Salient Vulnerability Theory:

A Grounded Theory Study of Nurses' Ethical Decisions in the Context of Workplace Violence

by

Jennifer Anne Clerihew Dunsford

A Dissertation submitted to the Faculty of Graduate Studies of the University of Manitoba

in partial fulfillment of the requirements of the degree of

DOCTOR OF PHILOSOPHY

Peace and Conflict Studies

University of Manitoba

Winnipeg

Abstract

This qualitative study examines the problem of how nurses navigate the moral dilemmas that arise when they encounter workplace violence. It considers the ethical decisions that nurses make, the considerations that factor into decisions about the course of action, and the experience of moral distress when workplace violence occurs. The study was conducted using a constructivist grounded theory methodology. Data from 36 interviews and six narrative documents were analyzed. The core category of *Managing Intersecting Vulnerabilities* was identified. With respect to ethical decisions, three subcategories were found: *Getting the Job Done (Stay), Shifting the Dynamic (Pause),* and *Withdrawing from the Situation (Leave)*. In terms of determining a course of action, participants identified factors that increase risks, such as factors related to the nurse, patient or environment, and factors that mitigate risks, including risk assessment, the availability of supports, and skills and tools. The experience of moral distress fell into four categories: *Choosing to Disengage, Living with Moral Residue, Witnessing Patient Impacts,* and *Working Under Structural Constraints*. This analysis resulted in the development of Salient Vulnerability Theory, a substantive theoretical framework for understanding how nurses navigate decisions about providing care in the context of violence. The theory proposes that patient vulnerability provides a moral obligation to provide care, however that obligation is limited by violence that places the nurse at risk. When this happens, the nurse's vulnerability becomes salient, and a decision to leave the situation can be practically and ethically justified until such a time as a balance is restored and the nurse can safely resume care. The recommendations issuing from this new theory are intended to reduce the incidence and impact of violence and the resulting moral distress by addressing the problem at a structural level, and include ensuring adequate staffing, the implementation of effective training and equipment, well-designed workspaces, and holding space for healing and practices of support. Empirical confirmation of Salient Vulnerability Theory and the effectiveness of suggested interventions is recommended.

Acknowledgements

I would first like to acknowledge the support provided in the form of a Graduate Fellowship from the Centre for Applied and Professional Ethics at the University of Manitoba, and a Doctoral Fellowship from the Social Sciences and Humanities Council of Canada. That funding made this work financially possible, and for that I am very grateful.

Now, for the people. I have had the incredibly good fortune in my lifetime to be surrounded by many people who have supported, championed, fed and watered, and believed in me. I owe them all a debt of gratitude that can never be repaid.

Firstly, I have been so very fortunate to have had the benefit of the wisdom, encouragement, and kindness of the three incredible women who were my initial advisors for this work: Dr. Jessica Senehi, Dr. Christy Simpson, and Dr. Annette Schultz. I learn something every time I speak with them. Jessica, Christy, Annette - I am so very grateful that you were willing to embark on this journey with me. Thank you from the bottom of my heart. I also want to offer a huge thank you to Dr. Douglas Brownridge, who so kindly agreed to join this committee when, at what seemed like the last minute, I found myself in need of an additional advisor. Thank you, Doug, for your kindness, openness, and constructive input. It will not have been easy to jump in at a late stage. I am thankful to have the benefit of your knowledge, experience, and compassion through the home stretch.

Who can accomplish something like this without supporters and mentors? My parents, Mary and Brian, who always offered unquestioning approval of my life choices, however surprised they might be (Nursing? Really? Ok…). They continue to set the standard for how to be accepting and inclusive, a critical competency for any nurse, by hosting Sunday dinner every week, and warmly welcoming everyone to the table. My BFF, Siobhan, published playwright and gifted toddler whisperer, who never failed to let me know she was proud of me (I'm proud of you too!). And my professional mentors, like Dr.

Anne Katz, who always believed I had this in me, Dr. Roberta Woodgate, who taught us Methods and coached us through our insecurities, and Rose Thomas, who hired me into my first nursing job despite a memorable interview. These nurses set me off on the right path and have been such an important part of my nursing journey.

Of course, I have to mention my children, Aimee and Jack (and bonus children, Madelaine and Max), who have been there through my seemingly endless pursuit of education. Thank you, not just for the dishes you washed while I bailed on kitchen duty to go back to my computer, but for never doubting I could do this, and not challenging my parenting skills too badly along the way. I have joked that this degree has been harder than raising children, but that doesn't mean as much when the kids are that great.

Finally, my husband Trevor, the best choice I ever made. I absolutely could not have done this without you, not only because of the hundreds of sandwiches and cups of coffee you brought me while I worked, or your willingness to let me "rubber duck" my ideas and arguments, safe in the knowledge that you would tell me honestly if they were completely insensible, or worse, grammatically ambiguous. Your support, and your willingness to provide tech support, and find things to do while I worked is really what got me across this finish line. I love you!

To all of you who have so profoundly influenced and supported me over the years, including so many I do not have the space to name here, thank you. You teach me, every day. I stand on your shoulders. This is as much yours as it is mine.

Dedication

My grandmother, Jessie Clerihew, died in 2022 at the age of 103, as I was in the midst of this program. She taught me the importance of education, hard work, and family. Until the end of her life, she appreciated the value of a good story, and often had one to tell, especially when prompted and encouraged by a curious grandchild. I dedicate this work to her memory.

Table of Contents

List of Tables

List of Figures

Chapter One: Background and Context

Background: The Moral Implications of Violence in the Nursing Workplace

Violence in the nursing workplace is ubiquitous (Babiarczyk et al., 2020; Liu et al., 2019; Mento et al., 2020). The incidence, prevalence, types, and outcomes of workplace violence are well described in the research literature, and examples can easily be found in grey literature, news, and social media. The reasons people act out against health care workers may even be understandable in some sense: when people need health care services, it is usually because they are sick, hurt, or otherwise experiencing a threat to their well-being, and health care providers such as nurses have the expertise and means to address those threats. Pain, fear, and frustration provokes a response, which can manifest as aggression. Furthermore, certain health conditions feature symptoms that are associated with patient[1] violence. For example, people with cognitive impairments from dementia or brain injury may be more prone to strike out in confusion or self-defence when approached for the provision of care. People under the influence of toxic substances or living with mental illnesses like schizophrenia may experience hallucinations or delusions that compel them to behave aggressively.

Incidents of abuse and aggression against health care workers, whatever the motivation, pose a threat to the worker's well-being. This places them in the unenviable position of deciding if they can safely attend to the person's health needs, or if they need to remove themselves from the situation to avoid becoming a victim of the person's aggression. A dilemma results when the decision to withdraw would leave the person without access to necessary care. Violence forces the health care provider to make a choice without positive options: they can either remain in the situation and provide care at the risk of being injured, or they can exit the situation, and leave the aggressor to the mercy of their health condition. When a nurse cannot complete assessments or provide therapeutic interventions because the

[1] The term "patient" is used for convenience throughout this document and is synonymous for this purpose with other terms commonly used to refer to people seeking health care, such as "client".

patient is striking out or brandishing a weapon, the person may need to be left without what might be essential (restorative or even life-saving) care. Either way, negative outcomes are likely.

Few would dispute the right to a safe workplace. Occupational health and safety legislation everywhere supports this goal. Likewise, unions exist to intervene on behalf of workers, to secure protections from harms that are present in the work environment. But what happens when hazards cannot be prevented without compromising the personal and/or professional values and principles of the people doing the work?

Nurses are highly impacted by workplace violence because they make up the largest proportion of health care workers (Canadian Institute for Health Information, 2024), and nursing work is necessarily done largely in direct contact with people. When a nurse is hurt, they are unable to provide care for anyone, sometimes permanently, depriving the entire health care system of an essential human resource. Compounded by a world-wide nursing shortage (*State of the World's Nursing Report - 2020*, 2021), this is a significant worry. Furthermore, as essential workers (Blau, Koebe & Meyerhofer, 2021), nurses are critical to the functioning of health care systems, so are expected, even required, to remain available for work, even when conditions place them at high risk of injury.

While much research explores the problem of workplace violence, there is a gap in the literature concerning the ways that nurses make decisions about whether and how to provide care when they experience or are threatened by violence. This study aims to address this gap by considering how nurses navigate the moral dilemmas that arise when they encounter workplace violence. How do nurses manage a care decision when the only real options are to provide essential interventions knowing they will experience physical, verbal or sexual assault in the process, or to abandon the person who, without interventions, will suffer preventable harms? This is a true dilemma: a conflict between two mutually exclusive goals. The duty to care is placed directly against the right to be safe at work.

I undertook this study to unpack this dilemma. To that end, I spoke with nurses who have experienced workplace violence about the decisions they faced, the considerations that factored into their choices and actions, and the ways these situations made them feel. What I learned was that nurses are incredibly conflicted about how best to manage patient care when placed in these impossible situations, leaving them with significant moral distress about circumstances where they cannot safely intervene to prevent or address a person's suffering. In the chapters that follow, I will share nurses' stories of workplace violence, and their insights on how care decisions came to be made despite the harms of aggression and abuse. I will describe the moral conflicts nurses identified and offer a theory of moral decision making that accounts for nurses' actions in these fraught situations.

To begin, I offer a brief discussion of moral conflict from the perspective of nursing ethics. I then outline the challenges of moral distress in nursing practice. The remainder of this chapter outlines the problem statement, the study's purpose and research questions, the rationale and significance of the study, some underlying assumptions that influenced the work. Finally, I situate myself in the research process by examining my own positionality in undertaking this research.

Moral Conflict

Nursing is a profession rife with opportunities for moral conflict. Moral conflict[2] can arise when multiple actions are morally justifiable yet incompatible due to the existence of irreconcilable values, obligations, or accepted principles. Personal and professional values such as accountability or maintaining confidentiality are broad concepts that provide structure for making care decisions in individual circumstances. These values are articulated in documents such as the Code of Ethics for Registered Nurses (Canadian Nurses Association (CNA), 2017) and internalized as part of the

[2] For the purposes of this dissertation, I use the terms "moral conflict" and "ethical dilemma" interchangeably.

development of a professional nursing identity (Liaschenko & Peter, 2016). Nursing values are not, however, definitive or all-encompassing. The situations in which they apply frequently conflict and overlap, and, as a result, values conflicts can occur, such as when a nurse must choose between maintaining a patient's privacy, or breaking confidentiality in the name of protecting another person.

