
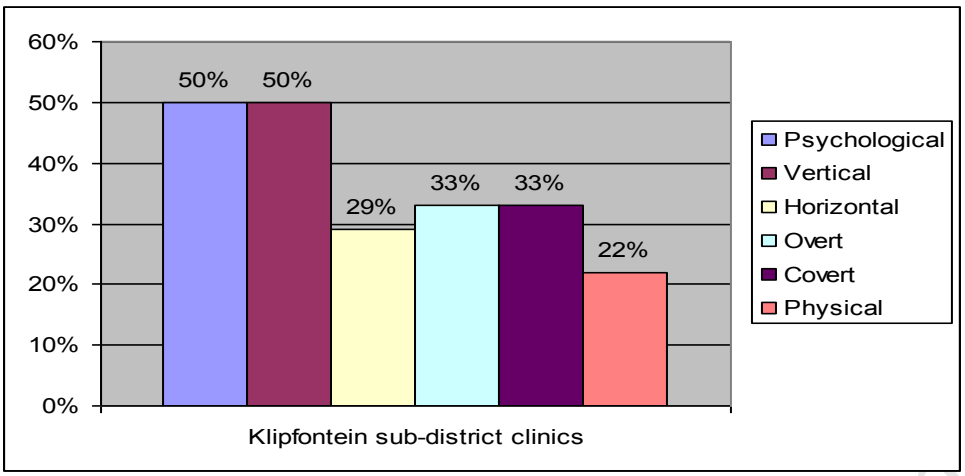


Chart 4.4k: Types of violence amongst Nurses in Klipfontein sub-district clinics



4.4.2 PHYSICAL VIOLENCE AMONG NURSES

Although physical violence was rated as the least form of violence amongst nurses, sabotage of other nurses work (Chart 4.4m), physical threats (Chart 4.4n), and assaults with no injury (Chart 4.4p) sometimes occurred. Categories of nurses with propensity to revert to sabotaging other nurses' work and threaten them were professional nurses (Charts 4.4m and 4.4n). Professional, enrolled and senior nurse managers would physical assault and push other nurses (Charts 4.4p & 4.4q).

Chart 4.4m: Propensity for categories of nurses to sabotage other Nurses work

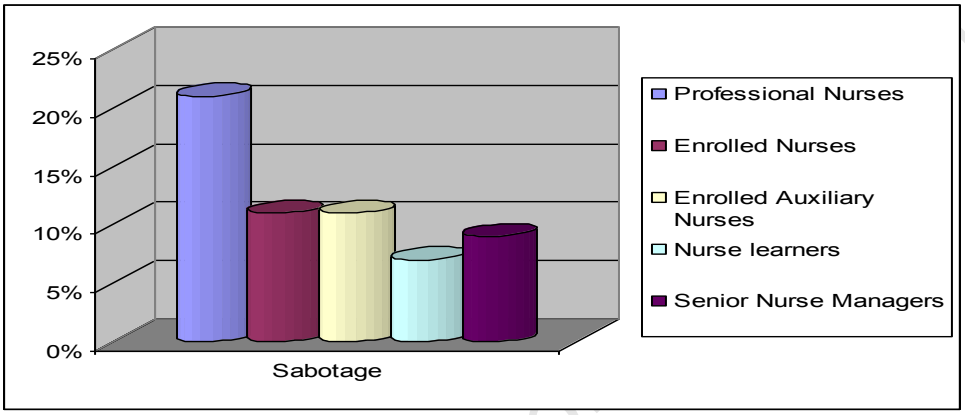


Chart 4.4n: Propensity for categories of nurses to threaten other Nurses

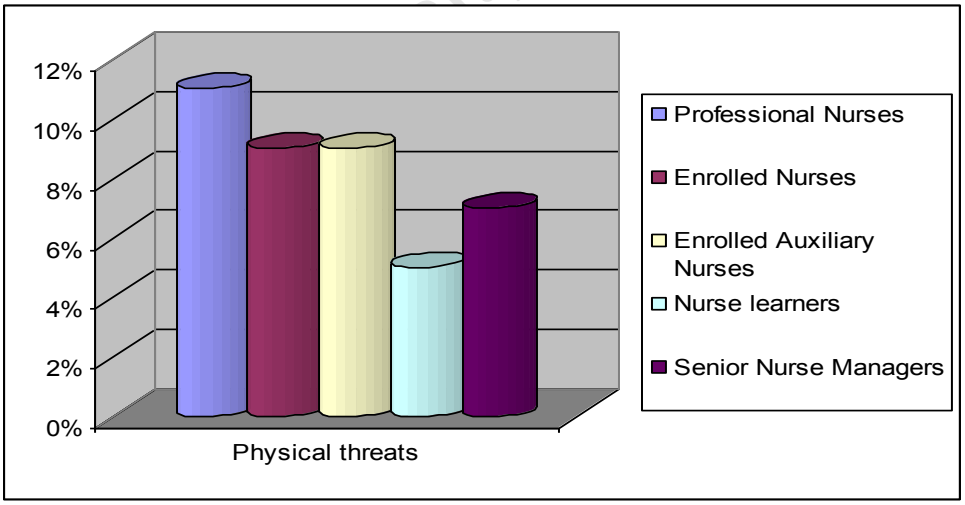


Chart 4.4p: Propensity for categories of nurses to assault other Nurses

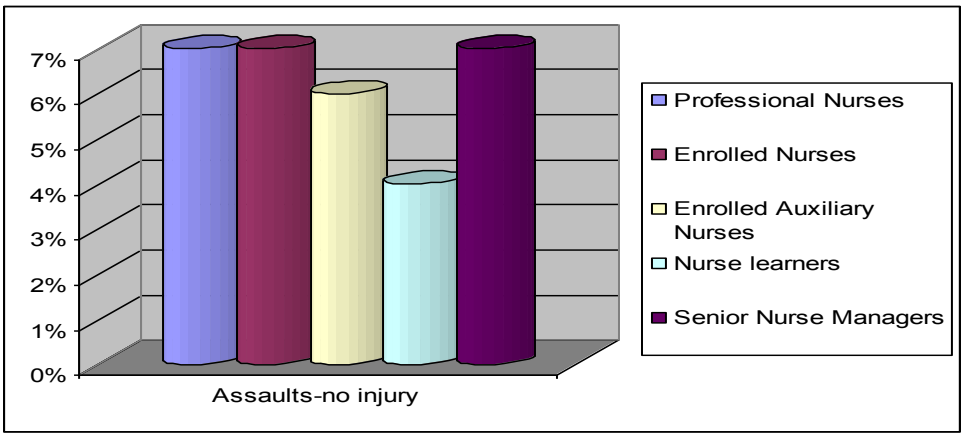
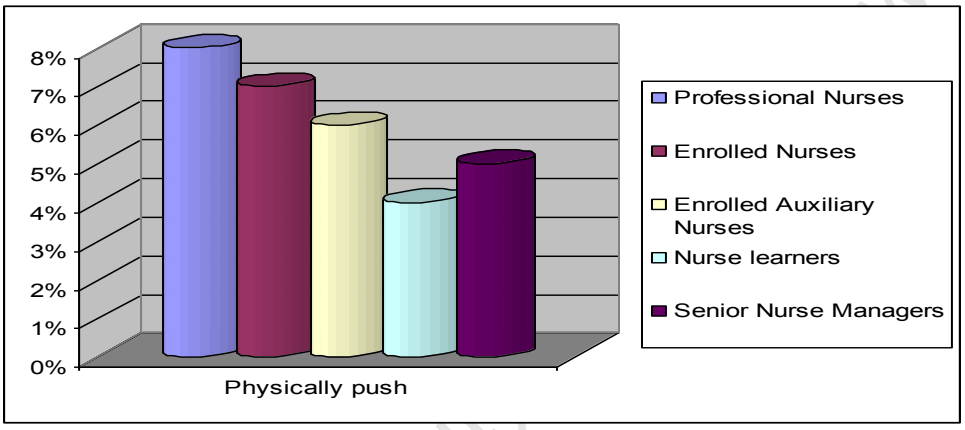


Chart 4.4q: Propensity for categories of nurses to physically pushing other Nurses work



4.4.3 Psychological violence among nurses

Respondents were requested to indicate categories of nurses that tended to psychologically violate other nurses. Professional nurses tended to verbally abuse and shout at other nurses (Charts 4.4r and 4.4s). Enrolled nurses tended to swear (Chart 4.4t), both Professional nurses and senior nurse-managers tended to humiliate and intimidate other nurses (Charts 4.4u and 4.4v). Professional nurses and senior nurse-managers were identified as the two main categories of nurses that had propensity to discriminate against other nurses (Chart 4.4w). Senior nurse-managers bullied (Chart 4.4x), professional nurses had tendencies to ignore and label or insinuate against other nurses (Charts 4.4y -4.4z; Chart 4.4aa).

During interviews with the four informants, they confirm that psychological violence exist amongst nurses. Some of their comments were

> *"At meetings, there is a bit of animosity sometimes that comes out very strongly. You see competition between the leaders. Especially when they do presentation of cases to the whole team, one wants to be better than the other. It appears to be jealousy that is more professional. No physical attack" (M3)*

> *"They would swear at each other in these meetings and it is like a platform to show your position of power Bad attitude you get all the time" (W2)*

4.4.4 Vertical violence among nurses

Categories of nurses with propensity to resort to vertical violence varied. Professional nurses were identified as the main category of nurses that resorted to verbally abusing (n=19; 22.4%), discriminating (n=14; 16.5%) and bullying (n=13; 15.5%) junior or senior nurses (Charts 4.4bb – 4.4gg). Although professional nurses were identified as the primary group of nurses that tend to humiliate (n=12; 14.1%) junior nurses, senior nurse-managers also resorted to the same behaviour (Chart 4.4ff). All categories of nurses except student nurses resorted to ignoring junior (n=16; 18.8%) or senior nurses (n=20; 23.5%: Chart 4.4gg). Enrolled nurses were identified as the main group of nurses with a propensity to shout (n=13; 15.5%) at junior or senior nurses (Chart 4.4cc).

Chart 4.4r: Psychological violence - categories of Nurses with propensity to verbally abuse other nurses

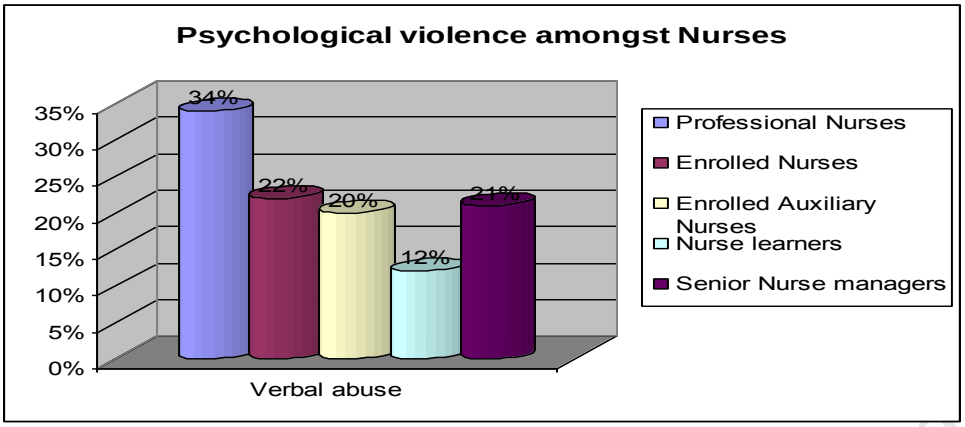


Chart 4.4s: Psychological violence - categories of Nurses with propensity to shout at other nurses

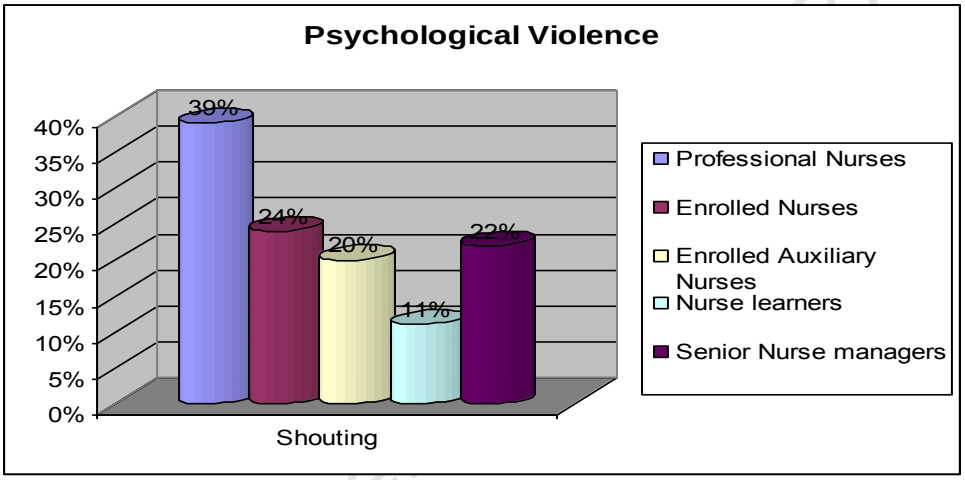


Chart 4.4t: Psychological violence - categories of Nurses with propensity to swear at other nurses

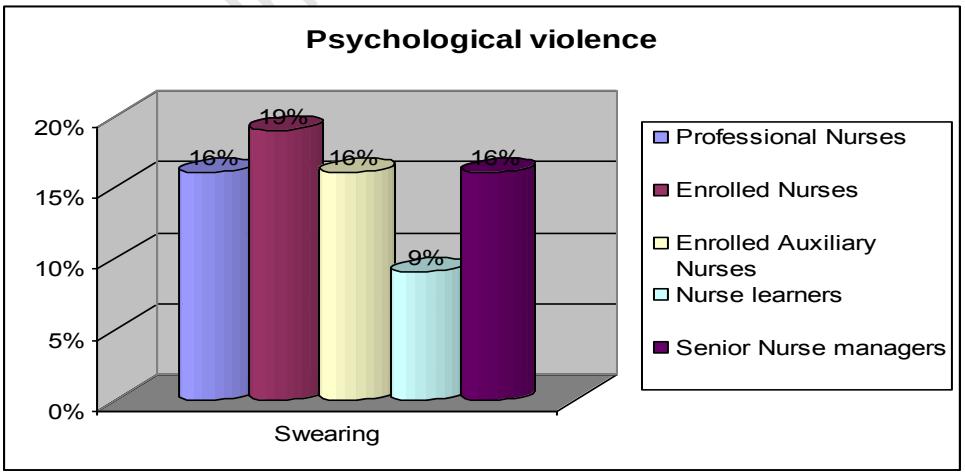


Chart 4.4u: Psychological violence - categories of Nurses with propensity to humiliate other nurses

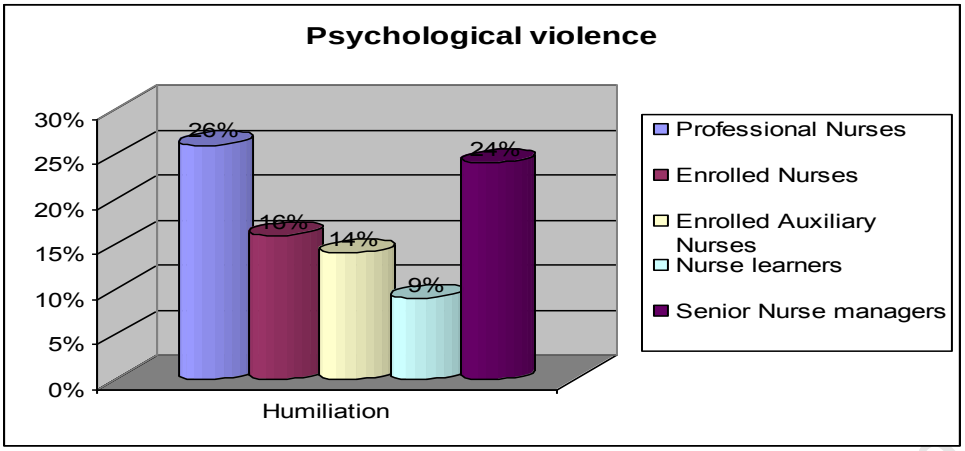


Chart 4.4v: Psychological violence - categories of Nurses with propensity to intimidate other nurses

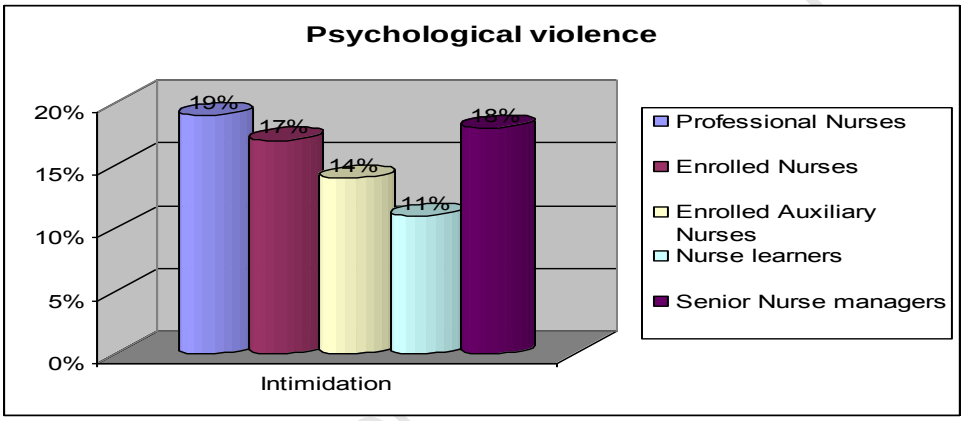


Chart 4.4w: Psychological violence - categories of Nurses with propensity to discriminate against other nurses

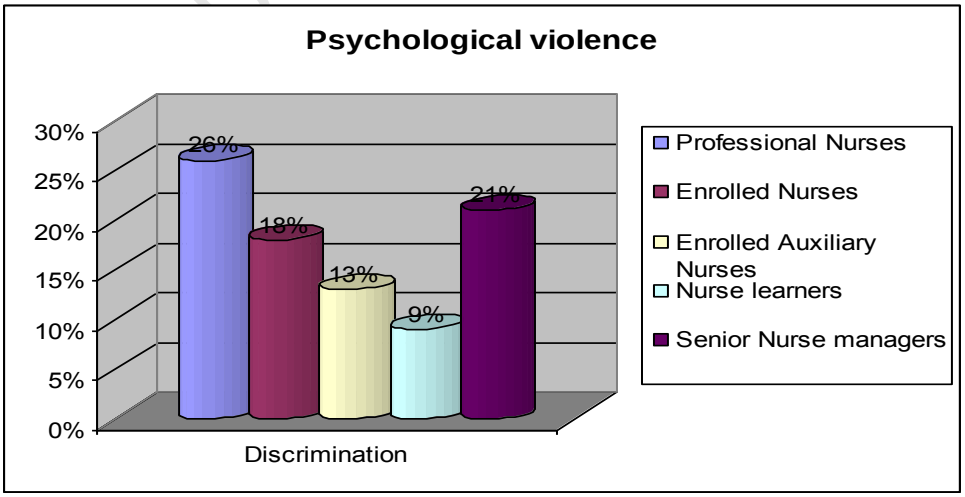


Chart 4.4x: Psychological violence - categories of Nurses with propensity to bully other nurses