Duties and obligations can also be sources of moral conflict (Liu et al., 2023). Duties are role-specific expectations that are incurred as a result of the nurse's position and associated therapeutic relationships. A patient needs something that the nurse has the ability to provide, generating an assumption that the nurse will attend to the need. There is trust that the nurse will use their knowledge, skill, and position to benefit the patient. Like values, however, duties can conflict. For example, a nurse may have equally strong obligations to provide care to two people at the same time, requiring a decision about which person to attend to first. Here, the nurse weighs contextual information about the patient and their needs to determine priority.

Similarly, ethical principles provide direction as well as being a source, at times, of moral conflict. Commonly accepted ethical principles include respect for autonomy, justice, and acting in the best interests of another (Beauchamp & Childress, 2019). While these principles serve as useful standards most of the time, there can arise situations where it is not possible to simultaneously maintain certain principles. For example, in western health care contexts, there is a strong emphasis on the respect for patient autonomy, but a patient's choice may not correspond with the health care provider's knowledge of what will meet the patient's goals of care. This forces a decision process on the part of the health care provider: whether to respect or override the patient's preferences.

Health care is necessarily intimate and highly individualized. Nurses are directly involved in its provision, placing them frequently in a position to make decisions about which values, obligations, or principles to prioritize when not all can be enacted at the same time. Incidents or threats of workplace

violence demonstrate this conflict well. When a nurse is involved with a patient, it is because the person requires something that the nurse can provide, for example, assessments, medications, or knowledge of therapeutic interventions. When someone in the health care environment behaves violently, or in a way that jeopardizes the safety of the nurse or others, the nurse must decide whether to provide the intervention, or to compromise or violate professional values, obligations, or ethical principles, and step away from the encounter to maintain their own safety.

Either choice carries risks. In staying in proximity to a patient who is aggressive or abusive, the nurse is at risk of physical or psychological injury. In leaving, the nurse may be protected from the immediate threat, but the patient becomes vulnerable to whatever health condition led them to seek the intervention of a nurse. Neither is a comfortable position because both disrupt deeply held beliefs on the morally correct action to take. No matter which option the nurse chooses, they fail on the other, resulting in a violation of the nurse's obligations and moral integrity.

Nursing Ethics

Where morality concerns the norms or principles of right and wrong action, ethics is the practice of considering or acting upon such codes of conduct (Driver, 2022). Consistent with the literature (Varcoe et al.,2004; Pilkington & Giuliante, 2023), I define nursing ethics as a way of being and doing that considers the dynamic moral landscape within which nursing is practiced. Specific to nursing (as compared with other fields in the biomedical sciences), nursing ethics comprises the values, norms, and principles that guide good nursing practice. This is not to say that nursing ethics is entirely different from, for example, medical ethics, as there are certainly principles and norms that are common to the practice of both nurses and physicians. However, for the purposes of this study, I am considering nursing ethics to be that which guides nursing practice specifically.

Sources of guidance on nursing ethics include documents like the Code of Ethics for Registered Nurses (Canadian Nurses Association (CNA), 2017), and principles of biomedical ethics (Beauchamp & Childress, 2019). Strong emphasis on principles such as beneficence, justice, and respect for autonomy, and on values such as caring (Fry, 1989) drive the practice of nursing in the sense that they provide a normative basis for nursing work, locating it in respect for persons and the promotion and preservation of human dignity. While not unique to nursing, this impetus is foundational to the work that nurses do. Indeed, Brune et al. (2023) identify care ethics, originating in feminist ethics, as core to nursing practice. One essential feature of caring is its relational nature, requiring a therapeutic connection between nurse and patient.

This relationality, the defining role of relationship in the practice of nursing, is what distinguishes nursing ethics from other branches of biomedical ethics (Pilkington & Giuliante, 2023). This is important for the present purpose, because the relational connection between nurse and patient is foundational to the caring encounter while at the same time being the source of the nurse's duty to intervene when a patient requires something that the nurse is able to provide. This requires reciprocal trust, a bond which is broken either by violence from the patient toward the nurse, or by the inability to provide care when it is not safe to do so, leaving the patient without therapeutic intervention.

Statement of the Problem

This study concerns those times when a nurse cannot both provide care and remain safe. When these two outcomes are not possible to achieve at the same time, nurses are forced to make a choice. In reality, there is never a situation where a patient would be completely denied care (Beattie et al., 2020; Gabe & Elston, 2008). Social norms (and legal structures) prohibit the abandonment of people in need of health care or protection. Yet, providing that care can come at a cost. When a patient strikes out, physically or verbally, others get hurt. However, the patient's basic and medical needs still need to be

met in some way. The option to put the patient out on the street to fend for themselves simply does not exist. Still, every worker has the right to be safe at work, even when the nature of the work cannot guarantee that this is possible. Navigating these irreconcilable positions is the subject of this study.

Purpose of the Study

In this study, I sought to explore how nurses manage those situations where neither staying nor leaving is seemingly justifiable. The purpose of this study was to examine the ways nurses navigate these impossible situations, and how they come to the choices they do with respect to providing care when abuse or aggression renders working conditions unsafe. A constructivist grounded theory method was chosen with the goal of developing a theoretical understanding of the nature of nurses' internal conflicts regarding workplace violence. Understanding how nurses recognize the decisions they face, the factors that contribute to their assessment of the right course of action, and the emotional sequelae that result from these conflicts addresses a gap in the literature and provides the basis for development of a normative framework for making sense of the moral conflict that accompanies violence in the nursing workplace.

Research Questions

The primary question I address with this work concerns how nurses navigate the moral dilemmas that arise when they encounter workplace violence. To do that, I posed three research questions:

1. What ethical decisions do nurses face in the context of workplace violence?
2. What considerations factor into decisions about a course of action?
3. How is moral distress experienced when nurses encounter workplace violence?

Significance of the Study

This study addresses an important gap in our understanding of nurses' internal moral landscapes. To date there is little research on the topic of ethical decision-making related to nurses' experiences of workplace violence. Given the ubiquity of the problem, the theoretical framework offered by this work will enable a deeper understanding of the processes that nurses use to make decisions in these difficult situations. This can serve to normalize the experience, and offer support to individual nurses, teams, and systems to develop appropriate and constructive responses to actual and potential incidents of workplace violence. This study will provide a foundation for a program of research intended to address the ethical elements of violence in the nursing workplace, which has not previously been well documented. Its recommendations comprise a suite of high-level interventions that if implemented, have the significant potential to reduce the incidence and impact of violence against nurses.

Assumptions

To acknowledge some assumptions made in the planning and completion of this work, I note that the research questions were developed, and the study undertaken with the following in mind:

1. Firstly, in questioning the ways that nurses navigate the moral dilemmas they face in the context of workplace violence, I assumed that nurses do indeed make decisions, and do not manage such situations simply on the basis of specific policies or instinctive reactions. I assume that there is some element of discretion involved in each situation. This is derived from observations I made in providing ethics consultation services over several years to health care teams dealing with patients who were violent, aggressive, abusive, or problematically disruptive. What I noticed was that there were usually some nurses willing to continue to provide care, and others who had a different level of tolerance for challenging patient behaviours. I also noticed that a nurse who was willing and able to manage on some days may not be prepared to do so at other

times. This indicated to me that these were invariably nuanced and dynamic situations where there were decision-making processes at work, and that there were factors that determined whether a particular course of action was reasonable or justifiable from a nursing perspective.

2. Secondly, I assumed that nurses experience moral distress related to the decisions they make in these situations. Again, this assumption is based on the interactions I had as an ethicist with members of health care teams that were dealing with responsive or violent patients. The people I spoke with expressed considerable discomfort with the decisions they were forced to take when none of the available options felt like the morally correct course of action. This moral distress derived directly from the situation and would not have been present otherwise.

Positionality Statement

I have been a registered nurse for over 20 years. I am grateful to have had few direct experiences of workplace violence. My interest in this topic arose through my experiences with providing ethics consultation and support to nurses facing difficult decisions about patients whose care needs were complicated by aggression. Nurses from all corners of the health care system described tensions in balancing a duty to provide nursing care against risks to safety, both their own and others'. I found there was a gap in how we understand and manage such dilemmas, and no helpful research extant. On the one hand, there was an assumption that care would be provided and a sense of obligation to do so under any circumstance. On the other was a prevailing narrative, touted by unions, employers, and regulators, that nurses need not accept unreasonable risks in the course of their work. My frustration was that there was no one-size-fits-all solution to the problem of violent people in health care contexts, leading me to consider more deeply the nuances and elements of notions of duty to care and safety.

My belief in the socially constructed nature of knowledge places narrative at the centre of my toolbox for understanding phenomena, especially as regards ethics. No matter the question, the answer

was always, “it depends”. And what it depended on was the story. Considering this frustratingly imprecise universal, I made it a priority in this study to monitor my interpretations of participants’ stories at the moment of hearing them. Because I was acutely conscious of the ways in which interpretation could influence the meaning of participants’ accounts of their experiences, I deliberately left transcripts to settle for a while, once they had been approved by the participant. This served the purpose of decontextualizing the data, so it was possible to go back to them later, once time had muted my immediate impressions, and look at them with fresh eyes, in the absence of assumptions formed unconsciously during the interview. This slightly removed perspective permitted the construction and linkage of more detailed concepts, and the sense of a “bird’s eye view” of the entirety of the data.

At the same time, I acknowledge the way each interaction with the participants shifted and evolved my understanding of the phenomenon of workplace violence. To that end, I recognized my ethical responsibility to incorporate deliberate and genuine reflexivity, to continually interrogate how my voice was showing up in the work, and to consider how best to foreground the voice of the participant. After all, the lived experience that sparks the story belongs to the participant, even as both teller and listener are impacted by the narrative. In the end, it was not difficult to foreground the participant’s story and background my assumptions about their perspectives or intentions.

Summary and Outline of Dissertation

In this chapter, I have provided a brief overview of the problem of violence in the nursing workplace. I position this problem as a moral conflict faced by nurses. The purpose of this study is to explore how nurses navigate these moral conflicts, a topic on which there is currently little research. Toward these ends, the remainder of this dissertation will proceed as follows. In Chapter Two, I review the existing literature on workplace violence and demonstrate the gap in our understanding of the ethical decisions nurses make in the face of violence, the considerations that factor into their choices,

and the impact of the moral distress that results from these situations. In Chapter Three, I describe the methodological foundations and design of the study. Chapter Four details the methods, participants, and process of data collection and analysis. Chapters Five through Seven provide findings from the analysis of each of the three research questions and Chapter Eight proposes Salient Vulnerability Theory, a theoretical understanding of nurses' experiences of ethical decision-making as it relates to violence in the workplace. Chapter Nine provides a discussion and recommendations stemming from the theory. Finally, Chapter Ten offers some implications of the theory for nursing practice, a brief comment on the study's strengths and limitations, and suggests opportunities for future research. Next, I turn to a review of relevant literature.

Chapter Two: Literature Review

To begin this chapter, I offer a review of the terms and concepts that are central to this dissertation. I begin by defining three key terms, then proceed to a review of the literature relevant to the project. Finally, I offer a secondary review of literature that supports and is supported by the theoretical model offered in Chapter Eight.

Definitions

It is useful to define important terms, to establish a solid understanding of how they are conceptualized and used throughout this dissertation. In this section, I provide a working definition for the following:

a. Workplace violence
b. Moral distress
c. Vulnerability

Workplace Violence

To begin, violence is "intense, turbulent, or furious and often destructive action or force" (Merriam Webster, n.d.a). Violence has also been defined as an insult to human needs (Galtung, 1968; Galtung & Fischer, 2013). Violence is problematic because it infringes autonomy, dignity, health and safety, or freedom, and causes harm in the form of avoidable injury, death, trauma, and other negative outcomes.

Galtung, a pioneer in the scholarship of peace and conflict studies, proposed a typology of violence (Galtung, 1968; Reimer et al., 2015), categorizing it as either direct or indirect. Direct violence is manifested as events such as abuse, aggression, or assault that cause or threaten to cause physical or psychological harm. Indirect violence includes the legitimization of structures such as racism, misogyny, and other biases that permit the inequitable distribution of resources and create oppression in the form of deprivation and disempowerment (Galtung, 1996).

Al-Qadi (2021) defines workplace violence as any act or threat of physical violence, harassment, intimidation, or other threatening behaviour that occurs in one's workplace with the potential for injuring the target. This can include physical violence, such as a punch, kick, or strike from another person. It can also be emotional or psychological violence, such as threats, insults or verbal abuse that demeans another person. Workplace violence can also take the form of indirect, structural violence, such as racist or homophobic slurs, or overt discrimination against a worker. Fear, or a reasonable expectation of imminent violence, is also included in this definition, because the risk itself is enough to prompt a response.

I chose this broad definition to include any behaviour on the part of another party that the participant identified as harmful or threatening (that is, anything which posed a risk of harm or provided a reasonable expectation that it would cause harm). I did not ask participants to limit their responses to their experiences of violence from patients, but left it open to them to consider visitors and patients' family members, colleagues, supervisors, and others in the work environment. This was a deliberate choice, as I did not want to lead participants to a particular conceptualization of violence but rather to see where their concerns focused. As it turns out, most participants spoke of violence experienced at the hands of the patient. I opted to focus on this particular subset of participant experiences, because they best exemplify the zero-sum impact of the dilemma of choosing between providing care and remaining safe.

Moral Distress

Moral distress is the focus of the third research question in this study. The concept of moral distress has evolved since it was proposed in the nursing literature in the 1980s (Jameton, 1984). For the present purpose, I am adopting the definition proposed by Morley et al. (2020), of moral distress as psychological distress caused by a moral event. They characterize this distress as, for example, the sense

of powerlessness to overcome constraints that prevent the nurse from doing what they consider to be morally right, anger or frustration stemming from disagreement with others about the appropriate course of action, guilt or regret at the lack of ethically acceptable options in a situation, or uncertainty about not knowing the right thing to do. This broad conceptualization captures and explains the spectrum of emotional outcomes from morally distressing events and corresponds to the range of responses to workplace violence described by participants of this study.

Vulnerability

As data analysis proceeded and a substantive theory about nurses' decision-making was developed, it became clear that vulnerability was a core factor in these situations and is therefore important to define here. While a deeper look at the literature on vulnerability can be found later in this chapter, I offer here a preliminary definition to situate the concept as it is used throughout this work.

Numerous conceptualizations of vulnerability have been proposed, but a functional definition seemed the most appropriate for the present purpose. A dictionary definition of vulnerability is the quality or state of being capable of being physically or emotionally wounded or being open to attack or damage (Merriam-Webster, n.d.b). Antonymous with security or resilience, vulnerability is multi-dimensional and relational. People are vulnerable to different things in different ways and are more vulnerable at some times and less so at others.

Ten Have's (2016) functional definition of vulnerability suits the purposes of this study well. He describes vulnerability as a function of (a) an individual's exposure to an external threat, (b) their sensitivity or susceptibility to harm from the threat, and (c) their ability to adapt or respond to the threat. For example, a nurse entering a patient's room is exposed to the threat of violence. They may be more or less sensitive to harm depending on their level of physical fitness or size relative to the other person. They may also alter the degree to which they are vulnerable by changing their approach or

bringing another person with them to moderate risk. All three conditions converge to determine the degree to which someone is vulnerable.

Vulnerability is conditional: actual harm is not required, merely the presence of a threat is enough to render someone vulnerable. Its negative implications exist irrespective of the proximity of a threat although they become increasingly compelling as a risk becomes more salient. Furthermore, vulnerability is always experienced in relation *to* something negative or undesirable: infection, or attack, for example.

Vulnerability conveys dependence due to constrained or diminished autonomy. The ability to mitigate exposure or enhance the capacity to manage a threat can be limited due to the person's circumstances, and their sensitivity to harm is also often mediated by their health condition. When a person is vulnerable, either their ability to select a preferential option is constrained, or the range of options is itself limited. Being vulnerable to assault, for example, means I am unable to remove myself from a dangerous circumstance (exposure), or perhaps that there is no safe space available to me (adaptation), leaving me susceptible to injury (ten Have, 2016).

I chose the functional definition of vulnerability for the purposes of analysis and theory-building because it captures the contextuality of the problem of violence against essential workers well. The three elements apply to both patient and nurse and offer a practical framework for understanding differences between and among people in terms of their responses to threat. For example, when two nurses are exposed to risk from the same person, their experiences will differ based on each one's assessment of their susceptibility to harm and ability to manage the threat. The patient's vulnerability is similarly dynamic, as it is affected by the potential impact of care withdrawal (exposure), including whether the patient's health condition could deteriorate in the absence of immediate care

(susceptibility), and/or the availability of someone who could take the nurse's place if required (response).

On analysis of the data in this study, it became clear that vulnerability was a consideration in participants' decision-making processes when confronted with people who are, or who could become, violent. This imbues vulnerability with the status of being the core, defining category in the theoretical approach developed. As I will demonstrate, the default of the nurses in this study was to recognize the vulnerability of people seeking their care, and to provide that care so long as the patient remained the more vulnerable party in the therapeutic relationship. However, when violence from a patient disrupted the relationship, it rendered the nurse more vulnerable in that moment, relative to the patient, justifying a decision to leave the situation, either temporarily or permanently. Ultimately, the stories offered by participants in response to the research questions continually brought me back to these elements, which ultimately formed the heart of the theoretical approach developed here. This emergent theory will be unpacked in detail in the later chapters of this dissertation.

Use of Literature in Conducting Research

A review of relevant literature is generally conducted early in a study, to inform development of the research questions and methodology, to situate the study in terms of what is already known about the topic, and to identify areas where more research is required. In grounded theory research, the literature review follows data collection (Glaser, 1978), to avoid imposing preconceived concepts or ideas on the analysis. This serves to enhance the sensitivity of the resulting theory, and better ensure the fit and relevance of the theory to the data by grounding the theory in the data rather than the literature (Charmaz, 2006). The pragmatist roots of constructivist grounded theory, however, support an approach to research which acknowledges that there may be value in a preliminary, critical review to situate the

research, with a subsequent secondary review conducted considering the finished analysis. This is the methodological process I followed.

The preliminary review of the literature served multiple purposes, including providing context for the study, identifying gaps in the existing research on the ethical elements of nurses' experiences of workplace violence, and supporting the development of research questions. This also had the benefit of providing the research ethics board with sufficient background to situate the problem. Once the data collection and analysis had been substantially completed, I revisited the literature to update sources and identify connections with the proposed theoretical framework. Throughout the research process, I engaged in reflexive appraisal of my own knowledge, biases, and intentions using a methodological journal and memo writing. This supported ongoing critical thinking and mindful analysis of the data and analytic process.

Search Techniques

To conduct the preliminary and secondary literature searches, I used the University of Manitoba Libraries collections, as well as Google Scholar, CINAHL and SCOPUS databases. I also consulted the reference lists of retrieved articles for additional resources. Sources were maintained in my personal Zotero citation manager database. Search terms in the preliminary review included variations of *workplace violence* and *nursing*. This generated lists of many thousands of books and articles on the incidence and prevalence of workplace violence, the causes and impacts, and the types of violence experienced by nurses. I also searched for grey literature and social media accounts of violence against nurses. To streamline and simplify the primary search and make it feasible within the timeframe, I prioritized review of meta-analyses and systematic reviews and selected publications from those to supplement and support this review.

Preliminary Literature Review: Workplace Violence

In the following section, I examine the literature on ethical decision-making in the context of violence in the nursing workplace, factors that impact workplace violence, and moral distress.

Internal Conflict and Ethical Decisions about Workplace Violence

The overarching research question in this study concerns how nurses navigate the ethical dilemmas that arise in the face of violence in the workplace. An extensive review of the literature reveals only two papers that address this question directly, although there is a handful of others whose conclusions have helped to inform the theoretical model developed through the present work. In this section, I review these two articles, as well as literature that demonstrates the gaps in theory and knowledge and supports the development of the research question. Next, I summarize the literature on intrapersonal or internal conflict related to nurses' experiences of workplace violence and provide examples of this type of conflict before moving on to a more comprehensive survey of the literatures on workplace violence and moral distress.