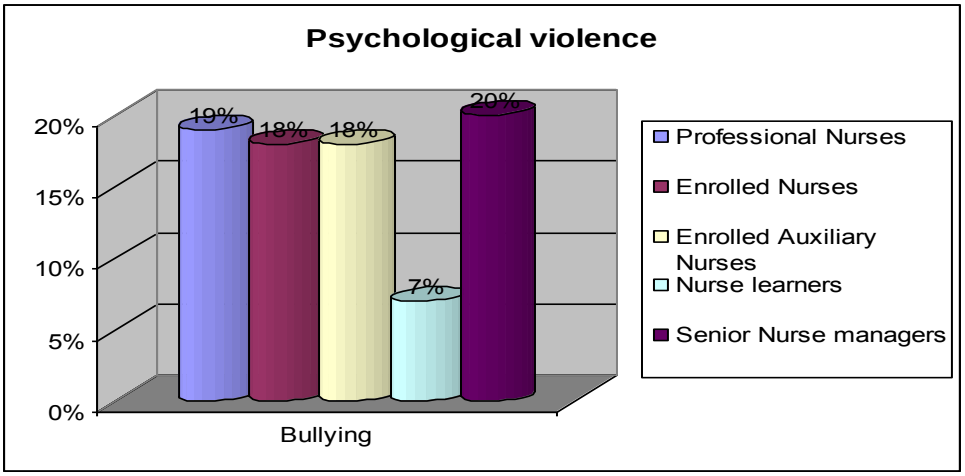


Chart 4.4y: Psychological violence - categories of Nurses with propensity to ignore other nurses

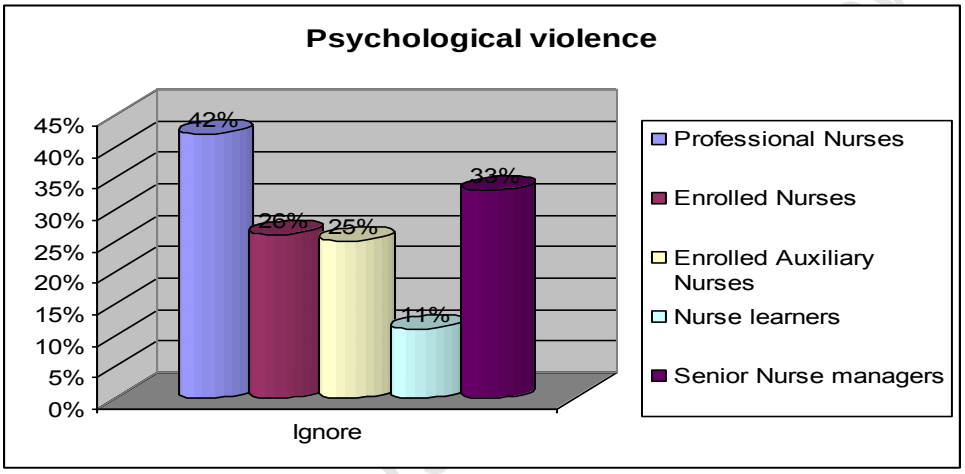


Chart 4.4z: Psychological violence - categories of Nurses with propensity to label other nurses

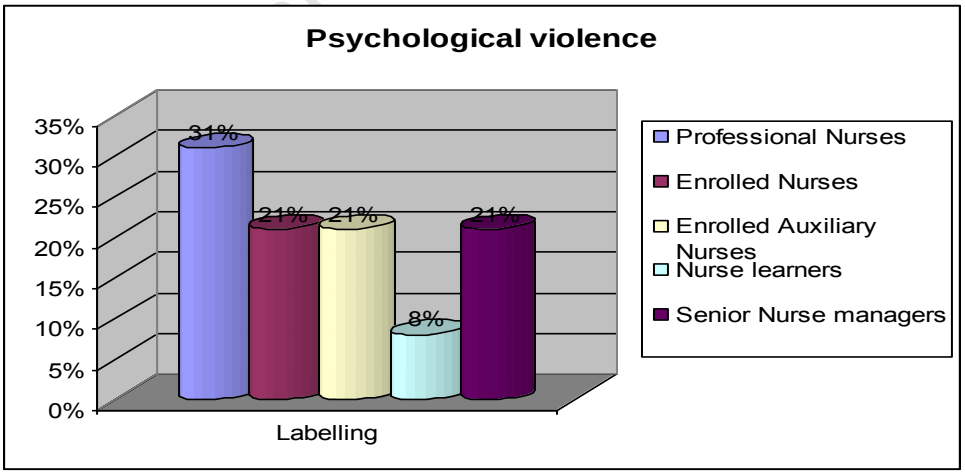


Chart 4.4aa: Psychological violence - categories of Nurses with propensity to insinuate against nurses

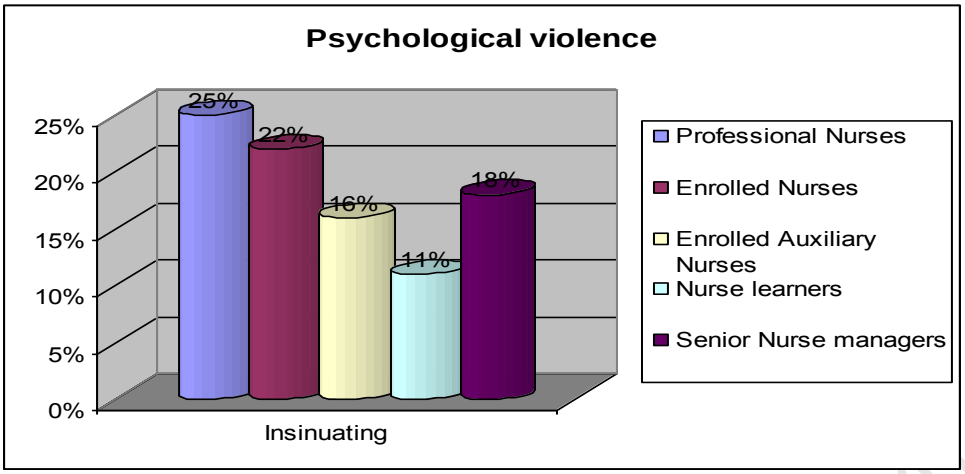


Chart 4.4bb: Categories of Nurses with propensity to revert to verbal abusing junior/senior Nurses

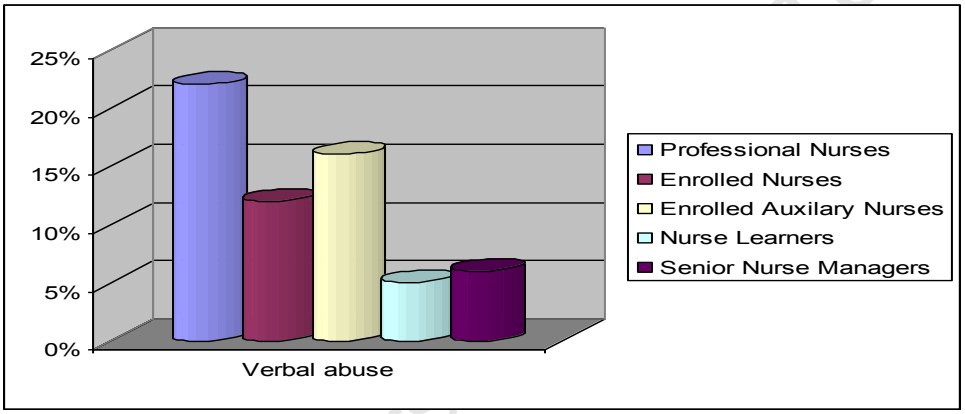


Chart 4.4cc: Categories of Nurses with propensity to revert to shouting at junior/senior Nurses

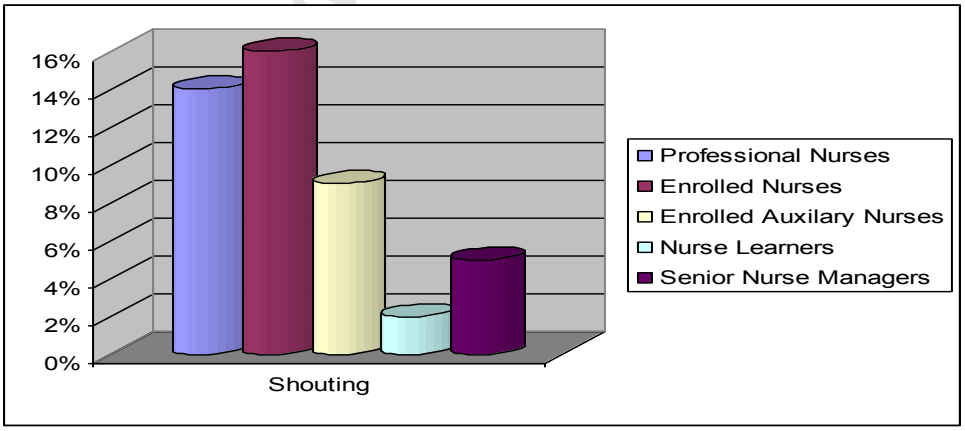


Chart 4.4dd: Categories of Nurses with propensity to revert discriminating against junior/senior Nurses

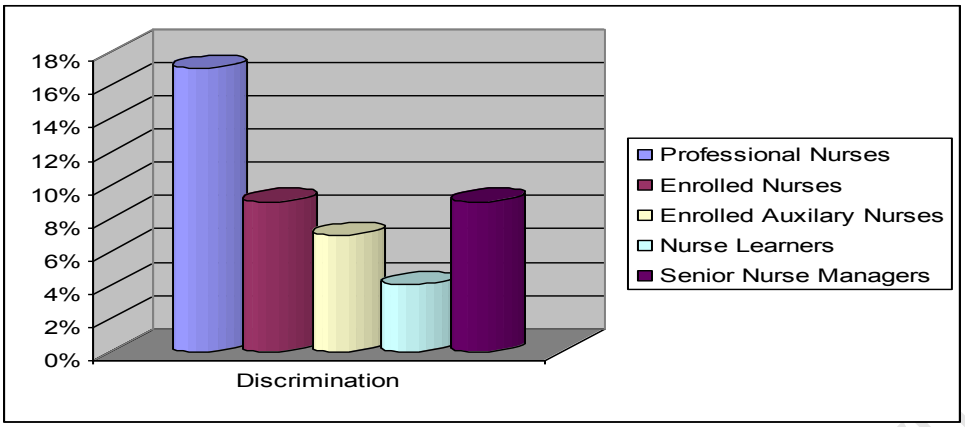


Chart 4.4ee: Categories of Nurses with propensity to bullying junior/senior Nurses

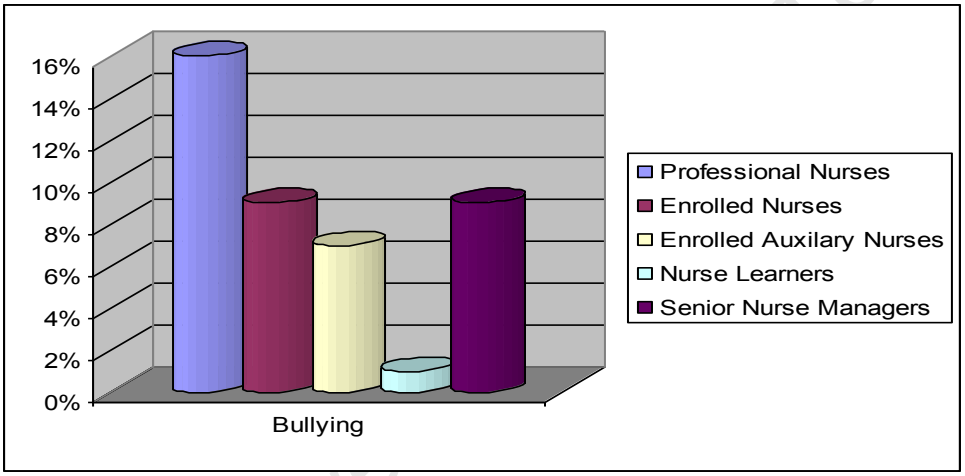


Chart 4.4ff: Categories of Nurses with propensity to humiliating junior/senior Nurses

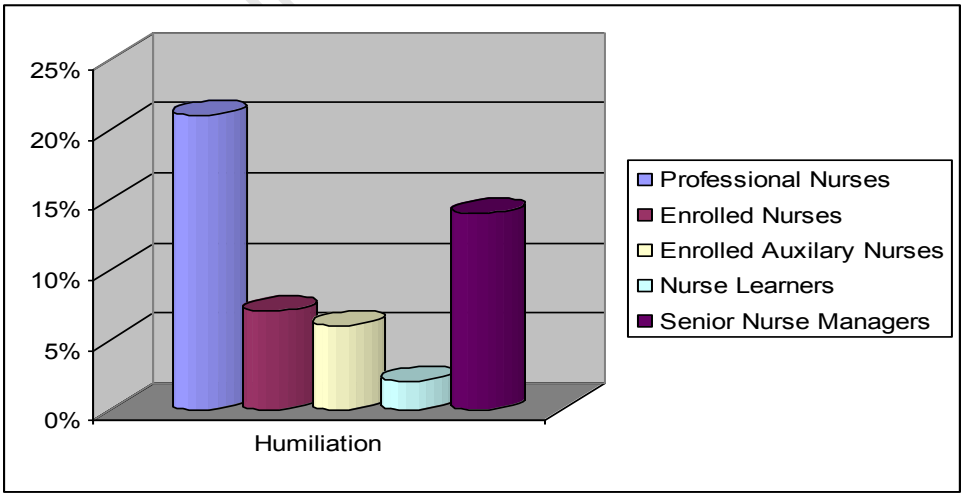
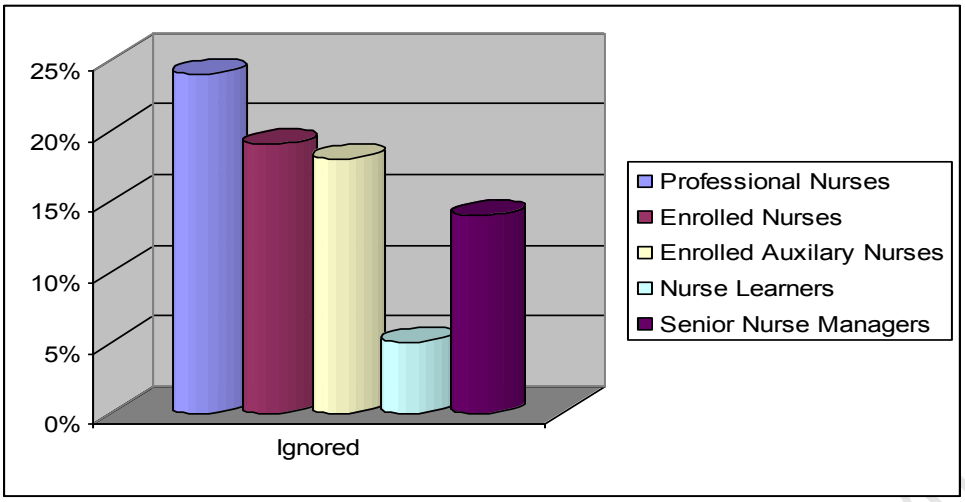


Chart 4.4gg: Categories of Nurses with propensity to revert ignoring Junior/senior Nurses



4.4.5 HORIZONTAL VIOLENCE AMONGST NURSES

Categories of nurses with the propensity to resort to differing types of horizontal violence varied. Professional nurses (n=18; 21.2%), was identified as the main category of nurses who resorted to verbally abusing their colleagues (Chart 4.4hh). Enrolled nurses (n=12; 14.1%) and enrolled auxiliary nurses (n=9; 10.6%) showed the propensity to resort to verbally abusing nurses of same rank. Shouting is a form of horizontal violence was frequently perpetrated amongst professional nurses (n=15; 17.7%), enrolled (n=13; 15.5%) and auxiliary nurses (n=9; 106%: Chart 4.4jj). Senior nurse-managers were identified as the primary group of nurses to discriminate (n=20; 23.5%) against colleagues of the same rank (Chart 4.4kk). Senior nurse-managers (n=19; 22.4%) and professional nurses (n=18; 21.2%) were the main group of nurses who showed the propensity to bully (Chart 4.4mm). Professional nurses (n=11; 12.9%) and senior nurse-managers (n=9; 10.6%) were identified as having tendencies to harass colleagues of the same rank (Chart 4.4nn). Senior nurse-managers (n=13; 15.5%) had the propensity to devalue colleagues of the same rank (Chart 4.4pp).

During the interviews with informants confirmed that horizontal violence exists among nurses of the same rank:

> *"AT meetings, there is A BIT OF ANAMOSITY (emphasis these works). Sometimes that comes out very strongly. You see competition between the leaders. Especially when they do presentation, the one wants to be better than the other. It appears to be jealousy that is more professional but no physical attack."(M3)*

> *"They would swear at each other in these meetings and it is like a platform to show your position of power. Bad attitude you get all the time."(W2)*

Chart 4.4hh: Categories of Nurses with propensity to verbally abuse other Nurses of the same rank

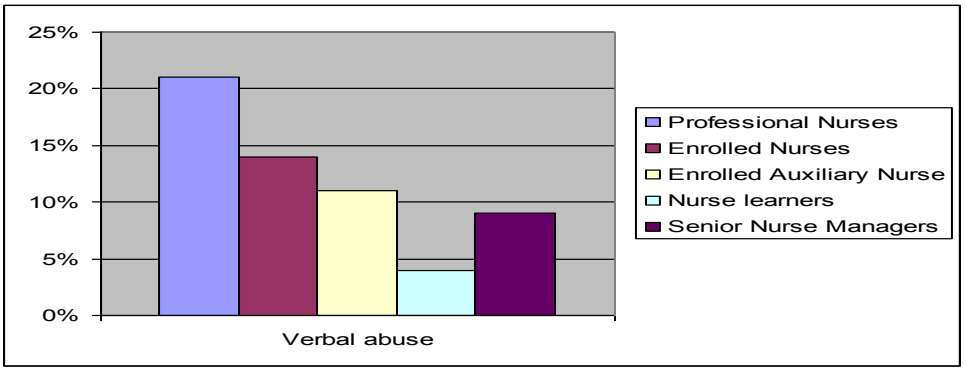


Chart 4.4jj: Categories of Nurses with propensity to shout at other Nurses of the same rank

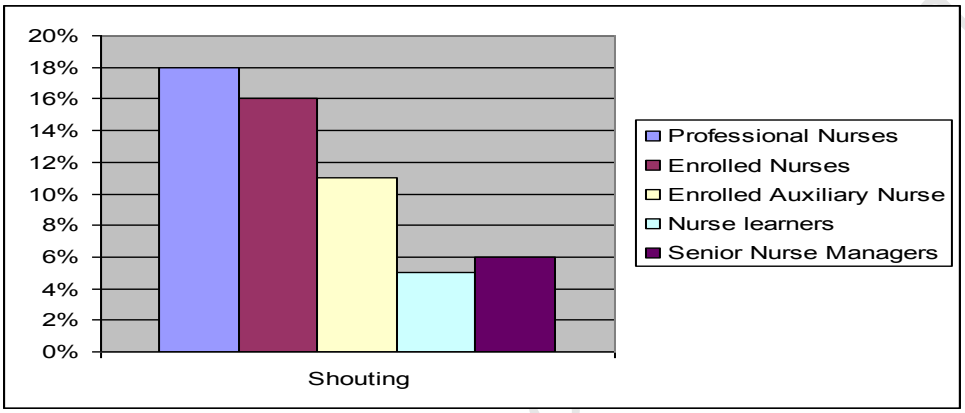


Chart 4.4kk: Categories of Nurses with propensity to discriminate against other Nurses of the same rank

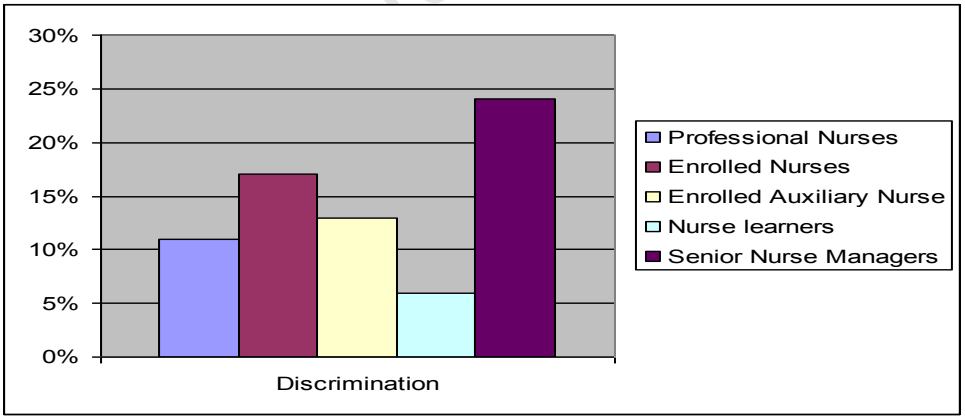


Chart 4.4mm: Categories of Nurses with propensity to bully other Nurses of the same rank