The first of the two papers that examine how nurses make decisions when exposed to workplace violence is by Copeland & Arnold (2021). They interviewed ten practicing nurses who had been assaulted by a patient within the previous 18 months, with the goal of identifying the ethical decision-making processes that nurses used to determine a course of action. Participants described an overarching concern for patient safety as the primary consideration in their decision-making process. The concern they described about what to do in the moment, that is, whether to provide care or leave the situation, was relatively minor. Rather, the question of what should happen to the patient after the incident was of greater ethical interest in their research. That determination depended entirely on whether the patient was competent at the time, and whether the nurse had been injured. Ultimately, if the nurse believed that the patient knew what they were doing when they committed the assault, and the nurse was

injured, the incident was viewed as a crime, and there was a tendency to want to bring charges against the perpetrator. If the patient was incompetent and the nurse was not injured, they saw the incident as a risk of the job. In between these two interpretations was a confusing and ambiguous space where participants described each situation as unique and nuanced, raising an intrapersonal conflict between their reaction to the violence, and their responsibility to the patient, behaviour notwithstanding. Participants felt conflicted about whether to press charges, or let the matter drop and move on, the only two options deemed available, and where the line was that tipped the decision one way or the other.

The second study examining the decision-making processes of nurses facing violence (Beattie, Innes, Griffiths & Morphet, 2020) considers the complex ethical tensions that arise between nurses' duty to care and their safety. Like the Copeland & Arnold (2021) study, these researchers found that participants felt obligated to provide care, irrespective of the patient's behaviour, but used strategies, such as de-escalation techniques, and tools, such as restraint, to maintain safety and meet both obligations. The resulting intrapersonal conflict was exemplified by the nurse's reluctance to initiate existing zero-tolerance policies, which would permit the removal of someone behaving violently from the care environment, as participants felt they could not ethically refuse to provide care. Aggression due to health conditions such as dementia and intoxication was viewed more empathetically than violence from people who chose to engage in unacceptable behaviour despite being cognitively capable of using more pro-social coping strategies, complicating matters further.

The intrapersonal conflicts described in these two studies come down to two conflicting and mutually exclusive goals: to fulfill a duty to provide care, and to remain safe from violence and abuse in the workplace. Resolution of internal conflicts requires a process for decision-making that accounts for the contextuality and nuance in each situation. There are three frameworks that provide guidance on balancing health care providers' duty to care against risks to their personal safety that are relevant to the

present study. The first two were proposed to address tensions that arose in the context of the Covid-19 pandemic but are quite relevant to the problem of workplace violence. Benedetti et al. (2020) propose a sliding scale model for determining the strength of a duty to care by weighing the risk to a provider against the benefit to the patient. Similarly, McDougall et al. (2020) described a five-step guide for balancing provider safety and the duty to care that would be equally as applicable to situations of workplace violence as to the provision of care during the outbreak of a novel infectious disease. This framework included calculation of the risk to staff, consideration of the options to protect the provider, quantifying the degree of protection and impact on patients for each option, and choosing the option with the most proportionate effect on patient care. The third decision-making framework is one I proposed in a previous paper (Dunsford, 2021). In it, I suggest that the strength of a nurse's duty to provide care is determined in part by the relative vulnerability of both the nurse and the patient. Like Benedetti et al. (2020) and McDougall et al. (2020), this model considers the magnitude and probability of the impact of violence in relation to the potential consequences of remaining or leaving for each party, as well as the nurse's perception of the risk. While difficult to use in the moment, these kinds of tools can be used for planning care, and for debriefing and analysis of decisions and actions after a problematic encounter has occurred.

This section has outlined the scant literature on ethical decision making as it relates to workplace violence. Although Copeland and Arnold (2021) and Beattie et al. (2020) sought to address the question, and Benedetti et al. (2020), McDougall et al. (2020), and Dunsford (2021) offer options for managing the inherent considerations, the need for a substantive theory of nurses' decisions on the care of people who are aggressive, abusive, or violent has not been satisfied. The study described in this dissertation builds on this literature and offers a theoretical approach to what Copeland & Arnold (2021) refer to as the "fuzzy and porous" middle space (p. 5) between obligations to provide care and justifiable

withdrawal from patently unsafe situations, where conflicting goals and duties create complex dilemmas with no single right answer.

In this study, I pose three research questions: what ethical decisions nurses face in the context of workplace violence, what considerations factor into their decisions about the morally correct action, and how they experience moral distress as a result of violent events. To provide background and situate the theoretical approach that was developed from this investigation, it is necessary to consider what is known about workplace violence and moral distress. The next section provides a summary of these two topics.

Factors that Impact Violence in Nursing Workplaces

A review of the literature on violence in the nursing workplace reveals a vast body of knowledge. In this section, I will offer a summary of the problem, and dive more deeply into the factors that are known to increase or decrease the risk of violence at work.

Background

There is a large volume of evidence supporting the proposition that violence in the nursing workplace is highly prevalent and a growing problem. Numerous reports indicate that most nurses have experienced abuse or aggression from patients or bystanders. A systematic review of 253 studies by Liu et al. (2019) found that 60% of nurses reported experiencing workplace violence in some form.

Violence is most commonly reported in inpatient psychiatry (Fujimoto et al., 2022; Havaei et al., 2020; Iennaco et al., 2024; Lim et al., 2023; Liu et al., 2019; Mento et al., 2020; Schlup et al., 2021), emergency (Casey, 2019; Garren-Grubbs & Hendrickx, 2023; Havaei et al., 2020; Iennaco et al., 2024; Liu et al., 2019; Mento et al., 2020), and long-term care settings (Blanchard, 2022; Brophy et al., 2019; Iennaco et al., 2024; Mento et al., 2020; Somes, 2023; Vidal-Martí, 2021), but is noted to occur across a wide variety of health care settings and countries. The perpetrators of assaults and aggression are

primarily identified as patients (Bekelepi & Martin, 2023; Choi et al., 2022; Samuels et al., 2018; Schlup et al., 2021; Sim et al., 2020; Tarzian & Marco, 2008) and relatives (Alsharari 2021; Boateng & Brown, 2022; Havaei & MacPhee, 2020). The most common form of violence cited is verbal, followed by emotional, physical, and sexual (Al-Ali et al., 2016; Al-Qadi, 2020; Al-Qadi, 2021; Babiarczyk et al., 2020; Bekelepi & Martin, 2023; Burke Draucker, 2019; Byon et al., 2021; Cetinkaya et al., 2018; Choi et al., 2022; de Lima Trindade et al., 2019; Kim, Mayer & Jones, 2021; Kołodziej et al., 2021; Kvas & Seljak, 2014; Magnavita et al., 2020; Mento et al., 2020; Rees et al., 2018; Reichert, 2017; Shea et al., 2017; Song et al., 2021).

Of relevance to the present study, the literature on antecedents to violent events provides a picture of the factors that increase the risks. Studies investigating mitigation and management of workplace violence provide additional perspective on the considerations that factor into nurses' care decisions. In the following section, I describe current research on the antecedent factors that influence violence, and those tools, strategies, and resources that nurses use to mitigate risks in the care setting.

Antecedents

Many factors have been identified as antecedents to violent events which are associated with alterations in the likelihood that violence will occur, and, if it does, the impact the event might have. These include factors related to the nurse, patient, and environment. Such factors, if present, may have a bearing on a nurse's decision-making process during care delivery.

Personal Factors Related to the Nurse. Several studies have examined gender as a predictor of experiences with violence in the workplace, but results are difficult to interpret, as nursing remains a female-dominated profession, and sampling biases of included studies may skew results. Some studies suggest that male nurses experience more physical violence (Edward et al., 2016; Li et al., 2020) and women more verbal violence (Edward et al., 2016), whereas others found the prevalence of violence,

especially sexual violence against female health care providers to be more common (Aivazi et al., 2017; Schlup et al., 2021). In general, however, gender does not appear to be a statistically significant factor in the likelihood of a nurse being subjected to aggression or abuse (Bekelepi & Martin, 2023; Li et al., 2020), although an individual's gender identity may play a part in their own sense of security or situational awareness of the risk of violence.

Experience was also considered in several studies, again with mixed results. While some studies identified younger age or less work experience as predictive of increased risk of exposure to violence (Cetinkaya et al., 2018; Li et al., 2022; Nowrouzi-Kia et al., 2019; Schlup et al., 2021; Shu-Fen et al., 2018; Chaiwuth et al., 2020; Wei et al., 2016), others found that nurses who were older or had more experience were more likely to report having experienced violence (Bekelepi et al., 2023; Liu et al., 2019; Shu-Fen et al., 2018). These findings suggest that less experience may be related to insufficient knowledge or skill in preventing or mitigating violence, and that a longer career duration provides more opportunity for violent events to have occurred and the resulting normalization fosters a higher threshold for considering an incident to be violence (Funk et al., 2021).

Nurses' mindset, emotional state, and resilience are also related to their experience of aggression from patients and bystanders. Kim et al. (2016) found that interpersonal conflict tends to occur when a person makes negative assumptions or judgments about another's intentions or competence. Burnout is also correlated with violence (Kobayashi et al., 2020; Kwak et al., 2020; Lantta et al., 2016; Li et al., 2020; Rees et al., 2018), and stress and fatigue are known to be mediating factors in the experience of verbal abuse (Kim et al., 2016). These findings suggest that these kinds of mindsets may predispose a nurse to view a patient's behaviour as aggressive, sparking an escalation of conflict. The experience of workplace violence is also noted to be linked to compassion fatigue (Kwak et al., 2020; Lantta et al., 2016) and job strain (Magnavita et al., 2020), which results in a self-reinforcing spiral of

conflict that leads to burnout, disengagement, and stress, leading to further conflict (Kim, Quiban, Sloan & Montejano, 2021; Saleem et al., 2020).

Protective factors related to emotional state have also been identified. For example, Başoğul et al., (2019) identified a relationship between awareness and management of emotions, and nurses' exposure to physical or psychological violence, suggesting that training on emotional regulation may be helpful for nurses. Funk et al. (2021) described the ways that some health care providers use "deep acting" (p. 95) through modification of their own emotional manifestations, to minimize the emotional impact of experiences of violence, although they state this is not always healthy. Personal characteristics support the development of resilience, which is seen to be protective against the consequences of violence (Beattie et al., 2018; Choi et al., 2022; Foli, 2022; Hollywood & Phillips, 2020; Rushton, 2018). Resilient nurses are those who use effective physical, psychological, and emotional coping strategies that enable them to function even in the face of difficult interpersonal encounters. Self-care (Beattie et al., 2018), and training in violence prevention and de-escalation techniques increases resilience (Brophy et al., 2018; Howerton Child & Sussman, 2017; Searby, et al., 2019; Spelten et al., 2022) and a feeling of preparedness. Although these strategies are likely insufficient to deflect or avert all incidents (Al-Ali et al., 2016; Morphet et al., 2018), they may support the ability to bounce back from a violent encounter. Furthermore, nurses who have high levels of personal well-being and support in the aftermath of a difficult encounter are able to rebound more easily from the incident and prepare constructive coping strategies to help them manage their response to future incidents (Han et al., 2021; Shi-Hong Zhao et al., 2018).

Patient Factors. Several factors predictive of workplace violence concern the health conditions that patients experience. Mental health conditions figure prominently in this literature, and findings indicate that violence is common in psychiatric care settings and emergency departments where people

with such illnesses may seek care (Asikainen et al., 2020; Bekelepi & Martin, 2023; Hiebert et al., 2022; Konttila et al., 2020; Li et al., 2022; Lim et al., 2023; Sim et al., 2020; Tiihonen et al., 2009). The diagnosis of mental illness and symptoms such as hallucinations increase the likelihood of health care provider risk (Asikainen et al., 2020; Fujimoto et al., 2022), as does the presence of dementia or cognitive impairment and intellectual or developmental disability, and, interestingly, Covid-19 (Blanchard et al., 2022; Brophy et al., 2019; Byon et al., 2021; Casey, 2019; Dal Pai et al., 2018; Garren-Grubbs & Hendrickx, 2023; Hiebert et al., 2022; Kleissl-Muir et al., 2018; Mitchell, 2022; Najafi et al., 2018; Senz et al., 2021; Shea et al., 2017; Sim et al., 2020; Somes, 2023; Spelten et al., 2020, 2022; Timmins et al., 2021; Vidal-Martí, 2021). Such health conditions, and the accompanying stress, lack of personal control, and discomfort may impact the patient's ability to manage their emotions and can manifest as what is termed "responsive behaviour" (Alzheimer's Society of Canada, 2019; Clifford & Doody, 2018). When a health condition, such as dementia or mental illness interferes with a person's ability to effectively moderate their own behaviour or express themselves, they may act out aggressively in response to fear, frustration, or confusion, or in an attempt to communicate unmet needs (Crandall et al., 2022). Given the ever-increasing rates of hospitalization of people with dementia, this is unfortunately a common occurrence (Beattie et al., 2018; Casey, 2019; Kleissl-Muir et al., 2018; Mento et al., 2020; Morphet et al., 2018; Samuels et al., 2018; Senz et al., 2021; Zaczyk et al., 2018). A sense of powerlessness amplifies patient uncertainty, wearing at patience and tolerance (Iennaco et al., 2024).

Nurses' perceptions vary with their assessment of the intentionality of patient behaviour. As Copeland and Arnold (2021) noted, when a patient is not in control of their actions due to a cognitive impairment, or does not display an intention to cause harm, it is easier to attribute the behaviour to their health condition. In contrast, when someone is evidently in control of their actions, yet chooses to be aggressive or abusive, their actions are seen as crimes. Beattie et al. (2020) concurred, stating that

their participants were willing to provide care for someone who is cognitively impaired, for example from dementia, and less inclined to do so when the person was acting out due to frustration or interpersonal conflict. This is interesting and relevant to the present study in that there are differences in tolerance of behaviour considered generally to be socially unacceptable when the person is impaired or otherwise organically unable to manage their responses to a situation as compared to someone who is perceived to have control yet chooses not to exercise it.

Environment. The environment in which nursing care occurs is an important factor in the development of violence. Crowding and noise tend to amplify stress, contributing to increased tensions and short tempers in care settings like emergency departments (Asikainen et al., 2020; Hattingh et al., 2019; Hiebert et al., 2022; Naseem et al., 2022; Timmins et al., 2021). Waiting for care has similar effects. Patients experiencing long wait times were noted to be at high risk for the development of volatility (Abdellah & Salama, 2017; Esposito & Contreras Sollazzo, 2021; Hattingh et al., 2019; Iennaco et al., 2024; Spelten et al., 2022; Timmins et al., 2021). These antecedents are understandable, as they likely interfere with patient comfort and basic needs such as sleep, and with nurses' ability to attend to essential tasks like providing medication.

Overcrowding, noise, and wait times are symptoms of an overtaxed health system, and nursing workloads are correspondingly high. Workload is also impacted by short staffing, compromising nurses' capacity for effective communication of expected wait times, diagnostic information, and care planning, which leaves patients and families feeling neglected and anxious (Al-Qadi, 2020; Alsharari et al., 2021; Havaei et al., 2023; Havaei & MacPhee, 2020; Hong et al., 2022; Kiymaz & Koç, 2022; Li et al., 2020; Chaiwuth et al., 2020).

The physical environment of the care setting is also noted to be germane to emotional instability. Especially on psychiatric units, lack of privacy is a concern, as is insufficient programming, boredom, and

lack of meaningful occupation (Asikainen et al. 2020). Having access to safe building design such as escape routes and sheltering spaces is important to nurses (Beattie et al., 2020). Many units do not have good lines of sight or sound, so that if a nurse was being attacked, it might go undetected (Hiebert et al., 2022). Even something as simple as signage purporting zero tolerance policies for aggression can itself be seen as aggression when it implies a threat to withdraw health necessary services if behaviour is not deemed appropriate by someone in a position of relative power (Beattie et al., 2020).

Security measures like alarm systems, communication devices, cameras, and trained security personnel play a role in the perception of environmental safety and the prevention or de-escalation of violence (Brophy et al., 2019; Hiebert et al., 2022; Rajabi et al., 2020; Shu-Fen et al., 2018; Spelten et al., 2017, 2022; Chaiwuth et al., 2020). Visible presence of security services and the prospect of being held accountable for actions may have a dampening effect on some kinds of volatile behaviour. Hsu et al. (2022) recommended adding security equipment, as their participants stated their additions were seen to increase staff safety in the environment. These kinds of environmental factors contribute to a sense of safety in the work environment, which in turn alters the likelihood of violence developing or having a detrimental impact on those in the setting. Implementation of safety processes such as protocols, reporting mechanisms, and case reviews contribute to root cause analysis and preventive measures (Dunseth-Rosenbaum et al., 2023). When the work environment is felt to be unsafe, nurses report increased likelihood of engaging in verbal conflict with patients who are deemed to be unreasonably demanding or inappropriate (Laeeque et al., 2019; Sim et al., 2020).

The literature on factors which increase the risk of violence is presented here to provide context for this study's examination of the considerations that factor into nurses' ethical decision-making in the context of workplace violence. It is suggested that these sensitizing influences on the development of increased volatility, including personal factors related to the nurse, patient-related characteristics, and

environmental influences play a role in the choices nurses make with respect to the planning and delivery of care when violence is a possibility. Nurse-related attributes include gender, experience, and emotional well-being. Patient factors include their health condition and the perception of the patient's intentions and level of self control. Environmental influences include overcrowding, long waits, and noise, the physical layout of the unit, and the presence or absence of security measures. Each of these has been shown to have the potential to contribute to a violent encounter in the nursing workplace. Next, I summarize the literature on those elements which mitigate or decrease the probability of aggression or abuse.

Decreasing or Mitigating Risk

Given the vast global presence of workplace violence and its devastating impact on individuals and health systems decimated by a shortage of nurses (World Health Organization, 2020), researchers have turned their attention to understanding the measures that mitigate the risks of violence. In this section, I summarize the literature on factors that address the likelihood of experiencing violence, and support nurses in building capacity for preventing and managing workplace violence. These include risk assessment, the availability of supports, and the skills and tools that can de-escalate or prevent aggression. Relevant to the present study, these are things that individuals and systems can do, and which, if unavailable, significantly constrain the options that a nurse has to choose from when considering options for managing a violent patient. The first of these is risk assessment.

Risk Assessment. Risk assessment is a process of using situational awareness to identify and monitor cues that a person's behaviours might escalate toward aggression or violence (Clarke & Leh, 2023). In their rapid review paper on evidence-based approaches to mitigate workplace violence in emergency departments, Recksy et al. (2023) identified several studies that show screening of patients and visitors for the risk of violence to be effective in reducing its frequency, when used in combination

with other measures such as enhanced communication and training. The use of a screening tool permits the early identification of potential aggression, enabling nurses to implement measures to prevent it, such as providing comfort and addressing concerns in a timely manner (Clarke & Leh, 2023; Quinn and Koopman, 2023).

As a risk assessment strategy, understanding reasons for behaviour can help to address or prevent negative sequelae (Somes, 2023). A thorough nursing assessment to determine a source of agitation, especially in a patient who is cognitively impaired, can ensure the measures taken are appropriate to the root cause. Paying attention to the things that underpin behaviours and make it more likely that someone will strike out is a simple way of warding off undesirable behaviours before they occur.

Availability of Supports. Structures and services available to support nurses can have an impact on the incidence and severity of workplace violence. The literature describes legal remedies, response teams and security, leadership support, effective reporting mechanisms, and a positive work environment as contributors to reduced risks of violence.

The law can play a role in violence prevention, although results of existing legal remedies is mixed. In Canada, as in some other jurisdictions, sentencing enhancements for assaults on health care workers are available, however Nelson et al. (2023) noted that these are imposed infrequently, if ever. They suggested that the reason for this is that violence against nurses is often a result of a patient's illness, making prosecution unlikely to be effective. Worse, the courts have not historically recognized health care as an inherently dangerous industry so prosecution and sentencing guidelines tend not to consider the fact of the victim being a nurse as an aggravating factor.