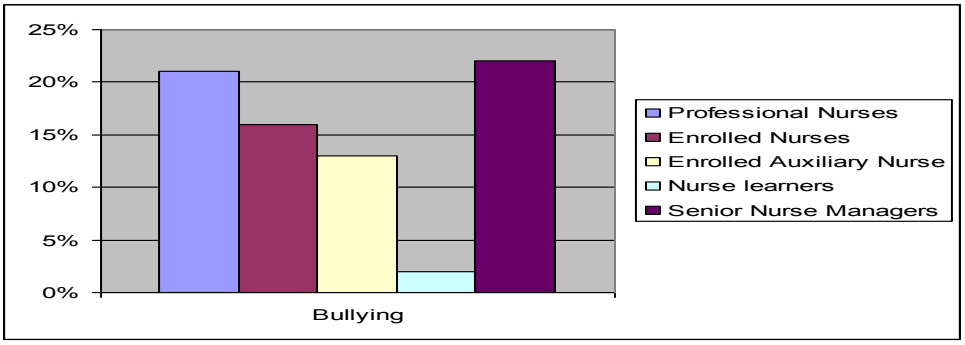


Chart 4.4nn: Categories of Nurses with propensity to harass other Nurses of the same rank

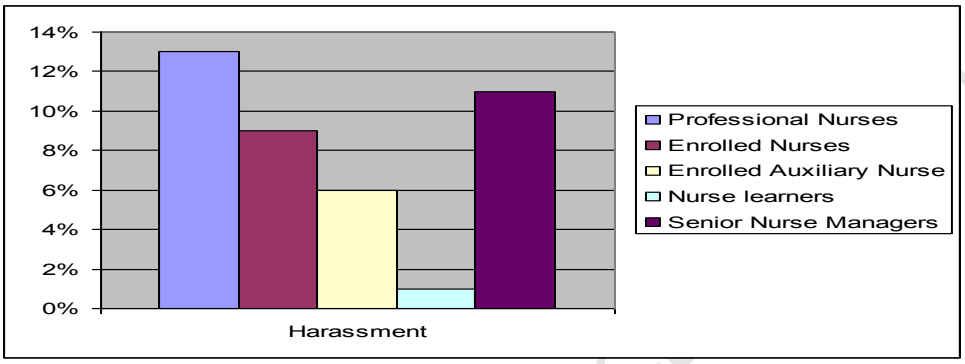
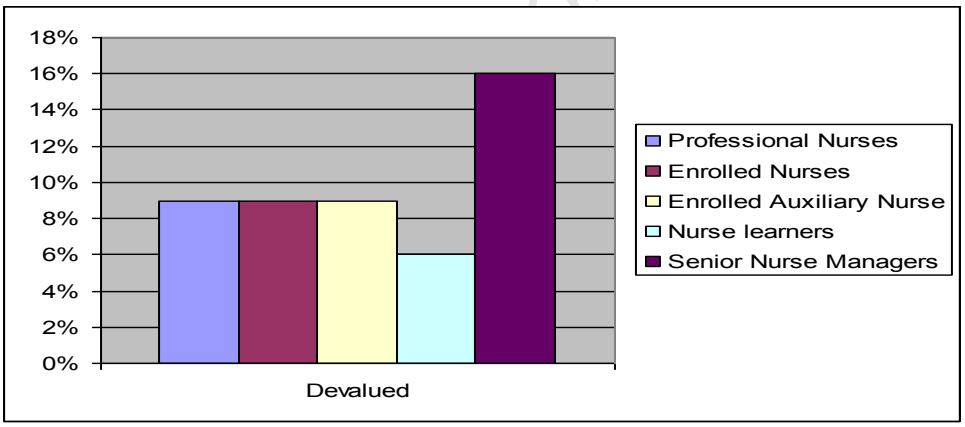


Chart 4.4pp: Categories of Nurses with propensity to devalue other Nurses of the same rank



4.4.6 COVERT VIOLENCE AMONGST NURSES

Categories of nurses with the propensity to resort to subtly or secretly abuse other nurses differed with different forms of covert violence. Professional (n=17; 20.2%) and senior nurse-managers (n=14; 16.5%) were identified as the main categories of nurses to resort to verbally abuse other nurses covertly (Chart 4.4qq). All categories of nurses except students secretly shout at other nurses (Chart 4.4rr). Professional (n=14; 16.5%) and senior nurse-managers (n=13; 15.5%) where identified as the primary categories of nurses who secretly discriminate against other nurses (Chart 4.4ss). All categories of nurses secretly gossip about other nurses except students nurses (Chart 4.4uu). Professional nurses (n=20; 23.5%) and senior nurse-managers (n=17; 20.2%) has the propensity to secretly label other nurses (Chart 4.4vv). All categories of nurses have the propensity to secretly manipulate other nurses, except student nurses (Chart 4.4ww).

4.4.7 Overt violence

Categories of nurses with propensity to resort to violence against other nurses in public varied. Professional nurses (n=25; 29.4%) and senior nurse-managers (n=20; 23.5%) were identified as the primary group of nurses who publicly avoid close contact with their colleagues (Chart 4.4ccc). Professional nurses (n=21; 24.7%) were identified as the main group of nurses who verbally abuse other nurses in public, senior nurse-managers (n=13; 15.5%) also resorted to same behaviour (Chart 4.4xx). Whilst enrolled nurses resort to shouting (n=17; 20.2%) and swearing (n=8; 9.4%) at colleagues in public (Charts 4.4yy - 4.4zz). Senior nurse-managers (n=14; 16.5%) were identified as the main group of nurses who publicly discriminate against other nurses (Chart 4.4aaa). All categories of nurses have the propensity to resort to bullying other nurses in public except students nurses (Chart 4.4bbb).

Chart 4.4qq: Categories of Nurses with propensity to secretly verbally abuse other nurses

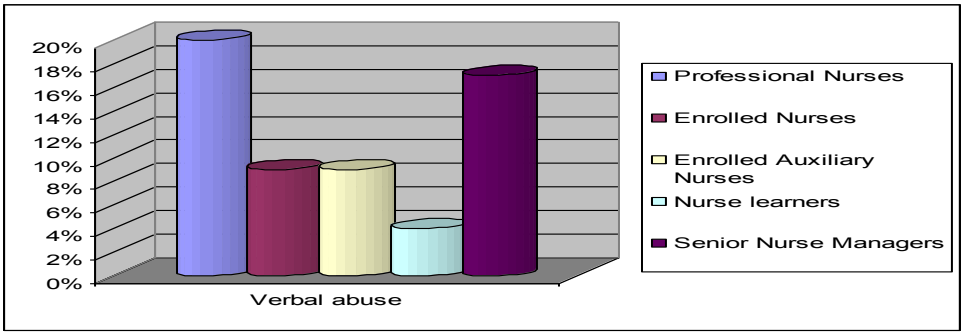


Chart 4.4rr: Categories of Nurses with propensity secretly shout at other nurses

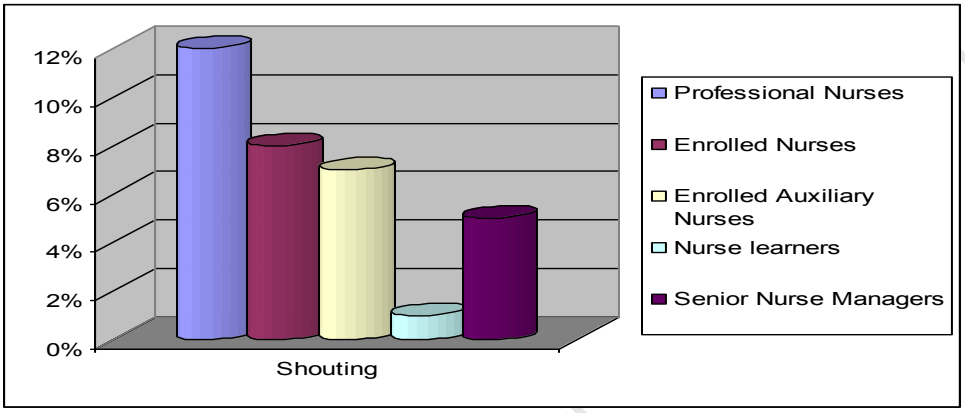


Chart 4.4ss: Categories of Nurses with propensity to secretly discriminate against other nurses

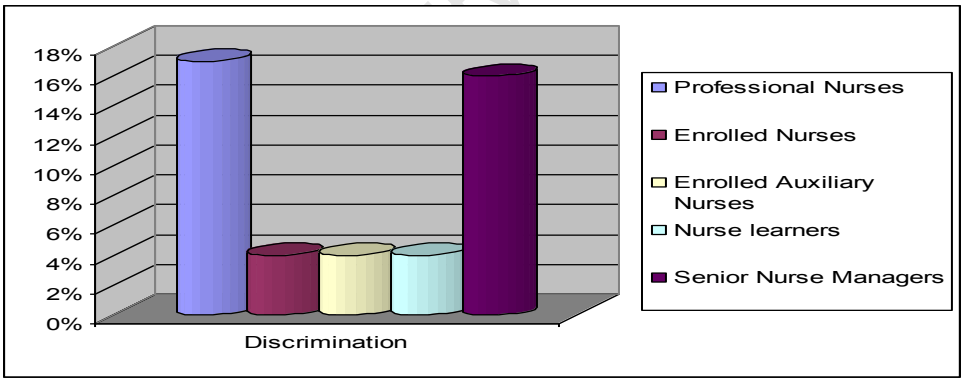


Chart 4.4tt: Categories of Nurses with propensity to secretly bully other nurses

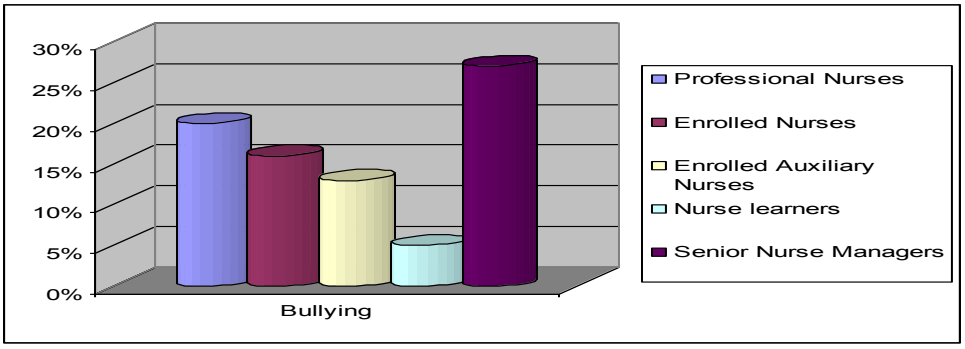


Chart 4.4uu: Categories of Nurses with propensity to gossip about other nurses

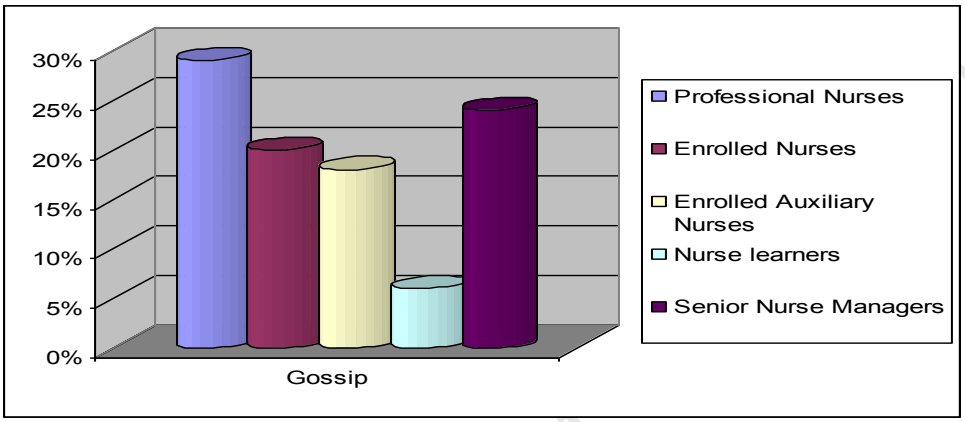


Chart 4.4vv: Categories of Nurses with propensity to secretly label other nurses

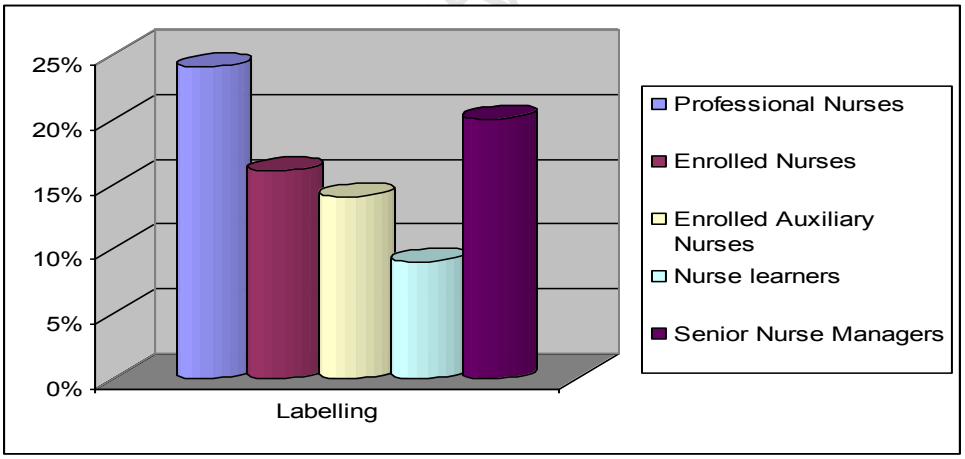


Chart 4.4ww: Categories of Nurses with propensity to secretly manipulate other Nurses

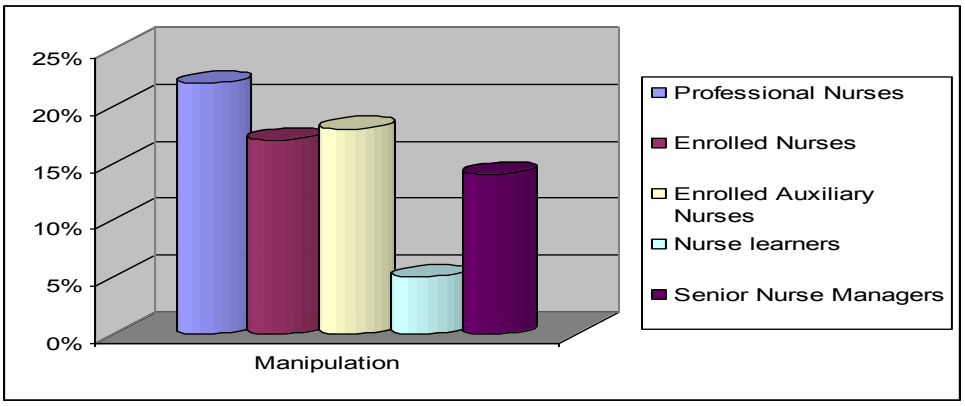


Chart 4.4xx: Categories of Nurses with propensity to verbally abuse other Nurses in public

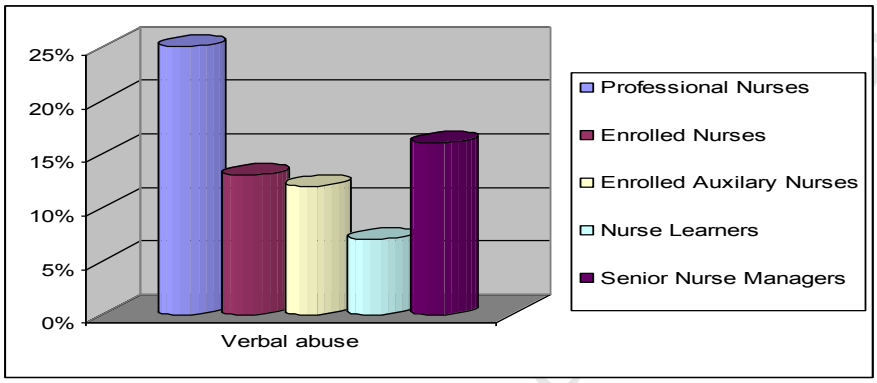


Chart 4.4yy: Categories of Nurses with propensity to shout at other Nurses in public

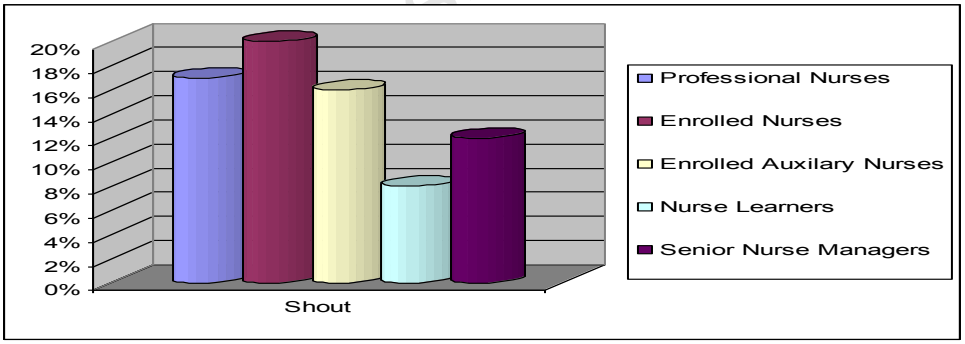


Chart 4.4zz: Categories of Nurses with propensity to swear at other Nurses in public

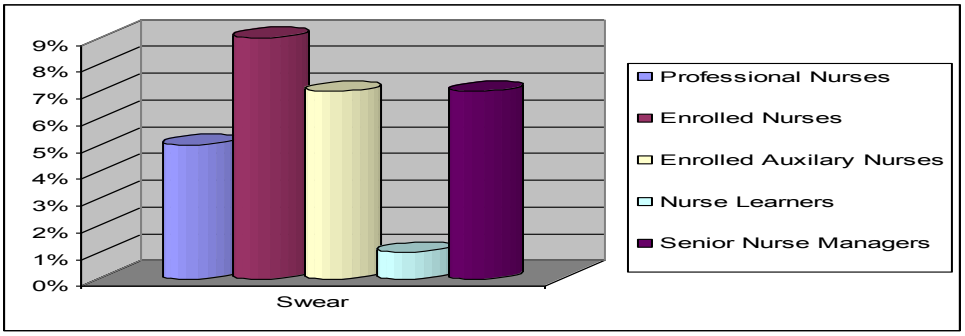


Chart 4.4aaa: Categories of Nurses with propensity to discriminate against other Nurses in public

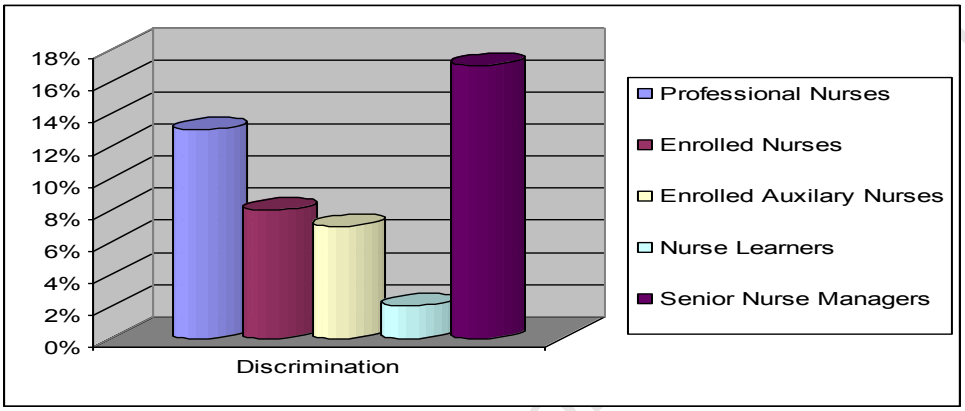


Chart 4.4bbb: Categories of Nurses with propensity to bully other Nurses in public