Zero tolerance policies, while well-intentioned as deterrents, tend to escalate tensions and lead to uncertainty in their application by nurses (Beattie et al., 2020). This is because they fail to account for

morally relevant differences between the aggression perpetrated by someone who is in control of their faculties, and someone who is ill and in need of care (Nelson & Baumann, 2021). Beattie et al. (2020) agreed, suggesting that the threat implied by zero tolerance messaging of exile from the health care setting despite an actual or perceived need for health services is at best inhospitable, and at worst, can itself be an act of aggression. Furthermore, people working in places with zero tolerance policies tended to be less tolerant of patient behaviours, which may well decrease empathetic responses to patient distress and escalate brewing tensions. In this sense, zero tolerance policies are not effective supports for the prevention or mitigation of violence.

The availability of security services, violence response teams, and police, however, can have a moderating effect on the need for nursing intervention in escalating situations. The review paper by Recksy et al. (2023) described several studies that included enhanced presence of security services within the high-risk environment. This could help by decreasing response times, but they suggest that such interventions must also be accompanied by training of both security staff and health care providers. Of note, in relatively isolated environments such as rural health care facilities, quick access to security and law enforcement is not available, so additional safety measures are required (Garren-Grubbs & Hendrickx, 2023).

The support of leadership and management in the aftermath of a violent incident is crucial, both in supporting the recovery of those involved, and in setting the tone for individual nurses' management of future events. For example, Andersen et al. (2021) noted that nurses who receive strong support from a supervisor after an incident are much more likely to remain committed to their position and are less likely to require mental health services later. Powell et al. (2023) also described the betrayal and loss of trust that nurses experience when they are not supported by their employer after experiencing a violent incident. Shea et al. (2018) concurred, suggesting working in a positive environment increases the

likelihood of receiving post-incident support. This has a massive impact on nurses' propensity to report incidents. Organizational implementation of a risk assessment tool also demonstrates leadership support for documentation and reporting of violent incidents (Clarke & Leh, 2023). Indeed, organizational norms around coping with the impacts of violence lead to significant emotional labour for nurses, not all of which is constructive (Funk et al., 2021).

Indeed, there is evidence that workplace violence is vastly under-reported (Byon et al., 2021; Spencer et al., 2023). A predominant belief cited by participants in numerous studies was that violence is a part of the job so documenting it serves no purpose (Babiarczyk et al., 2020; Byon et al., 2021; Nelson et al., 2023; Nelson & Baumann, 2021; Spencer et al., 2023). This is often attributed to actual or perceived barriers to reporting on incidents (Iennaco et al., 2024; Lim et al., 2023; Powell et al., 2023; Spencer et al., 2023; Chaiwuth et al., 2020; Tilley et al., 2023). A decision not to report an incident can also be due to a fear of reprisal from the patient or employer (Brophy, 2019), a sense of guilt for not having avoided the incident (Blanchard et al., 2022), the feeling that reporting is useless or not important (Dunseth-Rosenbaum et al., 2023), or organizational and professional norms (Funk et al., 2021). These beliefs and attitudes reflect a low level of trust in the employer, which can be overcome through policies and practices that provide institutional and emotional support in the wake of challenging interactions with patients or bystanders. Debriefing after an incident, for example, can help nurses process emotions and inform managers of the associated causes and consequences, presumably providing information they can act on to help prevent similar events in the future (Garren-Grubbs & Hendrickx, 2023; Recsky et al., 2023; Somes, 2023).

Debriefing can contribute to a positive work environment, which can also enhance nurses' ability to prevent, manage and deal with violent patient interactions (Andersen et al., 2021; Shea et al., 2018). Andersen et al. (2021) suggested that nurses may be willing to accept certain risks in the course of their

employment, if the employer provides the necessary supports to follow up on incidents where the risk is realized. Similarly, Escribano et al. (2019) recommended a positive social climate and effective institutional policies to support nurses impacted by violence and threat. In counterpoint, Nelson et al. (2023) observed that the practice of encouraging nurses not to identify themselves as health care providers outside of work undertaken during the pandemic, when protesters blocked entrances to health care facilities, places responsibility on the employee to prevent violence, and effectively absolves the employer of accountability for ensuring effective measures. Encouragingly, Zeng et al. (2022) found that a positive work environment can increase post-traumatic growth, and support of employees after violence is a critical element of that.

To summarize, the availability of supports, including legal and policy structures, security measures, and employer support can help to decrease the likelihood of incidents, and the severity of impact when they occur. The final category of research in this area is the skills and tools that nurses can develop to mitigate these risks.

Skills and Tools. Nursing skills and tools are important factors in the prevention and management of workplace violence. The literature describes approach, communication, debriefing, and training as relevant resources in the response to workplace violence.

The approach a nurse takes to interactions with a patient, especially if the person is cognitively impaired by a health condition such as dementia or delirium, or is experiencing symptoms such as paranoid delusions, pain, or hallucinations can be significant contributors to the outcome of the encounter. A study by Crandall et al. (2022), for example, showed that training staff who work with people living with dementia in person-centered, respectful ways, that focus on effective communication and interpersonal strategies, self-protective skills, and debriefing and reassurance techniques increased self-efficacy in managing patients with challenging behaviours. Knowledge of health conditions, nurses'

self-awareness of values, beliefs, and effective approaches to distressed patients results in improved care (ibid.). Approaching a patient care interaction with caring knowledge strengthens the therapeutic relationship and may decrease aggression and violence (Brune et al., 2023).

Likewise, communication can make a difference to the development of the tensions and conflicts that lead to violence. Firstly, patients with communication disorders or language barriers can easily become frustrated (AlShehri, 2020; Crandall et al., 2022). Effective communication from health care providers about things that cause frustration or anxiety, like wait times, the patient's condition, and care plans can help to alleviate some of the triggering antecedents of violence (Asikainen et al., 2020; Sinh et al., 2023). Uncertainty, lack of contact with staff, and having unmet needs have been identified as antecedents to violence, implying that at least some of the conflict can be averted simply through communication and connection between patient, family, and nurse (AlShehri, 2020; Hsu et al., 2022; Li et al., 2022; Nowrouzi-Kia et al., 2019). Knowledge of a patient's condition, especially if there are features or symptoms that suggest they are likely to be or become volatile, can support nurses' care planning in ways that maximize safety (Fujimoto et al., 2022; Recsky et al., 2023). Finally, if conflict does escalate, dialogue between and among parties to a conflict can help to de-escalate it before it reaches a crisis (Sato et al., 2016).

Debriefing is also important once an event has taken place. While informal debriefing after the fact can be helpful (Clifford & Doody, 2018), formal, in-depth analysis of an event can help nurses to understand what happened before and during a violent incident, and to make improvements to reduce the risk of recurrence (Asikainen et al., 2020; Iennaco et al., 2024). Whether formal or informal, support for those involved is crucial, to ensure situations are reported and to offer opportunities to address systemic and patient-specific issues (Iennaco et al., 2024; Shea et al., 2018). Powell et al. (2023) encouraged actively listening to people who have experienced violence to prevent the sense of betrayal

that nurses report when they have been hurt by a patient and the organizational follow-up is inadequate or absent. Debriefing an event improves the perception of safety in the environment (Brune et al. 2023; Thomas, et al., 2021).

Numerous studies have identified the benefits of training nurses in techniques for approaching patients, managing complex care, and de-escalating patient and bystander behaviours to improve safety and reduce violence. Indeed, a lack of training in self-defence is a barrier to prevention of aggression, as nurses may not have formal guidance on recognizing cues that may lead to violence (Al-Qadi, 2020). Training on de-escalation and early recognition of behaviours that could become violent offers new strategies and skills and increases confidence and self-efficacy (Abozaid et al., 2022; Crandall et al., 2022; Fujimoto et al., 2022; Kumari et al., 2022; Lim et al., 2023; Recsky et al., 2023; Wirth et al., 2021). Educational programs specific to common patient conditions and the provision of person-centered care have been recommended for all health care staff, not just nurses (Clifford & Doody, 2018; Crandall et al., 2022). Furthermore, training can also improve patient satisfaction and lessen the frequency of problematic behaviours that need to be managed (Sinh et al., 2023). Working in a facility where there is an emphasis on training also increases the likelihood of post-incident support (Shea et al., 2018).

To summarize, the literature on factors that decrease the likelihood of workplace violence, or the severity of its impact considers risk assessment, the availability of supports to the nurse, and the skills and tools nurses have at their disposal to recognize and respond to escalating behaviours. Risk assessment is a basis for the recognition of potential antecedents to aggression and conflict. Supports such as legal structures, security services, reporting mechanisms, and explicit support from supervisors are crucial. Skills and tools including a nurse's approach and communication, as well as the opportunities for debriefing and training have an important bearing on the development of violent incidents. These factors provide considerations for the ways nurses and their employing institutions can foster decreased

risks for violence. In conjunction with factors that increase a nurse's susceptibility to victimization, this literature provides some insight into the factors and considerations that nurses take into account when working with people who are violent.

Moral Distress

The third research question in this study concerns the ways nurses experience moral distress related to workplace violence. Moral distress is a term that has developed from research on nursing practice and has been studied and theorized extensively. In this section, I provide a short account of the evolution of the concept, and a summary of the current understanding of moral distress that is relevant to the study of workplace violence.

Background

Moral distress is a term coined by American philosopher Andrew Jameton, who called it the suffering resulting from a situation where institutional constraints prevent one from making a morally correct choice; in other words, knowing the morally correct action but being prevented from doing it (Jameton, 1984). The concept has evolved to encompass the angst that occurs at the point of challenging moral dilemmas, as well as in contexts where one was unable to act appropriately (Campbell et al., 2016; Corley, et al., 2005), or to live up to caring commitments such as preventing suffering (Walsh, 2018). Consensus about the attributes of the concept is elusive; for example, Sanderson et al. (2019) included harm as a necessary element, in the sense they attribute moral distress to the commission of avoidable harm through action or inaction; however, others do not. Irrespective of the features of a particular definition, there is agreement that the sense of moral failure at having compromised deeply held values or beliefs has a lasting impact (Morley et al., 2022; Webster and Baylis, 2000). The definition I have adopted for the purposes of this study is the one proposed by Morley et al. (2020), who described moral

distress as the psychological anguish that results from a moral event, including emotionally evocative situations arising from perceived violations of core values, or tensions between and among moral ideals.