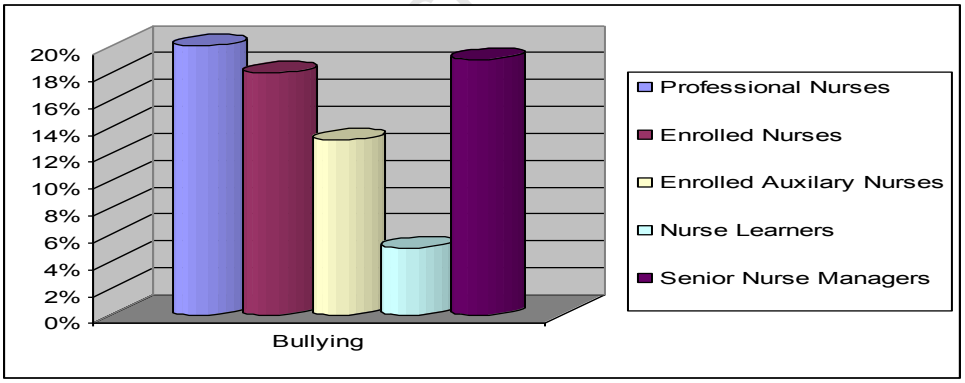


Chart 4.4ccc: Categories of Nurses with propensity to avoid contact with other Nurses in public

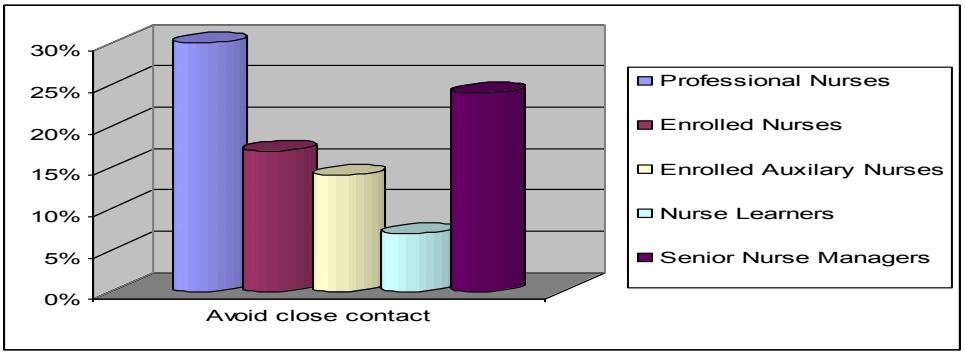


Chart 4.4ddd: Categories of Nurses with propensity to threaten other Nurses in public

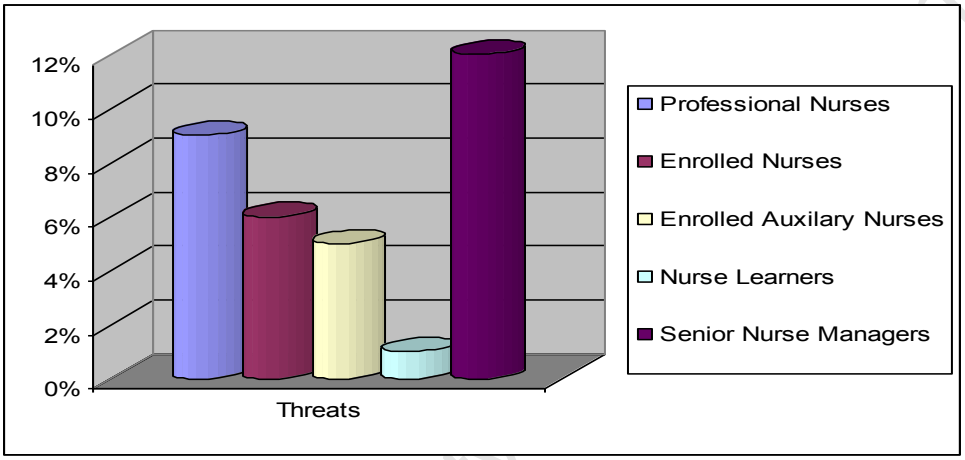
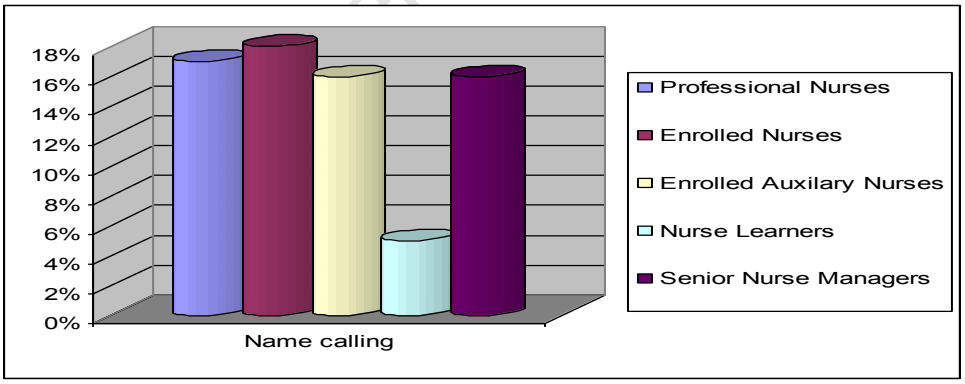


Chart 4.4eee: Categories of Nurses with propensity to calling other Nurses names in public



4.5 VIOLENCE BY NURSES AGAINST OTHERS

Nurses in all participating clinics indicated that some colleagues direct their anger at patients (n=31; 36.5%), senior nurse-managers (n=17; 20.2%), and patients' relatives (n=16; 18.8%). Professional (n=33; 38.8%), enrolled (n=20; 34.1%), and auxiliary nurses (n=20; 34.1%) were identified as primary groups of nurses that tended to gossip about health care consumers. The only group of health care consumers that nurses in the participating clinics do not attack, are white patients (Chart 4.5a). Professional (n=28; 33%) and enrolled (n=18; 21.2%) nurses tend verbally abuse people that are not nurses (Chart 4.5b). Professional nurses (n=25; 29.4%) tended to shout and auxiliary nurses (n=18; 21.2%) had the propensity to swear at people who are not nurses (Charts 4.5c and 4.5d). Senior nurse-managers (n=) were identified as the primary group of nurses with tendencies to discriminate (n=19; 22, 4%) against others (Chart 4.5e). All categories of nurses showed the propensity to bully and gossip against health care consumers (Charts 4.5f – 4.5g).

Key informants interviews confirm that some nurses were verbally abusive towards others including Doctors and student nurses, some of their comments were

> *"Not really violence, only difference in approaching a situation, e.g. when a doctor who wants to change how we should approach our students" (K1)*

> *"Verbal abuse towards patients - yes, some are abusive towards students when they allow them to do work that they are not suppose to be doing" (K4)*

Chart 4.5a: Types of people that nurses tend to direct their anger against

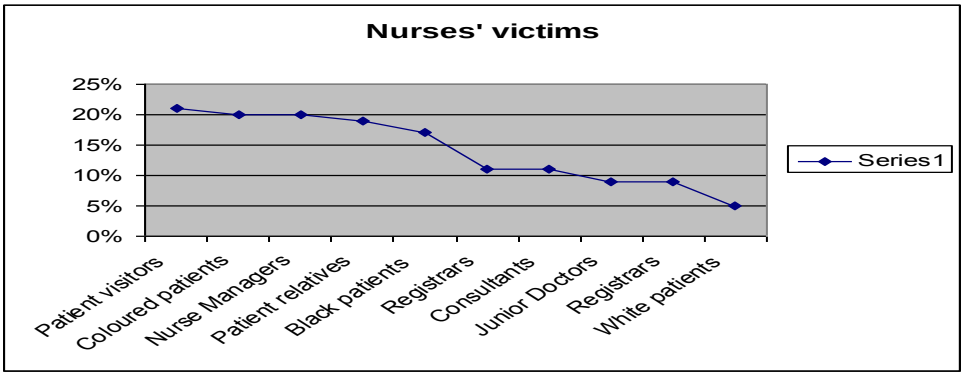


Chart 4.5b: Categories of Nurses that tend to verbally abuse people that are not nurses

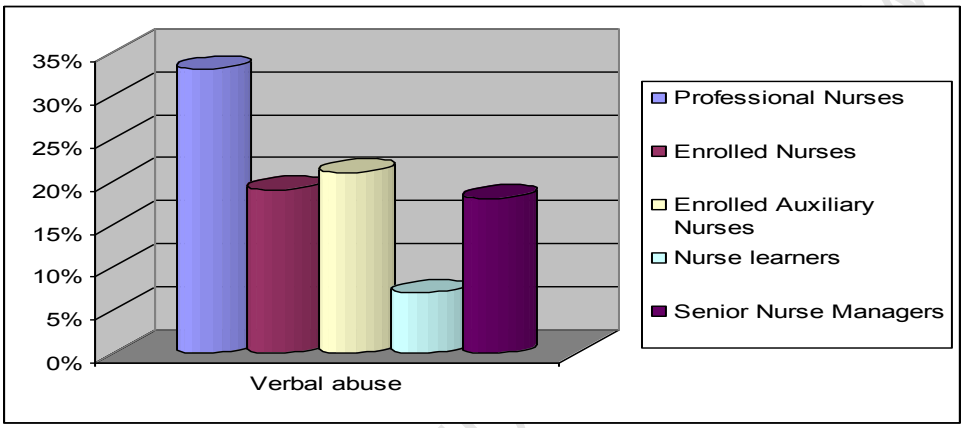


Chart 4.5c: Categories of Nurses that tend to shout at people that are not nurses

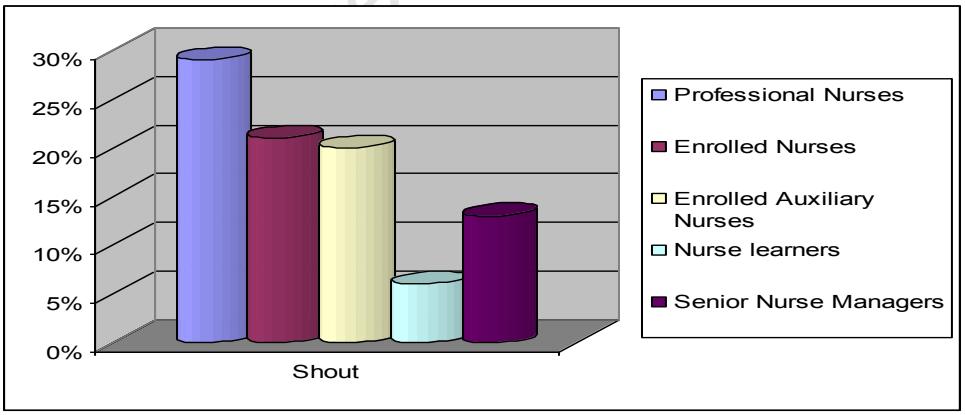


Chart 4.5d: Categories of Nurses that tend to swear at non-Nursing colleagues

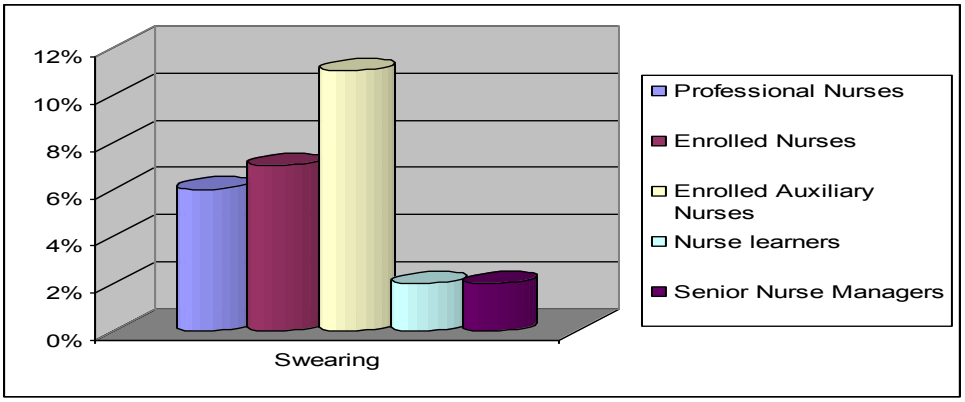


Chart 4.5e: Categories of Nurses that tend to discriminate against non-Nursing colleagues

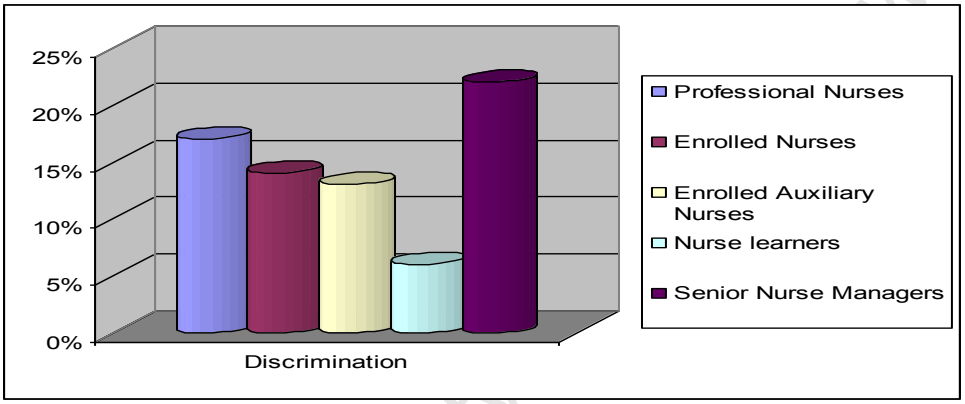


Chart 4.5f: Categories of Nurses that tend to bully non Nursing colleagues

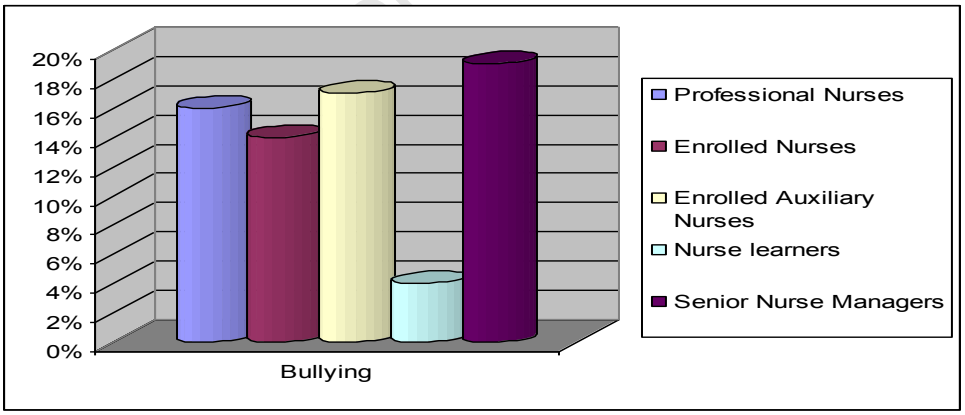


Chart 4.5g: Categories of Nurses that tend to gossip about non Nursing colleagues

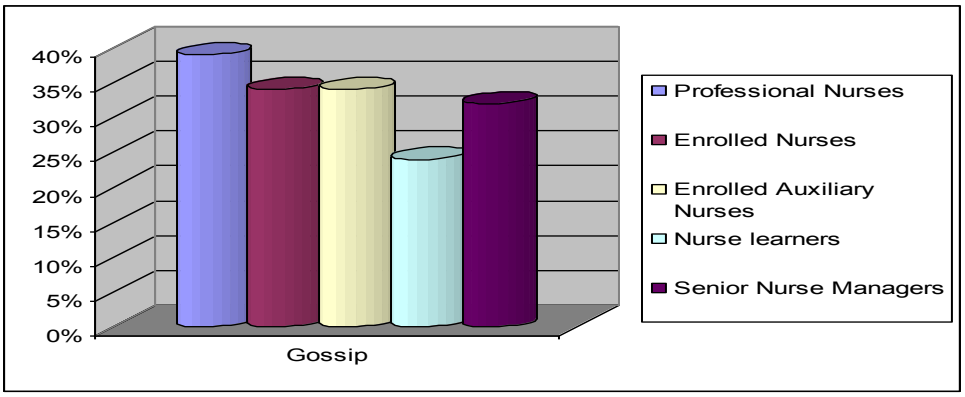


Chart 4.5h: Nurses attitude towards 'good patients'

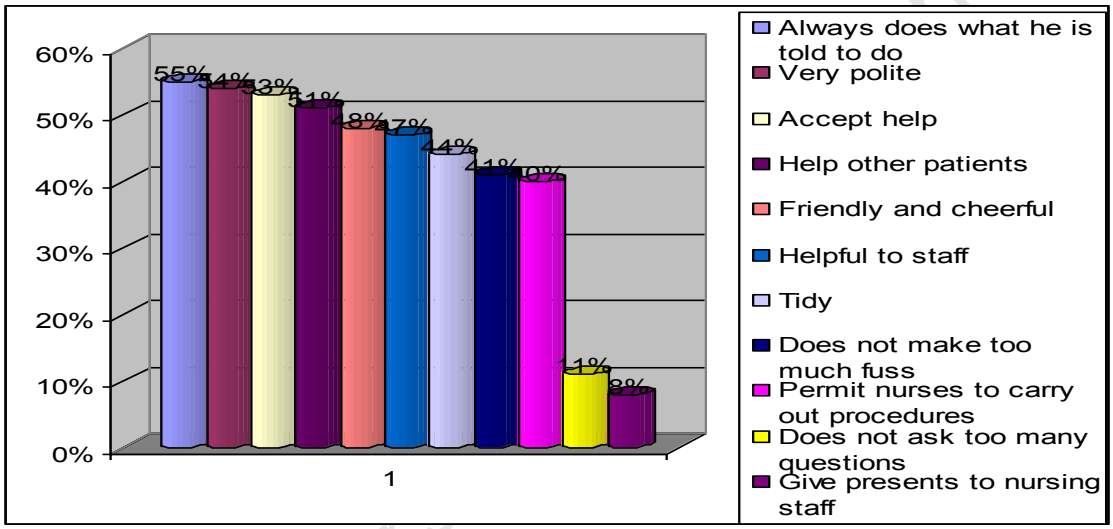
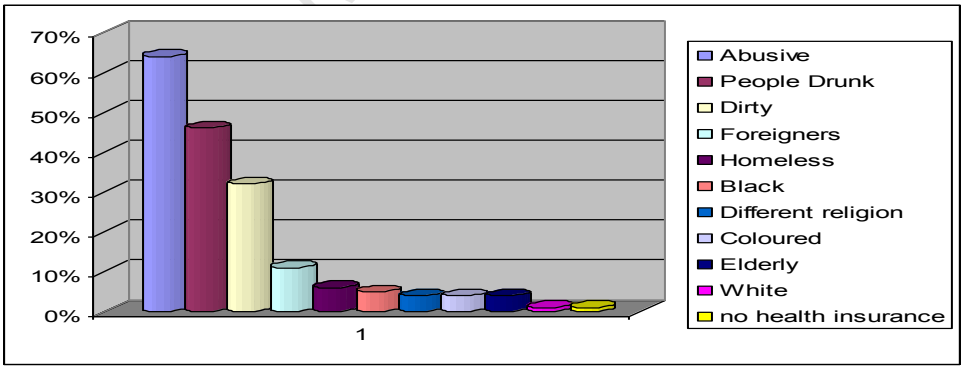


Chart 4.5j: Types of health care consumers Nurses refuse to care for



4.5.1 Qualities of 'good' patients and nurses' attitude towards them

Forty-seven respondents (n=47; 55.3%) from all the participating clinics provided information on qualities that nurses attribute to 'a good patient'. The highest quality that nurses expected from patients was that he/she should do what they were told to do (Chart 4.5h). Other qualities of a good patient were politeness (n=46; 54%), accepting help without complaining (n=45; 53%), being helpful to other patients (n=43; 51%) and being friendly and cheerful (n=41; 48.2%). On the other hand, forty respondents (n=40; 47.1%) provided information on ways that nurses rewarded good patients. Rewards included praise, helping those patients quicker, acknowledging good behaviour and respecting them. Some nurses may even do special favours for them, chatting with them and being more considerate of their needs. Birthday or end-of-year parties are also sometimes organized for 'good' patients getting long term care such as TB patients.

The interviewees had the following comments about 'good' patients:

> *"With friendliness, good excellent health care, always helpful, a good ear to listen, going extra mile for good patients" (K1)*
>
> *"Praise the patient or carer; Respectful and pleasant interaction with patient; More considerate of their needs" (K4)*
>
> *"By thanking them verbally, organising, a party at Christmas party, organising sponsors for patient events." (M3)*
>
> *"1). Give them an incentive or diploma. 2). Use to give TB patients a party at the end of year but due to a lack of funds it all stopped" (W2)*

4.5.2 Qualities of 'Difficult or Bad' patients and nurses' attitude towards them

Sixty-three respondents (n=63; 74.1%) provided information on qualities of bad patients and nurses attitude towards such patients. Twelve respondents (n=12; 14%) identified patients 'who constantly complain' as bad and difficult. Nine respondents (n=9; 10.6%) regarded patients that 'verbal abuse and swearing' at nursing staff as bad patient. Eight respondents (n=8; 9.4%) indicted patients who passes derogative remarks at nursing staff and causes disturbances in the waiting room, and ignoring nursing staff' as bad and difficult. Fifteen respondents (n=15; 17.6%) regarded patients who are 'non-compliant' with their medications and not appreciating what is being done to them and being uncooperative as bad. Fifteen (n=15; 17.6%) respondents indicated patients 'who demand medication not prescribed to them and making their own diagnosis' as a bad patient. Twenty-two (n=22; 25.9%) respondents identified patients 'who refuse to wait in long queues and being belligerence as well as refusing to accept the opinion of medical staff' as bad patients.

Fifty-eight respondents (n=58; 68.2%) indicated that they had observed some nurses treat 'bad patients' badly. Eight respondents (n=8; 9.4%) had observed nurses ignore patients and purposefully make them wait longer. Eleven (n=11; 12.9%) respondents had observed nurses verbally abuse patients, avoided refused to treat same patients. Twenty respondents (n=20; 23.5%) observed that some nurses help such patients quickly to get rid of them. Nineteen respondents (n=19; 22.4%) indicated that they treat "bad or difficult" patients professionally or the security staff to deal with such patients without getting personal with a patient that behaves badly.

4.5.3 Observation of Other Nurses mistreating health care consumers

Fifty-three respondents (n=53; 62.4%) indicated they observed nurses mistreating patients. Whereas five respondents (n=5; 5.9%) indicated they never observed such behaviour. On the other hand, fifty-three respondents (n=53; 62.4%) had observed such incidences at least once. Charts 4.5k to Chart 4.5p presents types of patients that nurses tended to mistreat were identified as abusive patient (n=54; 64%) alcohol abusers (n=39; 46%) patients who are dirty (n=27; 32%).

4.5.4 Action to be taken against Nurses covertly Mistreating Patients

Twenty one respondents (n=21; 24.7%) indicated that they had at sometime reported nurses that mistreat patients, forty (n=40; 42.1%) had never, and twenty-four (n=24; 28.2%) did not respond to the question. None of the respondents felt that nurses who mistreat patients covertly should not be disciplined. Thirteen (n=13; 15.3%) indicated that no action had been taken against nurse that mistreat patients, while twenty-two (n=22; 25.9%) indicated some form of disciplinary action including warnings, counselling, reprimands and disciplinary hearings to have been instituted. Eleven (n=11; 12.9%) respondents advocated special training, communication training or psychological assessments, debriefing sessions and teaching of coping skills to be necessary. Respondents indicated to be fired as an option for discipline, and being reported to the South African Nursing Council. In response to actions taken to support patients and relatives, twelve (n=12; 14.1%) indicated that no action was taken, whilst some nurses were forced to apologize to the patient, and in another instance, the nurse was relocated to another unit.

Chart 4.5k: Percentages of nurses that refuse to treat health care consumers who are verbally abusive

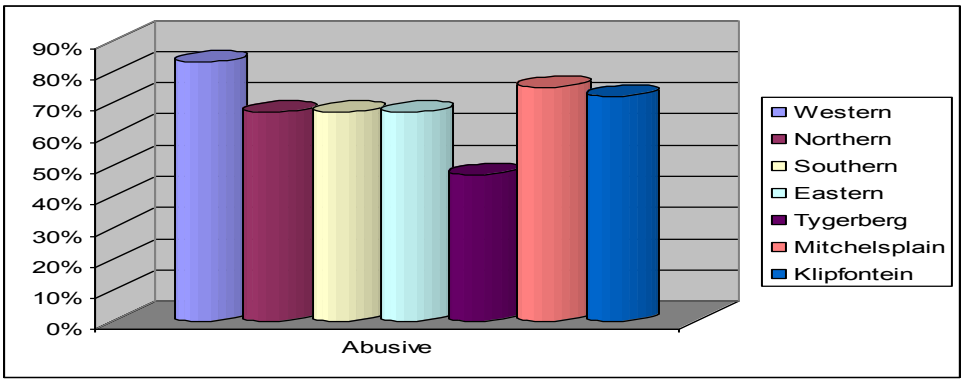


Chart 4.5m: Percentages of nurses that refuse to treat health care consumers who are alcohol abuser

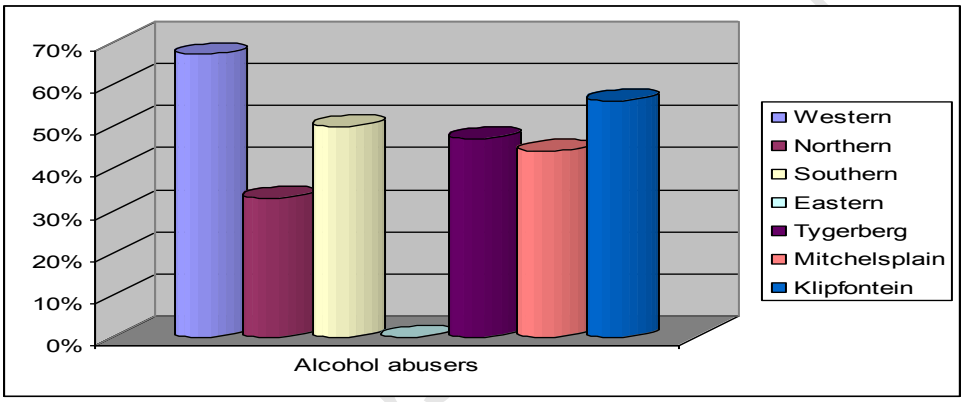


Chart 4.5n: Percentages of nurses that refuse to treat health care consumers who are dirty

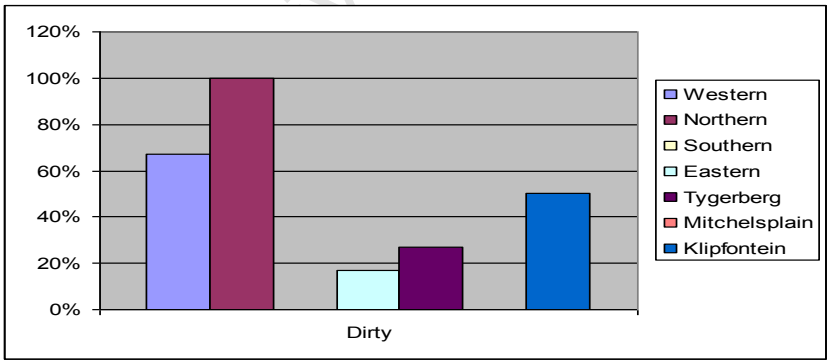


Chart 4.5p: Percentages of nurses that refuse to treat health care consumers who are deemed foreigners

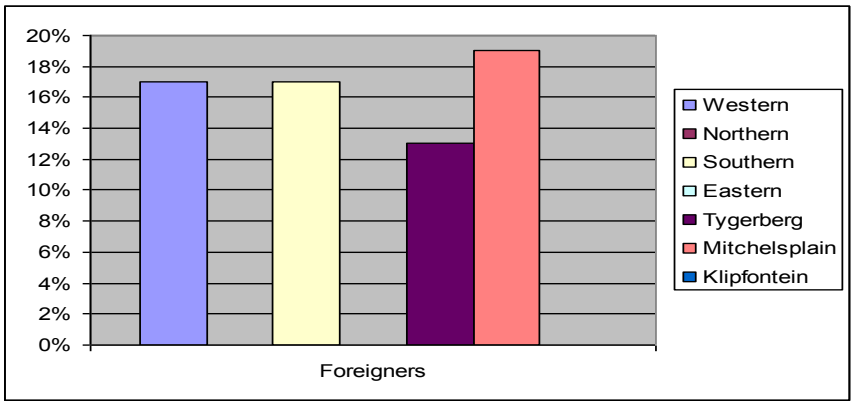
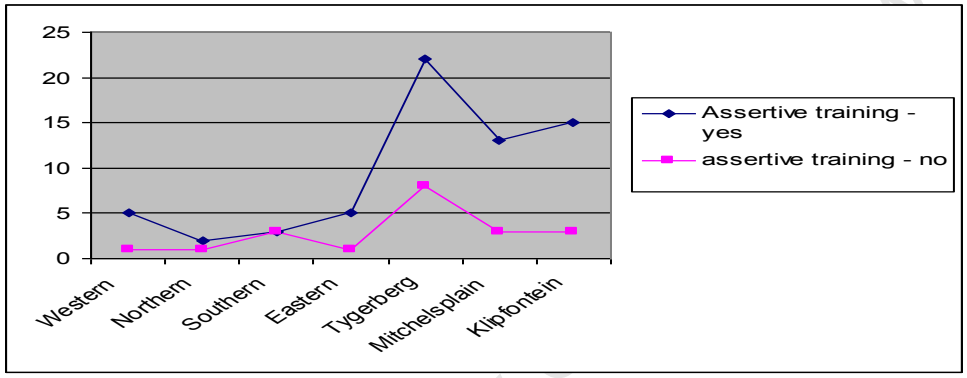


Chart 4.6a: Assertive training help nurses in dealing with workplace violence



4.5.5 Negative Publicity about Nurses

Twenty-five respondents (n=25; 29.4%) felt that the negative publicity surrounding mistreatment of patients by nurses was not justified. Six respondents (n=6; 7.1%) proposed reasons for this, including the claim that nurses has to defend themselves when attacked and that the media is often after sensationalism and hardly ever publish outcomes of investigations where nurses are exonerated. Twelve respondents (n=12; 14.1%) expressed views that many nurses' complaints were never heard or acted upon. Seven respondents (n=7; 8.2%) indicated nurses are overworked; resulting in frustration and often it is only a few nurses who tarnish nurses' reputation. Sixteen respondents (n=16; 18.8%) felt that this bad reputation was justified, some of the reasons being that any abuses by the patients should not be responded to in kind but should be dealt with through the proper channels.

4.6 Management of violence in nursing

4.6.1 Preparedness of nurses to deal with violent incidences

In response to types of training required to empower nurses deal with the violence in their workplaces, sixty-five respondents (n=65; 76.5%) highlighted the need for assertive training workshops to assist the nurses in dealing with violence in the workplace. However, seventy-three respondents (n=73; 85.8%) stresses that management should pay more attention to nurses exposed to violence when dealing with health and safety issues. Sixty-three respondents (n=63; 74.1%) indicated that not all nurses were compassionate towards patients.

4.6.2 Respondents' anger management strategies

Respondents were requested to express how they manage to cope with violence in the workplace. Fifteen respondents (n=15; 17.6%) indicated that they make a conscious efforts to remain calm, in order to control the situation. Eighteen respondents (n=18; 21.2%) admitted to shouting at their own family members, when incidences of violence occurred at work. Twelve respondents (n=12; 14.1%) specified that to talk to someone immediately after incidents proves to be helpful. One suggested that group discussions especially with family members assisted her to deal with the incident. Two respondents (n=2; 2.2%) indicated senior staff were always willing to listen. Six respondents (n=6; 7.1%) found saying prayers as a helpful strategy to cope with the situation. Seven respondents (n=7; 8.2%) identified the use of physical exercises to be a stress reliever.

4.6.3 Views on managers' attitude towards nurses experiencing violence

Managers plays a pivotal role in boosting the morale of the nursing staff as expressed by twenty respondents (n=20; 23.5%). Four respondents (n=4; 4.7%) indicated that their relationships with and attitudes towards patients were not affected by the negative attitudes of senior managers towards them. Sixteen respondents (n=16; 18.8%) specified that managers should show staff that their contributions were being valued to boost morale, self-image, and confidence in dealing with difficult patients. Thirty respondents (n=30; 35.3%) indicated positive re-enforcement behaviour from managers would make many nurses feel that "*they could go the extra mile*". During interview with key informants some of their responses were:

'*Attempt to solve the problem if not the line manager are then called in. If it is the case of emotional crises or high workload, speak directly to the staff member but there is nothing more done to solve the issue' (K1)*

'Coping of violence is more related to the huge workload and depending in the staff complement. It is also people going on leave, going on courses this build up the frustration' (M3).

'Stress, makes nurses ask for leave urgently. They will be seen by a line manager to sort the problems' (K4)

Twenty-three respondents (n=23; 27.1%) agreed that nurses were street level bureaucrats for the ministry of health and that nurses are rude to senior managers only. The replies included the suggestion that workshops should be organized for all level of staff, which should include training management. Ten respondents (n=10; 11.8%) indicated that providing more staff would alleviate the problem. Fifty respondents (n=50; 58.8%) indicated that employing more security staff is an ideal way of dealing with violent situations. Forty-five respondents (n=45; 52.9%) indicated that more meetings should be held with staff to address and find solutions to the issue, setting out policies to deal with various types of incidences.

Twenty-seven respondents (n=27; 31.8%) indicated that they knew about employee assistance programmes that had been made available for staff but thirty-three (n=33; 38.8%) were not aware, and twenty-five (n=25; 29.4%) were not sure. One respondent indicated that they support each other. Thirty-one respondents (n=31; 36.5%) indicated that clinic managers are very supportive of nurses experiencing violence from health care consumers, twenty-two (n=22; 25.9%) disagreed and thirty-two (n=32; 37.6%) were not sure. Sixty-one respondents (n=61; 71.8%) indicated that initial nursing training programmes did not prepare them adequately to deal with violence in the workplace, eight (n=8; 9.4%) disagreed and sixteen (n=16; 18.8%) were not sure. Significant numbers of respondents (n=65; 76.5%) indicated that assertive will assist nurses in dealing with workplace violence (Chart 4.6a).

4.6.4 Strategies to manage the violence in health clinics

In response to strategies, nurses would like to have implemented in order to control workplace violence, Fifty respondents (n=50; 58.8%) indicated that employing more security staff is an ideal way of dealing with violent situations. Twenty respondents (n=20; 23.5%) specified that

recruitment of more nurses and clinic staff would reduce waiting times and minimise patients' frustrations. Thirty respondents (n=30; 35.3%) suggested special training programmes for clinic staff, e.g. assertive training and self defence. Thirty-five respondents (n=35; 41.2%) recommended that policies be put in place to protect nurses that defend themselves during violent incidences instead of going through the trauma of disciplinary hearings.

Table 4.6a Assertive training help with dealing in work violence

Assertive training help with dealing in work violence	Total number of respondents	Count of ID
	4	4.71%
Agree	65	76.47%
Disagree	5	5.88%
No comments	5	5.88%
No Strong views	6	7.06%
Grand Total	85	100.00%

Table 4.6b Management to pay attention to nurses exposed to violence

Management to pay attention to nurses exposed to violence	Total number of respondents	Total
True	73	85.88%
No Comments	8	9.41%
False	4	4.71%
Grand Total	85	100.00%

Table 4.6c not all Nurses are compassionate towards patients

Not all Nurses are compassionate towards patients	Total number of respondents	Total
True	63	74.12%
No Comments	7	8.24%
False	15	17.65%
Total	85	100.00%

Table 4.6d Conscious efforts to remain calm

Conscious efforts to remain calm	Total number of respondents	Total
True	15	17.65%
No Comments	12	14.12%
False	58	68.24%
Total	85	100.00%

Table 4.6e Shouting at Family members

Shouting at Family members	Total number of respondents	Total
True	18	21.18%
No Comments	15	17.65%
False	52	61.18%
Total	85	100.00%

Table 4.6f Talking to someone after incidents proves to be helpful

Talking to someone after incidents proves to be helpful	Total number of respondents	Total
True	12	14.12%
No Comments	32	37.65%
False	41	48.24%
Total	85	100.00%

Table 4.6g Willingness of senior staff to listen

Willingness of senior staff to listen	Total number of respondents	Total
True	2	2.35%
No Comments	21	24.71%
False	62	72.94%
Total	85	100.00%

Table 4.6h Prayers are helpful strategies to cope

Prayers are helpful strategies to cope	Total number of	Total
True	6	7.06%
No Comments	19	22.35%
False	60	70.59%
Total	85	100.00%

Table 4.6j Physical exercises is a stress reliever

Physical exercises is a stress reliever	Total number of	Total
True	7	8.24%
No Comments	23	27.06%
False	55	64.71%
Total	85	100.00%

Table 4.6k Managers boosting morale

Managements boosting moral	Total number of	Total
True	20	23.53%
No Comments	17	20.00%
False	48	56.47%
Total	85	100.00%

Table 4.6m Relationships towards patients, affected by negative attitudes of managers

Relationships towards patients, affected by negative attitudes of managers	Total number of	Total
True	4	4.71%
No Comments	25	29.41%
False	56	65.88%
Total	85	100.00%

Table 4.6n Managers value staffs contributions

Managers value staffs contributions	Total number of respondents	Total
True	16	18.82%
No Comments	26	30.59%
False	43	50.59%
Total	85	100.00%

Table 4.6p Positive reinforcement behaviour from managers

Positive reinforcement behavior from managers	Total number of respondents	Total
True	16	18.82%
No Comments	26	30.59%
False	43	50.59%
Total	85	100.00%

Table 4.6q Nurses as street bureaucrats

Nurses as street bureaucrats	Total number of respondents	Total
True	23	27.06%
No Comments	13	15.29%
False	49	57.65%
Total	85	100.00%

Table 4.6r providing more staff would alleviate problems

Providing more staff would alleviate problems	Total number of respondents	Total
True	10	11.76%
No Comments	16	18.82%
False	59	69.41%
Total	85	100.00%

Table 4.6s Employing more security staff will assist in dealing in violent situations

Employing more security staff will assist in dealing in violent situations	Total number of respondents	Total
True	10	11.76%
No Comments	16	18.82%
False	59	69.41%
Total	85	100.00%

Table 4.6t Indicated that meetings deal with various types of incidences

Indicated that meetings deal with various types of incidences	Total number of respondents	Total
True	45	52.94%
No Comments	32	37.65%
False	8	9.41%
Total	85	100.00%

Table 4.6u Awareness of employee assistance programmes availability

Awareness of Employee assistance programmes availability	Total number of respondents	Total
Yes	27	31.76%
No	33	38.82%
Not sure	25	29.41%
Total	85	100.00%

Table 4.6v Support of clinic managers in violent situations

Support of clinic managers in violent situations	Total number of respondents	Total
True	31	36.47%
No Comments	22	25.88%
False	32	37.65%
Total	85	100.00%