There is a significant body of knowledge related to moral distress that is relevant to this study. As I will show in the findings of this work, moral distress can arise from the experience of workplace violence. The literature on antecedents to moral distress provides useful insights into the ways nurses make decisions and experience moral distress in challenging situations.

Moral distress occurs when the nurse encounters challenges, threats, or violations of their personal or professional integrity (Thomas & McCullough, 2015). These result from constraints on moral agency, such as the requirement to carry out decisions made by others that may be incompatible with the nurse's own values (Morley & Sankary, 2024), or from everyday situations in health care settings, such as witnessing suffering, or caring for marginalized people. Low levels of influence, high demands on time and emotions (Petersen & Melzer, 2023), failure of others to recognize nursing expertise, poor communication, and scarce resources (Morley, Bradbury & Ives, 2022) are all cited as antecedents to moral distress.

The impact of moral distress is known to be considerable. Moral distress is associated with compassion fatigue, decreased work satisfaction, and post-traumatic stress disorder (Austin et al., 2017; Jones-Bonofiglio, 2020). The experience of moral distress among nurses has been linked to withdrawal and disengagement, and intention to leave the profession (Dodek et al., 2016; Epstein & Hamric, 2009; Wilkinson, 1987). Numerous studies have demonstrated a connection between the experiences of moral distress and burnout (Arnold, 2020; Buitrago, 2023; Eche et al., 2023; Fumis et al., 2017; Jones-Bonofiglio, 2020; Mewborn et al., 2023; Petersen & Melzer, 2023; Rushton, 2018). Overall, Rushton (2018) described myriad physical, behavioural, emotional, and spiritual consequences of exposure to morally distressing events.

Moral residue is a term coined by George Webster and Francoise Baylis in 2000 (Webster & Baylis, 2000) to signify the lasting effects of moral compromise. Moral residue is painful and has a powerful influence on future action through fear, its creation of uncertainty, and shame for having acted, or having failed to act, in ways that compromise deeply held values. This reactive distress occurs in reflection of a moral event, after the initial crisis has resolved. The lingering discomfort alters the individual's baseline for moral distress and increases the emotionality of subsequent situations which evoke memories of previous distressing events (Epstein & Hamric, 2009). As additional morally distressing events are experienced, the baseline grows, resulting in a crescendo of moral residue, especially when resolutions to each event are unsatisfactory or there are systemic barriers repeatedly preventing the avoidance of predictable moral compromise. Tolerance drops and reactions become stronger and less helpful.

It is moral residue that is postulated to cause the more concerning sequelae of morally distressing events. For example, a connection has been demonstrated between moral distress and poor general well-being (Petersen & Melzer, 2023; Rushton, 2018). Chronic levels of stress, and the near constant need to manage situations that have no effective resolution leads to powerlessness, frustration, isolation, disillusionment, and shame, and have physical, emotional, and behavioural sequelae (Rushton, 2018). These inner conflicts persist, with a cumulative effect that makes each event more difficult to recover from than the last one (Arnold, 2020; Epstein & Hamric, 2009), with real-world implications, including links to a higher incidence of mental health issues and medication use (Havaei & MacPhee, 2021).

Fortunately, the news is not all bad. Moral distress can have positive outcomes when the nurse leverages their moral uncertainty and outrage into increased levels of empathy, and the provision of better care through ethical reflection (Cooke et al., 2022). Using the opportunity presented by morally

distressing events and circumstances to change outcomes can result in post-traumatic growth (Jones-Bonofiglio, 2020; Zeng et al., 2022). Varcoe et al. (2012) described this as using moral tensions as a catalyst for addressing those things that have literally de-moralized the nurse. That is, they suggest that the politicization of moral distress can be used to address the systemic constraints that result in the competing values and power dynamics from which it arises. The individual's sense of fractured integrity can begin to heal when they feel the issue is less likely to happen in the future, facilitating a kind of moral repair.

The Link Between Workplace Violence and Moral Distress

Workplace violence is intimately connected to the experience of moral distress. Impediments to acting on judgments about the morally correct action are exemplified by the dilemma of workplace violence. Thomas and McCullough (2015) described the categories of ethically significant moral distress as including challenges, threats, and violations of personal or professional integrity. An experience of violence, whether it is actual or potential, challenges the nurse's integrity in the sense that injury or harm damages the individual's bodily or psychological intactness. Furthermore, leaving a patient care encounter because it is unsafe to remain in the environment compromises or impairs integrity by preventing the nurse from upholding basic values of nursing practice like trust, care, and non-abandonment. This rupture of the therapeutic relationship due to missed care and a desire to disengage is felt as a violation that, while necessary to the nurse's personal safety, leaves the patient without care that may be life-sustaining (Al-Qadi, 2020; Bayram et al., 2023; Jussab & Murphy, 2015; Kim, Mayer & Jones, 2021).

These decisions are particularly fraught, when either staying in a dangerous situation to provide for a person's care needs or leaving them without care to de-escalate risk feels like moral wrongdoing. In their concept analysis, Liu et al. (2023) identified incompatible interests, competing values, and

ambiguous obligations as defining attributes of ethical conflict. Indeed, values conflicts between nurse and patient, or within inter- or intra-professional teams lead to disharmony and tension (Morley et al., 2022; Rushton, 2018). The nurse's personal and professional values are important here. While attention to the biomedical needs of a patient is crucial, nursing values are what creates a caring and therapeutic relationship. When values cannot be fulfilled, it creates moral distress. The inability to provide effective care due to incipient violence meets these criteria easily.

Structurally, violence is often precipitated by the same organizational constraints that produce moral distress in nurses (Sinh et al., 2023). The sense of betrayal that accompanies both violence and an inadequate response from supervisors after the fact is incredibly distressing (Powell, 2023). Factors like time limitations (Midtbust et al., 2022; Petersen & Melzer, 2023), low levels of influence and power, inadequate resources (Liu et al., 2023; Petersen & Melzer, 2023), and staffing levels and administrative support (Hamric, 2014; Hamric et al., 2012; Jones-Bonofiglio, 2020; Wilkinson, 1987) cause moral distress in and of themselves by preventing the nurse from providing good care, which in turn can lead to increased tensions and violence in many situations. Workplace violence is associated with emotional distress and fear (Woo et al., 2024) and depression (Sinh et al., 2023). The high emotional demands of nursing work, and prolonged exposure to ethical dilemmas and values conflicts inherent in patient care situations can lead to frustration and disengagement, which are again, antecedents to patient- or bystander-initiated aggression (Buitrago, 2023; Midtbust et al., 2022; Petersen & Melzer, 2023). It becomes a vicious cycle. The circumstances that create the moral uncertainties and impossible decisions that result in moral distress also set the groundwork for development of tensions that can escalate to violence, which in turn leads to moral distress when the nurse is faced with a decision on whether to provide care or remain safe.

Responses to aggression and abuse align closely with the outcomes of morally distressing experiences, such as work stress, decreased job satisfaction, physical and emotional impacts, and poor coping (Al-Qadi, 2021; Hiebert et al., 2022; Kobayashi et al., 2020; Kwak et al., 2020; Sinh et al., 2023). Another reaction to both moral distress and violence is disengagement or withdrawal from the work. This can take the form of compassion fatigue (Eche et al., 2023; Jones-Bonofiglio, 2020), a stress response which has been described by some as synonymous with moral distress, and which contributes to a loss of empathy and compassion (Sinclair et al., 2017). Compassion fatigue can manifest in apathy, unresponsiveness, or callousness. Furthermore, moral distress, like violence, has been shown to increase the intent to leave one's job, or even one's profession (Austin et al., 2017; Dodek et al., 2016; Petersen & Melzer, 2023). The traumatic experience of violence is a moral event highly likely to cause moral distress (Morley et al., 2020). This corresponds with research on workplace violence that demonstrates decreased empathy (Stevenson et al., 2015) and increased turnover intentions among people who experience it (Pariona-Cabrera et al., 2020; Park & Song, 2023). Fortunately, a supportive work culture may mitigate some of these impacts by moderating some of the desire to disengage (Saleem et al., 2020).

Given that the problem of moral distress, broader but intimately related to the experiences and impacts of workplace violence, is so pervasive and primarily experienced as undesirable, addressing and mitigating it is a priority. While studies have shown that interventions do not decrease the incidence of moral distress, they do tend to improve the outcomes for individuals. For example, when programs are implemented, people report less intent to leave, fewer physical and psychological effects, and better coping (Ishihara et al., 2022; Moverley et al., 2023; Sarro et al., 2022). Interventions aimed at reducing the impacts of moral distress include ethics education (Ishihara et al., 2022; Midtbust et al., 2022; Rushton, 2018; Zeydi et al., 2022) and strategies to improve interprofessional teamwork (DiGangi

Condon et al., 2021; Küçükkelepçeet al., 2022). A supportive work environment has numerous benefits, including attention to nurses' exposure to trauma, policies, procedures, and resources that prevent and respond to workplace traumas, adequate staffing and supportive leadership, and the development of moral communities that demonstrate the degree to which nurses matter to the system in which they work (Epstein et al., 2020; Foli, 2022; Midtbust et al., 2022). Finally, at an individual level, strategies to increase nurses' resilience to morally distressing experiences can positively impact their ability to recover from workplace traumas like violence.

The relevance of moral distress to this study is summed up by Jones-Bonofiglio (2020) in her discussion of the costs of caring and not caring. Caring, a core value and, some would argue, the primary purpose of nursing, requires selflessness, presence, engagement, and, importantly, the vulnerability to place oneself in the position of using skills, knowledge, and compassion to act for the benefit of another person. Nursing is entirely a relational endeavour, with ethics, the practice of considering and intervening based on values and moral principles, at its foundation. There is a cost to this, of course, in the form of potential harm from the exposure to such vulnerability, especially when the caring relationship results in physical or psychological injury from a combative patient. Similarly, there is a moral cost to not caring. The vulnerability of caring carries an emotional impact when professional outcomes are not possible, whether it is because of institutional constraints on the optimal provision of care, or because of the need to set safety-focused boundaries on a relationship means that care provided falls short of what the person needs.