Table 4.6w Preparedness of initial nursing training programmes

Preparedness of initial nursing training programmes	Total number of respondents	Total
Agree	61	71.76%
Disagree	8	9.41%
No Comments	16	18.82%
Total	85	100.00%

Table 4.6x Recruitment of more nurses

Recruitment of more nurses	Total number of respondents	Total
Agree	20	23.53%
Disagree	40	47.06%
No Comments	25	29.41%
Total	85	100.00%

Table 4.6y Suggested special training programmes

Suggested special training programmes	Total number of respondents	Total
Agree	30	35.29%
Disagree	37	43.53%
No Comments	18	21.18%
Total	85	100.00%

Table 4.6z Recommendation of policies to protect nurses

Recommendation of policies to protect nurses	Total number of	Total
Agree	35	41.18%
Disagree	38	44.71%
No Comments	12	14.12%
Total	85	100.00%

4.7 Effects of violence on nurses

4.7.1 Some effects of violence on nurses

Certain specific reactions to violence frequently associated with depression were listed and respondents were asked to indicate if they had experienced any of these reactions. Thirty respondents (n=30; 35.3%) indicated difficulties in sleeping at night after a violent incident at work (Chart 4.7a). Nurses working in the Eastern sub-district clinics reported high incidences of panic attacks before going on duty (Chart 4.7b). Nurses' working in Klipfontein, Northern and Tygerberg areas had propensity to become over active after experiencing violent incidences (Chart 4.7c). Twenty-three respondents (n=23; 27.1%) indicated that they self-medicate to help them cope with stress of attacks (Chart 4.7d). Twenty-nine respondents (n=29; 34.1%) resorted to becoming more withdrawn (Chart 4.7e). Nurses working in Western and Eastern sub-district clinics (Chart 4.7f) tended to resort to increasing their smoking habits in order to help them cope with the violence in the workplace. Interviews with informants confirmed that some nurses would request for transfer from specific health clinics or request extra leave. Some of their comments were

> '*Coping with workload, occasionally I have heard the nurses discuss in the staff room that they take medication to help them to sleep.'(M3)*
> *'The nurses usually request for a transfer if the violence/abuse becomes more.'(W2)*
>
> '*I think our staffs are overworked. I have heard of staff using any kind of drug to cope with the stress.'(K1)*

Chart 4.7a: Frequency of sleep disturbances as result of violence

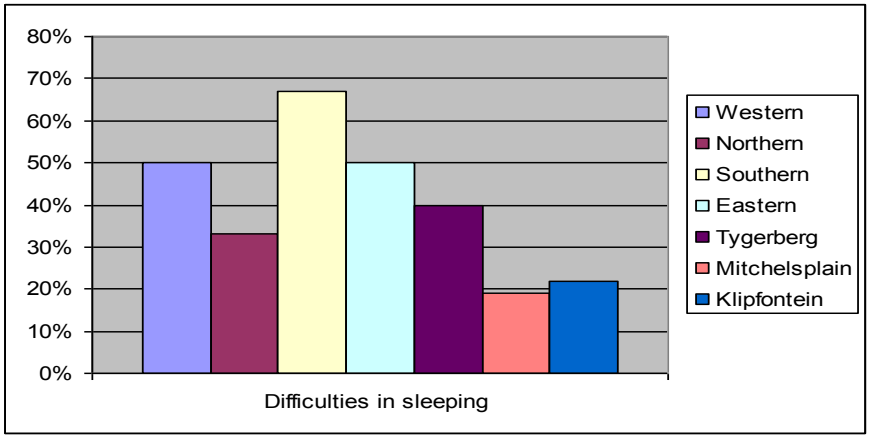


Chart 4.7b: Frequency of panic attacks before going to work

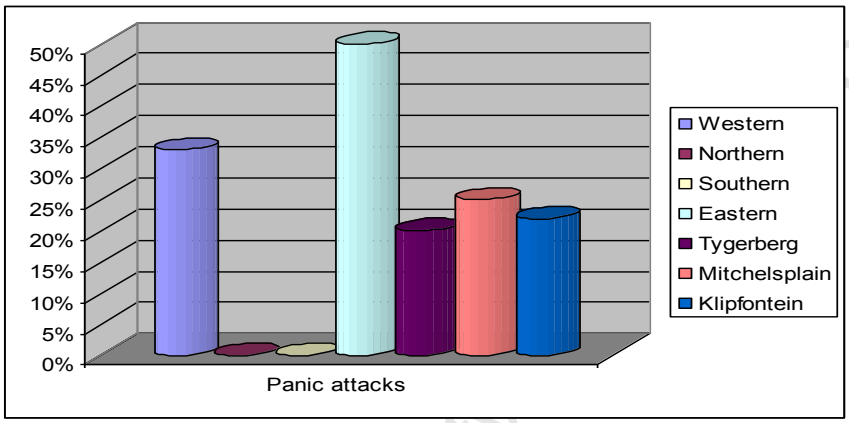


Chart 4.7c: Frequency that nurses indicated over activeness

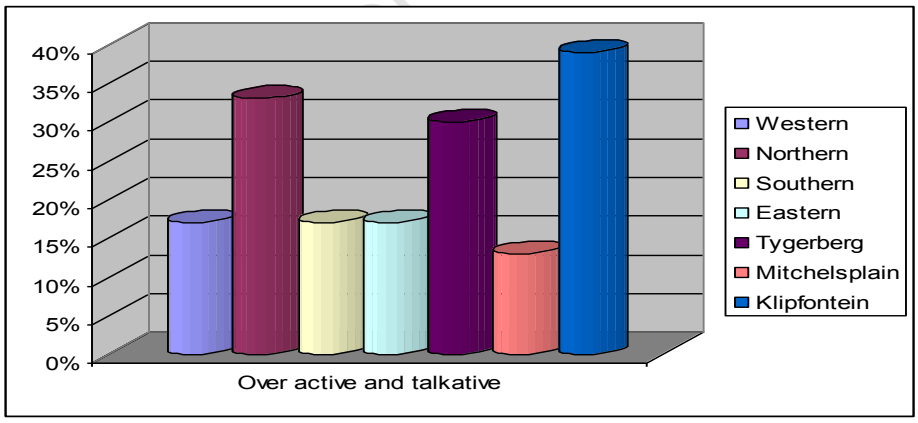


Chart 4.7d: Frequency of self medication among nurses working in the clinics

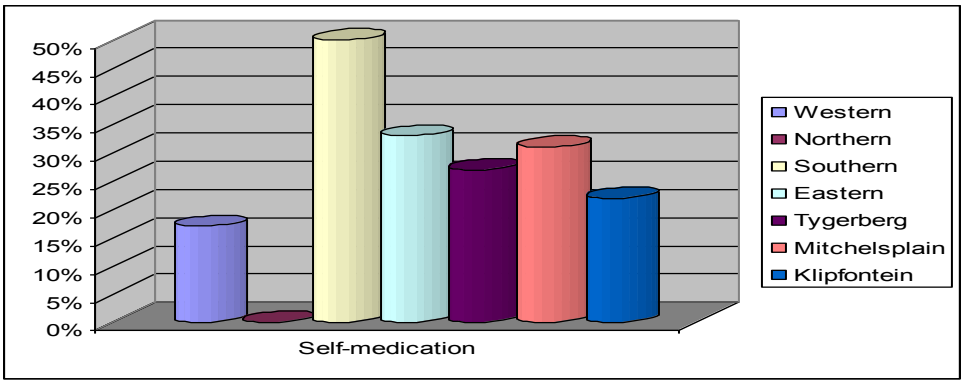


Chart 4.7e: Frequency of feeling of withdrawn among nurses working in the clinics

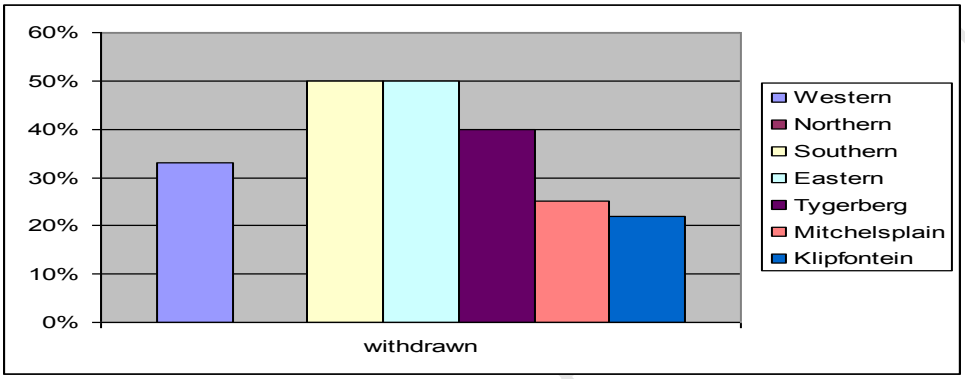
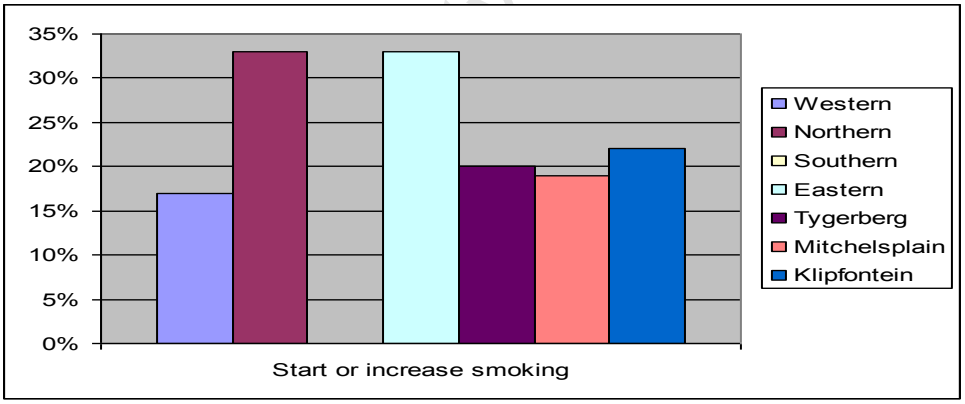


Chart 4.7f: Frequency of increasing smoking by nurses working in the clinics



4.8 Results of Official Documents Review

Efforts were made to gain access to official documentation as supporting information provided in questionnaires and interview responses. Difficulties were encountered with this process. According to Mitchells plain, Western and Klipfontein nurse managers from whom such records were requested, most cases are dealt with by the unit managers. Violence against nurses never gets officially recorded since nurses never lay complaints against patients for abusive behaviour. Five nurse managers indicated the worst that happens is that patients are evicted by security, but no record is kept of such incidences. Six clinic nurse managers were requested to provide access to official documents, e.g. incidence report, etc. all but one refused access. Only one clinic allowed access to one document. The one attendance records file made available to the researcher showed that over three months period, most nurses on the particular clinic reported sick for two day after violent incidences but return to duty on the third day. The two-day sick leave appeared to be a pattern across in the record book. All categories of nurses except senior nurse-managers had two-day sick leaves at regular intervals.

4.9 Similarities and differences in questionnaire and interview responses

The interview and questionnaire responses both confirmed that there had been violent incidences against nurses. In the same two data sources, women were identified as the main perpetrators of violence against nurses in the participating community health clinics. Although questionnaire responses identified Mondays (Chart4.4m) and Fridays (Chart 4.4n) as the most violence days in most participating clinics, interview responses did not support this information, i.e. no specific day was identified. From the two data sources, verbal abuse was identified verbal abuse as the most frequent form of violence perpetrated against nurses. Although some respondents had experienced physical abuses (Chart 4.4b) on numerous occasions, only one informant stated that she was attacked physically by a patient's family member. However the questionnaire respondents indicated that psychological violence had the highest response rates (Chart 4.4r-Chart 4.4w).

Interview and questionnaire responses (Chart 4.4b) confirmed existence of violence amongst nurses. Both interview responses and questionnaire results (Charts 4.4r – 4.4x) identified psychological violence as the most common form of violence among nurses in all participating clinics. Verbal abuse and shouting were the most common form of psychological violence among nurses. The main categories of perpetrators of psychological violence among nurses

were professional nurses and senior nurse managers (Charts 4.4r – 4.4x). Information on other levels of violence was evident only questionnaires but no information discussed during interviews because of time constraints.

Both questionnaire and interviews confirmed some evidence of violence by nurses. The main forms of violence by nurses in both data sources were verbal abuse and shouting but no physical attacks. Information on the effects of violence on nurses was only available from questionnaire responses. Both questionnaire and interview responses had similar information on management of violence within participating clinics. There were similarities of information in both data sources that there were support systems available for nurses experiencing violence.

4.10 Constraints and limitations during data analysis

During distribution and collection of questionnaire, clinics were geographically very far apart, e.g. from Tygerberg clinics to Mitchells plain clinics was about 25 kilometres distance between clinics. The other constraint during questionnaire collection was that in some clinics, they requested for extra time to complete and even with time extension, returned uncompleted questionnaires. As indicated earlier, only one official document was made available. The third constrain was that although senior nurse-managers agreed to be interviewed, at start of sessions they would indicate that they could only spare 5 minutes. Therefore, during the interviews only the key headings contained in the objectives were utilised to elicit information required. The fourth limitation related to analysis of responses from both questionnaires and interviews.

Written responses on questionnaire and interview responses generated 60 pages of information, whilst quantitative data from questionnaires' analysis generated 41 pages of tables (frequency distributions and percentages). However, because of academic requirements most of the table contents had been presented as charts or presented in the results above sections. The main limitations of the study were that although some respondents selected both yes and 'does not happen' sections on each question contained in the questionnaire. Some senior nurse-managers refused to participate in the study for fear of being reprimanded by area nurse-managers. Some key areas of the study could not be discussed during interviews because key informant permitted only few minutes' conversation and information giving sessions. Similarly, participants of the study were reluctant to be interviewed because of fear of possible intimidation from colleagues.

4.11 Summary

A total of 85 responses were achieved in the seven sub districts of Tygerberg, Mitchell plain, Klipfontein, Eastern, Northern, Southern and Western. The sample consisted mostly of experienced nurses. Women were found to be the main perpetrators of violence against nurses. Violence occurred mostly on Mondays, usually in the form of verbal abuse, with no specific predilection for category or group of nurses. Most nurses share their experiences with colleagues. Violence also occurs amongst nurses mostly in the form of psychological violence

using verbal abuse. Physical violence also occurs through the sabotage of other nurses' work. Vertical, horizontal and covert violence are mostly perpetrated by professional nurses using verbal abuse. Overt violence is mostly perpetrated by professional nurses through avoidance of close contact. Violence by nurses against others is mostly directed at patients through gossiping about them. Nurses generally thought of good patients as those who are obedient and polite, and bad patients as those who constantly complain.

Recommendations for the management of violence include counselling, attentiveness to nurses' complaints, assertive training, more security and employing more nursing staff. Many nurses felt depressed following violent episodes, including symptoms such as insomnia, panic attacks, self-medicating, smoking and withdrawing. Responses by nurses to violence includes a conscious effort to remain calm, shouting at their own families, talking to someone, group discussions, praying and physical exercise. Many nurses felt that managers' attitudes played an important role in reducing violence. Most nurses were not aware of employee assistance programmes. Recommendations of action to be taken against nurses who treat patients badly include reporting them, counselling and training. Sensationalism by the media was blamed for the negative publicity surrounding nurses treating patients badly.

Only limited access was granted to official documents. The main reason for this is the lack of official reporting of violent incidences. The document that was reviewed revealed a pattern of sick leave associated with violent incidences.

Interview responses and questionnaire responses were mostly in agreement concerning the occurrence of violent incidences. Constraints and limitations were mostly related to logistical problems, availability of interviewees, and time constraints in answering the questionnaires. Academic requirements limited the volume of data which could be made available in this study.

Chapter 5: Discussion and Recommendations

5.1 Introduction:

The chapter will present discussions on results obtained and supported with academic literature. The chapter will discuss violence against nurses, types of violence, and perpetrators and days of the week that violence attacks are at their highest. The will also discuss findings on violence amongst nurses and by nurses against others. It will discuss some of the effects of violence on nurses and management of violence. It will also indicate ways that study objectives had been achieved and suggest areas for further research.

5.2 Violence against nurses

Violence against nurses is a reality in the community health clinics as confirmed by the findings of this study (Luck, et al 2007; Farrell, et al, 2006: 778-787). Most respondents agreed that there is violence in nursing but that the violence were not consistent but occurred sometimes (Chart 4.3b; Wells and Bowers 2002: 230-240, Bronner, et al 2003: 637-644; Lee 2001: 3-8). Verbal abuses accounted for 92% all violent incidences against nurses in the participating clinics. The main perpetrators were women, gang members and patients' relatives (Table 4.3b; Wildschut and Mqolozana, 2008: 25; Steinberg, 2003: 134; Steinman, 2003:133). The study has found that the clinic situated in gang invested area has more violence e than those in more quiet sub-districts. Community health clinic are situated as close to the people it is therefore, impossible not to experience the social challenges the rest of the community experience (Silber and Geffen 2009; Gilson et.al 2004; Dinan 2004).However, perpetrators varied among the sub-districts, e.g. in Tygerberg gang members were the main perpetrators (Chart 4.3h) but in Klipfontein patient relatives were identified (Chart4.3k). The highest incidences of violence occur on Mondays and Fridays (Charts 4.3m-4.3n). Most nurses have heard of colleagues that had been verbal abused or threatened behaviours (Chart 4.3r; Wells and Bowers 2002: 230-240; Bronner, et al 2003: 637-644; Lee 2001: 3-8). The extent of violence in the community appeared much higher than the 53% found in the public hospital settings in Cape Town (Khalil 2009: 210). This study has achieved the first objective, i.e. to examine the extent of violence against nurses in community health clinics (Appendix G). Findings support stages one to three presented in the conceptual model (page 19)

5.2.1 Recommendations

- Clear guidelines needs to be formulated and standardized in all community health centres on protocol to be followed when faced with violent situations
- Nurse's needs to be well informed of protocols to be followed when faced with violence.
- Efforts should be made to educate the public through media houses and posters on issues affecting nursing services provision in the country
- Health care consumers who violate nurses should be identified and prosecuted (Coyne 2002; Khalil 2009).
- Increase security personnel's presence in clinics on days that violent incidences are at their highest.
- Provide specialised counselling services for nurses experiencing violence in community clinics.

5.3 Violence amongst nurses in community clinics

Majority of participants (57.6%) agreed that there is violence amongst nurses (Chart 4.4a; Khalil 2009). Psychological (51.8%) and vertical (48.2%) are the most common form of violence among nurses working the health centres (Anderson and Parish, 2003:237-243; Stanley et.al 2007:1247-1265). According to informants interviewed, some reasons for the violence amongst nurses were professional jealousy, and abuse of power. Verbal abuse was common amongst nurses at all levels of violence except physical (sections 4.4; Khalil 2009; Woelfle and MaCaffrey, 2007: 123-131 and Mckenna, 2003: 12). Professional nurses were identified as main categories of nurses that verbally abuse and shout at other nurses (charts 4.4r; 4.4s; 4.4bb; 4.4hh; 4.4qq; 4.4xx; Stanley et.al 2007:1247-1265)

Discrimination among nurses was evident at levels of violence among nurses except physical, (charts 4.4w; 4.4dd; 4.4kk; 4.4ss; 4.4aaa). Bully amongst nurses was evident and the main perpetrators were senior nurse managers (Charts 4.4x; 4.4gg; 4.4mm; Hippeli 2009:186; Mladineo, 2006:44-6; Joley and Brykczynska, 1995: 81; Stanley et.al 2007:1247-1265). However, all categories of nurses except student nurses tended to overtly discriminate against other nurses (chart 4.4bbb). The evidence showed that the study achieved its second objective, i.e. the extent to which violence exist amongst nursing staff working in community health clinics. The findings support stage four presented in the conceptual model (page 19).

5.3.1 Recommendations

- The fostering of teamwork is a requirement to counter violence among nurses
- Team building meetings should be held to clear any suspicions or ill feelings.
- Violence amongst nurses ought not to occur in the profession because such behaviours discredit the profession
- The consequences to the patient of lack of communication among staff should be continuously re-iterated
- There should be close monitoring of all forms of violence amongst nurses
- All complaints of bullying, discrimination, intimidation and harassment should be impartially investigated.
- All nurses must be made aware the negative effects of violence on other nurses and the consequences of such acts on patient care.
- The onus should not be on the victim to prove that he/she is being bullied, etc. instead managers should initiate systems of ensuring that all nurses are empowered to carry out their duties without any form of intimidation.

5.4 Violence by Nurses against other in Community Health Clinics

This study found violence by nurses against others in the community is evident. All categories of nurses showed the propensity to treat patients badly because they are noisy, drunk or disobey their orders (Chart 4.5a-Chart 4.5j). This study further highlighted the propensity of nurses to verbally (Chart 4.5b), to shout (Chart 4.5c), to swear (Chart 4.5d), to discriminate (Chart 4.5e), bully (Chart 4.5f), and gossip (Chart 4.5g), about patients. Khalil (2009) study found nurses were rude with patients and shouted at patients. Khalil (2009) study suggested that nurses tended to label patients as either being 'good' or 'difficult'. These patients were awarded with kindness and tender loving care, and the 'bad' ones were completely ignored or any intervention or care was deliberately delayed (Khalil 2009). Other nurses were showing racial discrimination towards patients (Khalil 2009). Jewkes, Abrahams and Mvo (1998:1781-1795) found that many of the patients had experienced violence from nurse in the form of verbal and physical abuse. Lucas and Stevenson (2005: 195-203) also documented abuse of psychiatric patients. The finding confirmed that the third objective of the study had been achieved, i.e. to explore nurses' response and attitude towards health care consumers based on violence in the workplace. The findings support stage five presented in the conceptual model (page 19).

5.4.1 Recommendations

- Interpersonal skill training should be part of curricula of nurse training to learn how to deal with difficult patients avoiding perpetrating of violence
- Medico-legal exposure needs to be increased at training level to increase the awareness of consequences of certain actions or lack thereof.
- Ongoing professional training similar to that implemented with doctors should be commenced, including ongoing compulsory ethical training.
- Immediate short term solutions is to motivate for increasing the staff compliment for those health care centres experiencing the most violence in order to reduce workload on individual staff members.

5.5 Management of violence in community health clinics

Violence against nurses was found to have severe consequences on the nurses' health. The majority of respondents expressed that they have difficulties in sleeping at night (Chart 4.7a). All types of reactions presented were experienced to a greater or lesser extent by respondents, including being over active and talkative, visit doctor for medication, panic attacks before going on duty, marked changes in bodily functions, eating more, started or increased smoking, skin changes e.g. eczema, visit psychologist for support and increased alcohol intake. The study had shown nurses tended to self-medicate (Chart 4.7d) and became more withdrawn (Chart 4.7e) in order to cope with the level of violence (Stanley et.al 2007:1247-1265).

The study findings were similar to Celik and Celik, (2007: 359-366) who found in their study conducted in Turkey, workplace violence affected their work performance and headaches were more frequently reported. They also concluded that the victim's reactions against abusive behaviour were anger, helplessness, humiliation, and depression (Stanley et.al 2007:1247-1265). This resulted in an increase in absenteeism and sick leave. The key interview informants indicated that nurses tend to request more sick leaves (Stanley et.al 2007:1247-1265). The findings confirmed that the study achieved the fourth objective. Findings also support stage seven presented in the conceptual model (page 19).

5.5.1 Recommendations

- Violence in nursing ought to be managed in-service training programmes
- Government to address the severe shortage of nurses in community health clinics in cape town
- Increase security for nurses in community health clinics as indicated earlier

5.7 Recommendations for Future Research

5.7.1 Violence against nurses

- Violence against nurses is inextricably linked to violence in the community. Dealing with violence against nurses cannot therefore be confined to the medical environment, but has to involve the entire community. Co-operation and discussion between sociologist and the nursing fraternity would be more productive in managing violence against nurses.
- An important finding of this dissertation is the fact that women are the foremost perpetrators of violence. Possible links to women abuse and their abusive behaviour towards nurses needs to be explored. This requires a separate investigation, in conjunction with the assistance of sociologists involved in the area of women abuse research.
- Clear guidelines needs to be formulated and standardized in all community health centres on protocol to be followed when faced with violent situations
- Nurse's needs to be well informed of protocols to be followed when faced with violence.
- Short term measures needs to be introduced in the form of improved security. Research findings have shown Mondays and Fridays to be days on which security should be increased. This dissertation will also provide various sub-districts specific information as to the days on which these areas experience the most violence, and can therefore customize their security needs.
- Recommendations should be made that separate records are kept of all violent related incidences. This would serve as a quick guide to learn from previous experiences. Trends as far as increasing or decreasing frequency of violent incidences can then be traced, and acted upon.
- Experts in assertive training should be invited to conduct assertive training workshops to empower staff with the necessary skills to be assertive without being violent.
- Findings of the study will be published in three articles

5.7.2 Violence among nurses

- The fostering of teamwork is a requirement to counter violence among nurses
- The consequences to the patient of lack of communication among staff should be continuously re-iterated
- Team building meetings should be held to clear any suspicions or ill feelings.

5.7.3 Violence by nurses against others

- Interpersonal skill training should be part of curricula of nurse training to learn how to deal with difficult patients avoiding perpetrating of violence
- Medico-legal exposure needs to be increased at training level to increase the awareness of consequences of certain actions or lack thereof.
- Ongoing professional training similar to that implemented with doctors should be commenced, including ongoing compulsory ethical training.
- Immediate short term solutions is to motivate for increasing the staff compliment for those health care centres experiencing the most violence in order to reduce workload on individual staff members.

5.7.4 Summary

This chapter discussed the results, comparing it to international and local findings. Questionnaire findings were cross referenced with interview findings demonstrating in this process the achievement of all five objectives of the study. The first objective is the extent of violence against nursing staff which was shown to occur in all seven sub-districts. These findings are consistent with international findings confirming the presence of violence directed at nurses in the nursing environment. The second objective achieved was to show the extent of violence amongst nurses. This also occurred across the seven sub-districts, mostly in the form of psychological violence. The third objective achieved was that of exploring nurses' attitudes resulting from the experience of violence. These latter experiences were found to be associated with violence by nurses against others in the community, violence to others occurring mainly because patients were noisy, drunk or disobedient. Forms of violence by nurses against others were mainly verbal, discriminatory, bullying, shouting and gossiping. The fourth objective achieved was the identifying of strategies used to manage violence in the community health care clinics. These strategies included being lenient to staff, referring to EAP, and disciplinary

measures such as warnings. The final objective achieved was to offer recommendations based on this study. These included the working out of protocols to be followed when violence occurs, official recording of violent incidences to aid future research, fostering of teamwork, interpersonal skill training and addressing staff shortages. Recommendations for future research were also made which included exploring the link between violence in the community and violence occurring in the nursing environment and also its link to women abuse.

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Appendix A: Permission to conduct research

Civic Centre
12 Hertzog Boulevard
Cape Town 8001
P O Box 2815 , 8000
Ask for: Dr I Bromfield
Tel: 021 400 2100
Cell: 084 629 5364
Fax: 021 421 4894
E-mail: ivan.bromfield@capetown.gov.za
Website: http://cityweb.capetown.gov.za
Ref:
Filename: \\cbd-civic-039\Home$\lbosman1\My Documents\novell\wpdocs\city Health\letters\Permission to visit clinics ~ Prevalence of violence in nursing profession.doc

Iziko loLuntu
12 Hertzog Boulevard
Cape Town 8001
P O Box 2815 , 8000
Cela: Qrh I Bromfield
Umnxeba: 021 400 2100
Cell: 084 629 5364
Ifeksi: 021 421 4894

Burgersentrum
Hertzog-boulevard 12
Kaapstad 8001
Posbus 2815 , 8000
Vra vir: Dr I Bromfield
Tel: 021 400 2100
Sel: 084 629 5364
Faks: 021 421 4894

CITY HEALTH

2008-09-05

Ms Faiza Kajee

Dear Ms Kajee

PERMISSION TO CONDUCT RESEARCH – PREVALENCE OF VIOLENCE IN NURSING PROFESSION

The City Health Department has no objection in you visiting the mentioned City Health facilities in order to conduct the above research.

This permission is subject to you liaising with the relevant Sub District Manager prior to the visit (contact details below).

Manager	Sub District	Tel No.	Email
Dr Paul Nkurunziza	Eastern	850-4315	Paul.nkurunziza@capetown.gov.za
Dr Virginia Azevedo	Khayelitsha	360-1258	Virginia.DeAzevedo@capetown.gov.za
Ms Gertrude Mathe (Acting)	Klipfontein	633-2010	gertrude.mathe@capetown.gov.za
Mrs Soraya Elloker	Mitchells Plain	391-5012	Soraya.elloker@capetown.gov.za
Mr Andile Zimba	Northern	980-1230	Andile.zimba@capetown.gov.za
Mrs Lumka Bakana	Southern	710-8295	Lumka.bakana@capetown.gov.za
Mrs Merle Alexander	Tygerberg	938-8279	Merle.alexander@capetown.gov.za
Mrs Monica Sifanelo	Western	443-7108	Gloria.Monica.Sifanelo@capetown.gov.za

Yours sincerely

DR IVAN BROMFIELD
EXECUTIVE DIRECTOR: CITY HEALTH

THIS CITY WORKS FOR YOU ESI SIXEKO SISEBENZELA WENA HIERDIE STAD WERK VIR JOU

Appendix B: Ethical Approval UCT

UNIVERSITY OF CAPE TOWN

Health Sciences Faculty
Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6338 • **Facsimile** [021] 406 6411
e-mail: lamees.emjedi@uct.ac.za

20 May 2008

REC REF: 166/2008

Ms Faiza Kajee
C/o Dr D Khalil
Nursing & Midwifery
Health & Rehab

Dear Ms Kajee

PROJECT TITLE: VIOLENCE IN NURSING: ITS PREVALENCE AND IMPACT IN COMMUNITY HEALTH CLINICS IN THE CITY OF CAPE TOWN

Thank you for submitting your study to the Research Ethics Committee for review.

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above-mentioned study.

Approval is granted for one year till the 31st May 2009.

Please submit a progress report if the study continues beyond the expiry date or a closure report if completed within the period of approval.

Your comments to the queries raised are noted with thanks.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

lemjedi

Appendix C: Ethical Approval

UNIVERSITY OF CAPE TOWN

School of Health and Rehabilitation Sciences

Divisions of Communication Sciences and Disorders
Nursing and Midwifery. Occupational Therapy
Physiotherapy

Old Main Building Groote Schuur Hospital Observatory ·7925
Telephone: +27 21 4066401
Fax: +27 21 4066323

Prof. T. Zabow

Chairperson

Research Ethics Committee

REC.REF: 410/2004

November 2007-12-27

Dear Sir

Re: Ethics Approval

I am requesting ethical clearance for Ms Faiza Kajee (UCT M .Sc Student).

She will be conducting research in the Community Health Clinics and be part of my broader study into "Violence in Nursing". Ms Kajee request to modify the questionnaire of my study, to focus on violence amongst nurses, against nurses and by nurses in the Community Health Clinics in the Western Cape. The population of her study would include all categories of nurses in the CHC.

I have attached the following documents:

- My ethics clearance letter
- Copy of Ms. Kajee's research proposal

I am Ms Kajee's supervisor and take full responsibility for her research activities. I look forward to hear from your office soon

Yours sincerely

Doris Khalil

PhD MA BA (Hon) RN RM RNT

Appendix D: Invitation to participate in the study

UNIVERSITY OF CAPE TOWN

School of Health and Rehabilitation Sciences

Divisions of Communication Sciences and Disorders
Nursing and Midwifery, Occupational Therapy
Physiotherapy

Old Main Building, Groote Schuur Hospital Observatory, 7925
Telephone: +27 21 4066401
Fax: +27 21 4066323

November 2007

Dear Participant

Re: Study on Violence amongst nurses, against nurses and by nurses in CHC in Western Cape

I am currently an M.Sc (Nursing) student at the above university and a clinical supervisor at the University of Western Cape, School of Nursing. Part of my requirements to complete my Msc, I have to conduct a research project. This research will be part of a bigger study that will examine the phenomena of violence in nursing. My research project will contribute violence in the Community Health Clinics. The area of research would be violence against nurses, violence amongst nurse and violence by nurses in the CHC in the Western Cape. This is a consent letter that will explain the purpose of the study and requesting permission from you to participate in the research.

Purpose:

I am herewith inviting you to participate in a research study. The purpose of the research is to collect data concerning violence in nursing in the CHC in the Western Cape, and present these findings to management.

Potential Benefit:

The study will benefit you and future nurses, in that management should act on these findings in an endeavour to continuously improve the working conditions in the CHC.

Risks:

There should be no risks or discomfort in sharing your experiences.

Time Commitment:

Your participation will mean that you will have to complete a questionnaire that would take approximately half hour to complete.

Explanation of procedure:

I will keep a record of who has participated in the study, and I will keep the recordings of the questionnaires together with the transcription. The data obtained will not be linked to your name.

Anonymity:

All data will be stored in a secure place and nobody except the primary researcher will have access to this information. Your identity will not be revealed when the study is published.

Offer to answer any questions:

If you have any questions concerning the study or about participating in it, please feel free to contact me (Faiza Kajee) at 021-6968285/0826608480.

Voluntary consent option to withdraw:

Your participation in this study is totally voluntary. You have no obligation to participate, and you may withdraw anytime you so desire, without having to fear repercussions or penalties. There is absolutely no financial commitment required from you.

Board of Ethics Committee:

The research committee of the University of Cape Town and Director of Metro Health Services of the Western Cape has approved this study and its procedure.

I understand that my participation is voluntary and that I may refuse to participate, or withdraw my consent and stop taking part at any time without incurring a penalty. I hereby freely consent to take part in this research project.

Researcher: Ms Faiza Kajee

Clinical Supervisor UWC 3RD and 4TH year

Contact Details:

Tel: 021-6968285/0826608480 Subject signature: Date:

Appendix E: Permission to conduct research

UNIVERSITY OF CAPE TOWN

School of Health and Rehabilitation Sciences

Divisions of Communication Sciences and Disorders
Nursing and Midwifery. Occupational Therapy
Physiotherapy

Old Main Building Groote Schuur Hospital Observatory ·7925
Telephone: +27 21 4066401
Fax: +27 21 4066323

November 2007

TO: Director of Metro Health Services

Re: A research study on violence in nursing: violence amongst, against and by nurses.

I am currently an M.Sc (Nursing) student at the above university and a part-time clinical supervisor at The University of Western Cape, School of Nursing. Part of my requirements to complete my master's degree is to conduct a research project. My area of interest is community health clinics. I herewith request your permission to conduct a research project in all the Community Health Clinics in the Western Cape. The main focus of the proposed study would be: violence amongst nurses, violence against nurses and violence by nurses.

The global phenomena of violence in the health sector are on the increase. The aim of this study is to explore violence in nursing within community health care settings.

Objectives:

To examine the extent of violence against nursing staff in community health care settings

To determine the frequency of violence against nursing staff in community health settings

To investigate the extent to which violence exists amongst nursing staff working in community health care settings

To explore nurses' response and attitude towards health care consumers based on violence in the workplace.

The process of the study consists of a distribution of questionnaires to all the CHC in the Western Cape and will be utilised for collection of data. Data will be collected over one to two month period, specifically in March and April 2008. A pilot study was conducted amongst first year nursing students, to establish the prevalence of violence in nursing in the Western Cape. This

determined the appropriateness of the questionnaires distribution method, the suitability with regards to instructions given, the language used and the time it took to complete it.

Confidentiality and anonymity is assured, in this manner no names or personal details will be indicated or be available for scrutinising except to the primary researcher. The final report of the study will be given to the director of Metro Health Services. Should you require any further information regarding this proposed research project, please do not hesitate to contact me.

I thank you in anticipation for your support and co-operation.

Yours faithfully

……

Ms. Faiza Kajee, Primary Researcher

Appendix F: Questionnaire

Research Title: Violence in Nursing

Confidential QUESTIONAIRE

Thank you for agreeing to participate in the study. The aim of the study is to examine the dynamic relationships and extent of violence in nursing. Kindly spend some time to read through and answer all questions. The questionnaire is divided into sections to help you focus your responses. Please do not write your name

Section A - general questions

1. How long have you been working as a nurse or midwife or nurse learner? **Please tick only one box**

Less than one year	1-2 yrs	3-4 yrs	5-6 yrs	7-8 yrs	9-10 yrs	11-12 yrs	13-14 yrs	15-16 yrs	More than 16 yrs

2. Which specialist areas are you currently working?

Elsies River Clinic [ ] Adriaanse Clinic [ ] Bishop Lavis Clinic [ ] Ravensmead Clinic [ ] Leondale Clinic [ ] Netreg Clinic [ ] Kasselsvlei Clinic [ ] Mathew Gonewe Clinic [ ] Vanguard Clinic [ ]

Guguletu Clinic [ ] Bonteheuwel Clinic [ ] Langa Clinic [ ] Guguletu Clinic [ ]Keyalitsha Clinic [ ] Heideveld Clinic [ ] Silvertown Clinic [ ]

Hanover Park Clinic [ ] Manenberg Clinic [ ] Lansdowne Clinic [ ]

Honeyside Clinic [ ] Philipi Clinic [ ] Lotus River Clinic [ ]

Grassy Park [ ] Diep River Clinic [ ] Claremont Clinic [ ]

Wynberg Clinic [ ] Retreat Clinic [ ] Chapel Street Clinic [ ]

Bellville South Clinic [ ] Newlands Clinic [ ] Private satellite H/C [ ]

Delft South Clinic [ ] Belhar Clinic [ ] Blue downs Clinic [ ]

Matroosfontein Clinic [ ] Agency nurse [ ]

Community Health Clinics not mentioned, please specify [ ]

3. Do you agree with the aims of the study?

4. What other aspects of violence in nursing would you like to be included in the study?

Section B- violence against nurses

1. Do you believe there is violence in nurses within the workplace environment?

No [ ] Yes [ ] Sometimes [ ] Not sure [ ]

Please elaborate ….

2. Which of the following groups tend to be violent against nurses?

Men [ ] Women [ ] Young children [ ]

Adolescent males [ ] Adolescent females [ ] Vagrants [ ]

Drunks [ ] Drug addicts [ ] Doctors [ ]

Emergency service staff [ ] Ambulance drivers [ ] Student nurses [ ]

Medical students [ ] Patient relatives [ ] Enrolled nurses [ ]

Psychiatric patients [ ] Professional nurses [ ] Gang members [ ]

Enrolled nursing auxiliary [ ] All of the above [ ] none of the above [ ]

Others please specify…

3. On which of these days and time in your opinion, do people display violent behaviour against nurses?

Monday [ ] morning [ ] afternoon [ ]

Tuesday [ ] morning [ ] afternoon [ ]

Wednesday [ ] morning [ ] afternoon [ ]

Thursday [ ] morning [ ] afternoon [ ]

Friday [ ] morning [ ] afternoon [ ]

End of the month [ ] every pay-day [ ] during bank holidays [ ] every day [ ] none of the above [ ]

4. What types of violent incidents have you observed in your areas of practice?

Threatening behaviours Yes [ ] No [ ] Sometimes [ ]

Physical assaults Yes [ ] No [ ] Sometimes [ ]

Verbal abuses Yes [ ] No [ ] Sometimes [ ]

Others please specify-

5. What types of violent incidents have been indicated to you?

Threatening behaviours Yes [ ] No [ ]

Physical assaults Yes [ ] No [ ]

Verbal abuses Yes [ ] No [ ]

Others, please specify -

6. How many nurses had discussed their experiences of violent incidents with you? Please indicate numbers

None	1 nurse	2-3 nurses	4-5nurses	6-7 nurses	8-9 nurses	10 or More nurses

7. What types of violent incidents have you experienced personally?

Threatening behaviours Yes [ ] No [ ]

Physical assaults Yes [ ] No [ ]

Verbal abuses Yes [ ] No [ ]

Use of sharp or blunt objects Yes [ ] No [ ]

Others please specify …

8. In your view, is violence directed against specific grade of nurses?

Yes [ ] No [ ]

If yes, please elaborate

9. From your working experience, are violent incidents directed at a specific category of nurses?

Yes [ ] No [ ]

10. Which of these categories of nurses tend to be exposed to violent incidents? Please indicate below

Categories of nurses	Frequency of violent incidence				
	Often	Sometimes	Occasionally	Never	Not sure

Enrolled nurses					
Professional nurses					
Learner nurses					
Midwives					
Emergency care nurses					
Theatre nurses					
Matrons					
Enrolled nursing auxiliary					
Intensive care nurses					
Forensic nurses					
Nursing managers					
Psychiatric nurses					
Paediatric nurses					

11. In your view, is violence directed against nurses from specific ethnic, cultural, or religious groups?

Ethnic: No [ ] Yes [ ] Cultural group: No [ ] Yes [ ]

Religious group: No [ ] Yes [ ]

12. Which of these groups tend to be frequently exposed to violent incidents?

	Yes	No	Not sure
White nurses			
Black nurses			
Coloured nurses			
English speaking			
Afrikaans speaking			
Xhosa speaking			
Muslim nurses			
Christian nurses			
Atheist nurses			
Jewish nurses			
Hindu nurses			
Agnostic nurses			
Foreign nurses			
All types of nurses			
None of the above			

13. From your observations, would you say violence against nurses is on the increase?

Yes [ ] No [ ] Not sure [ ]

- If your answer is yes - what in your view are some of the factors contributing to the increase in violence against nurses?

- If your answer is no - what in your view are some of the factors contributing to the decrease in violence against nurses?

14. If yes, what are some of the factors that have contributed to the decrease in violence

against nurses? Please specify

15. Please, use this section to share your views and experiences of violence against nurses.

Section C- violence amongst nurses

1. Do you believe that nurses are sometimes violent against other nurses?

Strongly agree	Agree	Not sure	Disagree	Strongly disagree

Please elaborate or give example: -

Please indicate with a cross (X) the number that represents in your view, the extent of violence amongst nurses, i.e.

(0=none and 10=high)

0	1	2	3	4	5	6	7	8	9	10

2. From your experience, indicate whether **violence amongst nurses** is evident at these levels.

Physical No [ ] Yes [ ] Not sure [ ]

Psychological or mental No [ ] Yes [ ] Not sure [ ]

Vertical or up/down line of command No [ ] Yes [ ] Not sure [ ]

Horizontal or among same grade No [ ] Yes [ ] Not sure [ ]

Covert or secretly No [ ] Yes [ ] Not sure [ ] Overt or clearly obvious No [ ] Yes [ ] Not sure [ ]

3. Based on your observation and/or experience of **violence amongst nurses**, please rate the frequency of the following, *i.e.* 1= less often; 10 = more often

Types of violence	1	2	3	4	5	6	7	8	9	10
Verbal abuse										
Shouting										
Insinuations										
Swearing										
Pushing										
Hitting										

Fights										
Discrimination										
Marginalisation										
Bullying										
Threats										
Use of wet objects										
Use of blunt objects										
Use of sharp objects										
Use of other objects										

Others please specify …

4. Please indicate which of the following could be referred to as **physical violence amongst nurses** and by which category of staff

Types of physical violence	By professional nurses	By enrolled nurses	By enrolled auxiliaries	By learner nurses	Senior nurse managers	Does not happen
Physical threats						
Pushing						
Assault with no external injuries						
Fist fights with no external injuries						
Sabotage of personal items						
Assault with wounds inflicted						
Fist fights with injuries inflicted						
Fights or attack by a group of nurses						

Others please specify ….

5. Please indicate which of the following could be referred to as **psychological violence among n**urses

Types of psychological violence	By professional nurses	By enrolled nurses	By enrolled auxiliaries	By learner nurses	Senior nurse managers	Does not happen
Verbal abuse						
Shouting						
Insinuations						
Swearing						
Humiliation						
Devalued						
Intimidation						
Discrimination						
Isolation						
Marginalisation						
Bullying						
Being ignored						
Labelling						
Innuendoes						

Others, please specify

6. Please tick (X) which of the following occurs more frequently in **vertical violence amongst nurses** i.e. either down or up along the hierarchical system.

Types of vertical violence	By professional nurses	By enrolled nurses	By enrolled auxiliaries	By learner nurses	Senior nurse managers	Does not happen
Verbal abuse						
Shouting						
Insinuations						
Swearing						
Pushing						
Assault						
Fist fights						
Discrimination						
Marginalisation						
Bullying						

Humiliation						
Being ignored						
Devalued						
Innuendoes						

Others please specify ….

7. Please indicate which of the following occurs more frequently as evident of **horizontal violence amongst nurses** of the same grade/level.

Types of horizontal violence	By professional nurses	By enrolled nurses	By enrolled auxiliaries	By learner nurses	Senior nurse managers	Does not happen
Verbal abuse						
Shouting						
Insinuations						
Swearing						
Pushing						
Assault						
Fights						
Discrimination						
Marginalisation						
Bullying						
Harassment						
Devalued						

Others please specify -

8. Please indicate which of the following occurs more frequently and/or could be referred to as **covert violence amongst nurses,** i.e. subtly or secretly 'conducted'**.**

Types of covert (secretly) violence	By professional	By enrolled	By enrolled auxiliaries	By learner	By senior nurse	Does not

	nurses	nurses		nurses	managers	happen
Verbal abuse						
Shouting						
Insinuations						
Swearing						
Pushing						
Assault						
Fights						
Discrimination						
Marginalisation						
Bullying						
Innuendoes						
Isolated						
Being ignored						
Malicious Gossip						
Stigmatisation						
Name calling						
Labelling						
Work sabotage						
Manipulating others to reject						

Others please specify …

9. Please indicate which of the following could be referred to as **overt violence amongst nurses**, i.e. obvious or easy to be noticed by all

Types of overt violence	By professional nurses	By enrolled nurses	By enrolled auxiliaries	By learner nurses	By senior nurse managers	Does not happen
Verbal abuse						
Shouting						
Insinuations						
Swearing						
Pushing						

Assault						
Fist fights						
Discrimination						
Marginalisation						
Bullying						
Avoiding close contact						
Innuendoes						
Threats						
Name calling						

Others please specify -

Section D-violence by nurses against others

1. Some nurses tend to act out their anger or frustrations against others. Please indicate which of these are affected by violence from nurses by rating 10 = more often, and 1 = less often

Groups	1	2	3	4	5	6	7	8	9	10
Other nurses										
Registrars										
Social workers										
Physiotherapists										
Patient visitors										
Patient relatives										
Black patients										
Coloured patients										
White patients										
Learner nurses										
Medical students										
Nursing tutors										
Nursing managers										
Own partner										
Own family										
Own children										
Consultants										

Junior Doctors										
Registrars										

Others, please specify -

2. Please, indicate types of violence displayed by the following:

Violent behaviours displayed	By professional nurses	By enrolled nurses	By enrolled auxiliaries	By learner nurses	By senior nurse managers	By other health professionals	Does not happen
Verbal abuse							
Shouting							
Insinuations							
Swearing							
Pushing							
Assault							
Fights							
Discrimination							
Marginalisation							
Bullying							
Use of objects							
Malicious gossip							

3. In your view, what are some of the qualities or behaviours displayed by patients that make them 'good patients'?

4. From your experience, in what ways do nurse reward 'good patients' in your unit/ward/department?

5. Indicate which of following qualities or behaviour, in your view makes a 'good patient'

Does not make too much fuse [ ] always does what he/she is asked to do by the nurses [ ]

Keep his/her area clean [ ] helpful to staff [ ] give presents to the nursing staff [ ]

Permit nurses to carry out procedures without complaint [ ] very polite [ ]

Does not ask too many questions [ ] helpful to other patients [ ]

Friendly and cheerful most of the time [ ] accept help without complaining [ ]

6. From your experience, what are some of the qualities or behaviours displayed by patients that make them 'bad or difficult patients'?

7. From your candid observations, how are 'bad patients' treated by other nurses?

8. How often have you noticed other nurses treating patients badly? Please indicate number of times

9. What actions in your view should be taken against nurses who covertly (secretly) mistreat patients in any health care institution?

10. From your experience, have you ever indicated another nurse or nurses for treating a patient badly?

11. What action or actions were taken against that nurse or nurses?

12. What actions were taken to rectify the situation or support the patient?

13. Have you ever witnessed a nurse treat relatives or families of patients unkindly, or speak rudely to them

14. From your experience, are some nurses mistreat or refuse to care for some patients because they are:

a) Dirty [ ] b) of different religion [ ] c) alcohol abusers [ ] d) foreigners [ ]

e) Abusive [ ] f) black [ ] g) coloured [ ] h) white [ ] i) have no health insurance [ ]

j) Old people [ ] k) homeless [ ]

15. Since you have been working as a nurse, have you ever witnessed a nurse or nurses physically attack a patient or his/her relatives? Please describe the incident.

16. Are the complaint and negative publicity that some nurses mistreat patients justified? Please elaborate your answer

Section E- management of violence in nursing

1. Please, indicate your position on the following statements

Violence in nursing exist because -	Not True	No views	True
The public are not happy with service provided by nurses			
Patients and their families have no respect for nurses			
Nurses are the street-level bureaucrats for the ministry of health			
Violence in society has spread to the hospitals and clinics			
Some nurses are in the job because of financial reasons			
Nurses as professionals do not support each other			
Some nurses equate quality patient care with bullying of other nurses			
Nurse managers bully junior nurses			
Not all nurses are compassionate to colleagues			
Not all nurses are compassionate to patients			
All nurses must undergo assertive training			
Nurses need to be trained in basic self-defence techniques			
In-service training programmes will increase the confidence of nurses			
Health and safety at work must focus more on nurses exposed to violence			
Some nurses are rude to senior managers only			
Nursing is no longer a calling but just like any other job			

2. In your view, how could violence in nursing is best managed at all levels of service provision?

3. Are there support systems in place to assist nurses to deal with violence in the work place?

Yes [ ] No [ ] Not sure [ ]

Additional comments -

4. Most ward and unit managers are supportive of nurses experiencing violence in the work place

True [ ] False [ ] No comments [ ]

Additional comments -

5. Initial nursing training programmes do not adequately prepare nurses to deal with violence in the work place.

Agree [ ] Disagree [ ] No strong views [ ] No comments [ ]

Other comments -

6. Regular assertiveness training workshops would enable nurses to deal with violence in the work place

Agree [ ] Disagree [ ] No strong views [ ] No comments [ ]

7. What measures and strategies would you like to be initiated or implemented to control the level of violence in nursing?

Section F- violence against self - optional information

1. How do you deal with work-related anger in the following situations?

a. at work
b. at home
c. your family

d. others in your community

2. Does the extent to which you are valued by your immediate manager and/or clients in the work environment affect your relationships with other?

Yes [ ] No [ ]

Please elaborate your answer…

3. Does the level of violence in nursing affect you in any of the following ways? Please circle as appropriate

a) Eating more	yes	no
b) Increase your alcohol intake	yes	no
c) Visit your Doctor for medication	yes	no
d) Visit Psychologist for support	yes	no
e) Self medication	yes	no
f) Become more withdrawn	yes	no
g) Difficulties in sleeping at night	yes	no
h) Skin changes, e.g. eczema	yes	no
i) Over active and talkative	yes	no
j) Panic attacks before going on duty	yes	no
k) Start smoking or increased	yes	no
l) Marked changes in bodily functions	yes	no

Others please specify …

5. General comments welcomed

Thank you for taking part in this study

Mrs Faiza Kajee Adams

Appendix G: Abstract Published Holland conference (October 2010)

Title: "Violence against Community Health Nurses in Cape Town, South Africa"

Authors: Mrs. Faiza Kajee Adams and Prof. Doris Dedeei Khalil

Affiliation: Division of Nursing, University of Cape Town, South Africa

Abstract:

Introduction: The paper will be focusing on violence against nurses working in community health clinics in Cape Town. The study is a replication of Prof Doris Deedei Khalil's (principle researcher) larger studies on violence in all areas of nursing including general, paediatric and psychiatric nursing, midwifery and undergraduate nursing schools. **Aim and objectives**: to explore violence in nursing within community health care settings. Some of the objectives of the study examined the extent and frequency of violence against nursing staff in community health clinics. **Research design:** phenomenological approach was selected to capture experiences and views of nurses working in selected health centres. The sample group or research participants was drawn from seven sub-districts public funded clinics within the Cape Town Metropole Health District, namely Tygerberg, Mitchell's Plain and Klipfontein, Southern, Eastern, Western and Northern sub-districts. Categories of nurses that participated in the study were Professional Nurses (RN), Clinical Nurse Practitioners (CNP), Unit Mangers (UM), Registered Auxiliary Nurses, Enrolled Nurses (EN) and Student Nurses. Ethical approval to proceed with data collection and permission to access research sites was granted in 2008. **Methods of data collection**: data was collected from three sources, i.e. questionnaires, interviews and documents. Although phenomenological approach normally does not use questionnaires as a means of data collection because of the nature of the topic under study, confidentiality has to be assured to avoid the possibility of reprisals or intimidation. SPSS computer software were utilised to capture information obtained from questionnaires and interviews. **Results:** The main types of violence were verbal abuse, and threats to assault. Significant number of respondents indicated that women attack nurses more often than gang members and patients' relatives. Nevertheless, perpetrators of violence against nurses varied among the sub-districts, e.g. Western sub-district clinics identified women whereas, Klipfontein identified patient relatives and Tygerberg identified gang members as regular perpetrators of violence against staff in their clinics. Results indicated that violent incidences occur on Mondays and Fridays in all the

participating clinics. The highest number of violent incidences in Tygerberg clinics occurred on Mondays. On the other hand, threats to assault nurses were high in Western and Southern sub-districts clinics compared to the other sub-districts. Conclusions: violence against nurses in most health clinics of the study is on the increase because of substance abuse and gang violence. Recruitment of additional staff could minimise the time patients have to wait to see a doctor. However, it is essential that some nurses working in these clinics be more compassionate and polite towards their patients

Learning outcome:

Participants will be presented with views and experiences of violence against nurse working in community health clinics

Some factors contributing to violence against nurses are shortage of staff, long waiting time, rudeness from some members of the nursing staff

Title: "Violence against community health Nurses in Cape Town, South Africa"

Authors: Prof. Doris Deedei Khalil and Mrs. Faizah Kajee Adams

Key words: Violence, types of violence, nursing, community health clinics, community health nurses

Introduction:

In 1992 the then minister of health declared that a policy of primary health care must be followed to make healthcare more available, accessible and affordable to all South Africans (Hatting, Dreyer & Roos 2004). At that time, community care clinics were understaffed with overworked nurses, a situation that still exist after eighteen years of the policy implementation. The White Paper on the Transformation of the Health System, adopted in 1997, devolved responsibilities for health care delivery to districts authorities, thus establishing District Health Systems which would be more responsive to needs of people at grassroots levels (De Haan 2005). Violence in community health clinics reflects historical events.

During the apartheid era in South Africa, violence was viewed as legitimate response to oppression. That oppression resulted in more than thirty years of violence, reaching peaks during the Sharpeville Massacre in 1960, the Soweto uprisings in 1976 and other uprisings in 1985 and 1986 (Baldwin-Ragaven et al, 1999). Violence became feature of social life in the country until the African National and the Communist political parties were unbanned.

To explore the extent that violence affected health care workers, Steinman (2003), studying Greater Johannesburg Metropolitan region found that sixty three percent of respondents experienced some form of violence. Marais, Van der Spur and Rontsch (2002) survey of health professionals in Cape Town found that fifty percent of respondents had experienced some form of violence at work. Di Martino (2000) reported evidence of workplace violence internationally. Kingma (2001) and Di Martino (2000) indicated that nurses were three times more likely to experience violence than other professional groups. Other studies had shown evidence of violence against nurses

(Armstrong 2002; Adib, AlShatti, Kamal, El-Gerges, and Al-Ragem 2002; Atawneh, Zahid, Al-Sahlawi, Shahid, and Al-Farrah 2003; Khalil 2009). Based on the above literature, objectives of the study were to examine extent and frequency of violence against nursing staff in community health clinics.

Methods

The research design was survey. Methods of data collection were distribution of confidential questionnaires (Brink 2002). Approval to conduct the study was granted by the University of Cape Town, Faculty of Health Human Ethics Committee and the Metro pole Health Directorate. The study population consist of all nurses working in the community health clinics in Cape Town. Research participants were recruited from community health clinics of seven sub-districts in Cape Town Metro pole area of the city, i.e. Tygerberg, Mitchells plain, Klipfontein, Southern, Eastern, Western, and Northern. A total of twelve clinics formed the research sites for the study and to protect identities of participating clinics, each clinic was given a unique number, e.g. T1 representing Tygerberg community health clinic number 1.

Results:

Out of the eighty-six respondents, 61% had been working as nurses for over 16 years. Mitchells Plain, Southern and Klipfontein health clinics had the highest number of more experienced nurses. Eighty respondents (N=80; 94%) agreed agreed that there is violence in nursing. Supporting written comments were:

> "Yes, nurses' work under so much stress. Clients come to the clinic with personal problems and fight with the staff" (Clinic T2)

> "In our facility we have endless abuses from clients and sometimes from the community outside." (Clinic K2)

Women were reported to be responsible for 81% of violence against nursing staff. Other perpetrators were gang members (60%), and patient relatives (59%). However, perpetrators varied among sub-districts, e.g. 100% of respondents from Western sub-district indicated that women, Klipfontein identified patient relatives (83%) whilst Tygerberg regarded gang members (73%) as the main perpetrators.

Results indicated that violent incidences occur on mainly on Mondays and Fridays of the week in all the participating clinics. However, Tygerberg (16 incidences) and Klipfontein (11 incidences) reported that violent attacks against nurses in health clinics occurred on daily bases but such attacks were at their highest on Mondays and Fridays. For example, Tygerberg reported 16 incidences on Mondays and 6 on Fridays, whilst Klipfontein had 11 incidences on Mondays and at least 5 on Fridays. Northern and southern sub-districts had the lowest incidences of violence against nursing staff. However, Thursdays were the quietest day of the week for nurses in all participating clinics.

In all the participating health community health centres, verbal abuse (86%) was the most common form of violence against nurses whilst threats to physically assault ranked second at 62%. Western and southern sub-district clinics nurses experience more verbal abuses compared to other clinics (100% and 83% respectively). Whereas Mitchells Plain (69%), Western (67%) and Northern sub-districts (67%) nurses received more threats to assault. Actual physical assaults against nurses were more frequent in Southern (68%) and Mitchells Plain (44%) than in other sub-district clinics. Most respondents (98%) confirmed that all categories of nurses irrespective of skin colour, ethnicity or religious affiliation were target of violent attacks. Large numbers of respondents (77%) maintained that violence against nurses working in community health clinics were on the increase.

Conclusion

In response to measure that could be put in place to assist nurses manage violence in community health clinics, respondents identified three key areas, i.e. assertive training, professional development programmes, and health and safety issues. All respondents agreed that assertive training workshops would equip them with the necessary skills to deal with violence in the workplace. Other nurses indicated that not all their professional colleagues were compassionate towards patients and that assertive training would not change those negative attitudes. Professional and in-service training programmes were identified as essential to upgrade nursing staff on new skills that would increase their

confidence in dealing with aggression from health care consumers. Others recommended measures to increase security in the clinics, e.g. more security staff or police presence Monday and Friday clinic days.

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