In summary, research on moral distress has been developing the concept since it was first proposed (Jameton, 1984). In the intervening 40 years, the definition of the term has evolved to encompass the psychological distress caused by the experience of a moral event (Morley, et al., 2020), including witnessing or being party to negative outcomes for patients, working under structural

constraints, and, certainly, the experience of workplace violence. Violence in the nursing workplace has the hallmark of being a moral event, capable of generating moral distress, moral residue, and moral injury. Indeed, outcomes for nurses when experiencing violence mirror the literature on the sequelae of moral distress, including moral residue and disengagement, and an increased likelihood of leaving the job. The positions that violence places nurses in are situations where no action will fulfill all moral obligations at the same time. The required compromises force a choice between incompatible, yet simultaneously compelling values and priorities, fracturing the individual's sense of integrity, and leading to moral sequelae with wide and deep impacts. This literature is relevant to the present study as the experiences of nurses who face workplace violence place them in ethically precarious situations, forcing impossible choices, and leading almost inevitably to moral distress.

This preliminary literature review provided a summary of the literature on ethical decision-making with respect to violence in the nursing workplace, including the two studies that examined the question directly (Beattie et al., 2020; Copeland & Arnold, 2020), and a brief synthesis of relevant recent literature on violence and moral distress. Together these provide a backdrop for examining questions of how nurses navigate the moral dilemmas that arise when they encounter workplace violence. Consistent with the study's constructivist grounded theory methodology, a secondary literature was conducted after data analysis, to identify and examine empirical support for the developing theory. The results of this secondary review are provided next.

Secondary Literature Review: Vulnerability

Consistent with the study's constructivist grounded theory methodology, and to support the emergent theory, a secondary literature was conducted after data analysis, to identify and examine empirical support for the developing theory (Charmaz, 2006; Glaser, 1978). The concept of vulnerability

arose as a defining consideration in the responses of participants to workplace violence, and I offer here a brief survey of the literature on vulnerability as background to the conceptual model.

As I did during the preliminary literature review, I used the University of Manitoba Libraries collections, as well as Google Scholar, CINAHL, and SCOPUS databases for this secondary search. I also consulted the reference lists of retrieved articles for additional resources. Sources were maintained in my personal Zotero citation manager database. To critically examine the new theory against current literature, I focused the secondary literature review on vulnerability, combined with terms and concepts like *ethics*, *nursing ethics*, and *moral distress*, and limited the search to articles published in English in the past five years. I also included seminal sources gleaned from the reference lists of current articles.

The concept of vulnerability has been discussed for many years but was not well defined in the scholarly literature until the 1970s (ten Have, 2016). A dictionary definition of vulnerability refers to the capability of being wounded, openness to attack or damage, and being assailable (Merriam-Webster, n.d.b). The word was most often used in the early literature to refer to biological, social, or military fallibility, and has come to refer also to populations at risk of disease, exploitation, or environmental impacts. Practically speaking, vulnerability is a universal and defining characteristic of humanity, as no one is impervious to all possible harms (Butler, 2004). The human body is the source of vulnerability as it is fallible and susceptible to injury or damage (Fineman, 2021). The word implies dependency, a lack of control, or inability to cope with adversities. People are vulnerable when their autonomy is diminished or constrained; they are exposed and sensitive to threat because they lack either the capability or the opportunity to avoid harm. Philosophically, it is foundational to the principles of respect and justice and carries normative significance (ten Have, 2016). Ultimately, we are all dependent on social relationships and institutions to meet needs which we are not capable of meeting independently (Fareld, 2023; Fineman, 2021). This shared dependency and mutual vulnerability is what makes us human.

Vulnerability is multi-dimensional in that we can be vulnerable physically or emotionally. Both nurses and patients are vulnerable to harm. It is also contextual. It affects some people more than others, at different times and locations. While everyone has the possibility of being injured or harmed, some people are more vulnerable than others due to age, health condition, social status, geographical location, or any number of other factors. In this way, vulnerability is also a determinant of health (East et al., 2020; Fareld, 2023; Luna, 2009, 2019; Victor et al., 2022). Vulnerability is intersectional, or layered, and dispositions toward injury are actualized when circumstances allow them to be (Fareld, 2023; Fineman, 2021; Luna 2009; Mergen & Akpinar, 2021).

The disproportionate impacts of health and social conditions that place some people at higher risk of harm demand social action to mitigate their effects (ten Have, 2016). The contextual and specific nature of vulnerability suggests that those at particular risk deserve special protections from those modifiable external forces that will trigger harm, demanding that we care for each other, and refrain from actions that threaten or endanger others (Luna, 2009; ten Have, 2016). The conditionality of vulnerability and the capacity to prevent harms impose a moral obligation on those relatively less vulnerable to take action to protect an individual at risk (Luna, 2009). Goodin's ethic of responsibility (Goodin, 1985) suggests that vulnerability and dependency impose responsibilities for those on whom someone is dependent. He argued that we are accountable to others for our choices, as our responsibilities are proportionate to others' vulnerability in relation to us (Goodin, 1985; Walker, 1989). Tronto (1993) concurred, suggesting that the more serious the need, the more serious the offence when care is refused.

While vulnerability confers dependence, it also provides others with the capacity to respond, when we recognize the vulnerability of another person, and our ability to meet their needs (Fareld, 2023). This notion contributes some of the normative force of the concept. The state of assailability that

is both biological and universal, implies a basic equality among humans that encourages solidarity and mutuality (Gilson, 2014). The possibility of being harmed implies that prevention of the harm is possible. It offers the opportunity for intervention to nurture or restore control and choice. Furthermore, there is the knowledge that without some kind of assistance, the vulnerable person will be harmed. The protection of another from harm through caring actions permits the actualization of positive potentials that are impeded by bodily dis-integrity and compromised autonomy (Sellman, 2005). This compels action to prevent the damage.

Having considered this conceptual background, ten Have (2016) described a functional account of vulnerability which is highly useful to the present purpose. By this account, vulnerability is a function of exposure to hazards or triggers, sensitivity to their effects, and the capacity to adapt or adjust to threat. All three of these elements must be present for vulnerability to exist. The nature and degree to which each is at play will help to determine the appropriate response. This functional understanding of the concept incorporates both the universality of vulnerability, and the intersectional implications of health and social conditions on the prospect of threat and adds explanatory value to the findings of this study.

The practical implications of vulnerability and its ethical import are relevant to this study. While the asymmetry of vulnerability is normative in the sense that nurses respond by default to patients who are dependent on them for nursing skills, knowledge, and resources, the nurse must at the same time balance their own vulnerability to risks inherent in the patient's condition, like communicable disease or violence. This manifests in the level of engagement that the nurse can achieve with the patient, which ranges from singular attention to withdrawal from the situation.

This proposition is supported by the literature. Ford et al. (2016) showed that job engagement creates a state of vulnerability to workplace violence; people with greater engagement in their work

were more likely to be exposed to violence and sensitive to its impacts. Likewise, disengagement has a protective effect, reducing exposure and sensitivity. Similarly, Heaslip & Board (2012) concluded that nurses who feel vulnerable are more likely to treat care encounters as a series of tasks to complete, rather than a caring relationship with a person. This type of disengagement or emotional withdrawal may be protective of the nurse, that is, to minimize their experience of vulnerability to the potential emotional harms that come with genuine, caring presence. In contrast, the development and nurturing of caring relationships is thought to decrease the fear of vulnerability, which permits true engagement and makes work more enjoyable and meaningful (East et al., 2020; Heaslip & Board, 2012; Lackey, 2020; Spiers, 2000). Indeed, Thorup et al. (2012) suggested that moral agency and courage develop through exposure to vulnerability and suffering, which results in the courage to help, to bear witness to patients' suffering, to advocate and provide care, and to endure the uncertainties associated with engagement. The implication here is that vulnerability plays an important role in the ethical decisions of nurses who face the prospect of being harmed by a patient.

In summary, this section has examined the concept of vulnerability, which arose during this study's data analysis. Defined as an openness to attack or capability of being wounded, someone is vulnerable when they are dependent on others to meet their needs. Although universal, in the sense that everyone bears some inherent level of vulnerability by virtue of being human, some people are more vulnerable than others, either due to exposure, sensitivity, or diminished capacity to adapt to threats. The conditionality of vulnerability suggests that it is possible to ameliorate or prevent it, providing a moral obligation to protect others from harm. Patients are vulnerable to the choices and actions of nurses, who have the knowledge skills and abilities to address their particular vulnerabilities, conferring a responsibility on the nurse to provide care. It is this responsibility that sets up the ethical

conflict that occurs when a nurse must consider whether a patient's aggression renders the nurse more vulnerable than the person for whom they are caring.

Summary

This chapter has outlined the literature search conducted to inform this research study. By way of introduction, I provided working definitions of three key terms: workplace violence, moral distress, and vulnerability. In the primary literature review, I described the scant resources that have considered the question of nurses' ethical decisions in the context of workplace violence and provided a brief description of the problem. Next, I addressed the research on antecedents and mitigating factors in the development of violence, to provide background for the research question concerning the considerations that factor into nurses' decisions in the face of violence. I provided an overview of the literature on moral distress, to inform findings on the third research question. Finally, as a secondary review, I offered a short summary of the concept of vulnerability, to set the stage for the development of the substantive theory that I propose for understanding how nurses navigate the moral dilemmas that arise when they encounter workplace violence. This survey of the literature on nurses' experiences of workplace violence demonstrated an important gap in our understanding of how nurses manage the ethical elements of these scenarios. This study and its findings begin to address that gap, offering a new theoretical approach to explain, describe and predict nurses' decision-making processes when they are faced with the dilemma of workplace violence.

In the next chapter, I provide the methodological framework used to approach this study.

Chapter Three: Methodology

Researching Moral Phenomena

Moral phenomena are the norms, values and obligations that guide action. The act of engaging with and examining these is the practice of ethics (Driver, 2022). This qualitative study examines important moral questions related to how nurses navigate the decision-making process when faced with a patient whose behaviour poses a risk of harm to themselves or others. Nursing ethics and the narrative paradigm are the theoretical frameworks that form the foundation of the decision to employ a constructivist grounded theory methodology to explore these questions. Altogether, this approach to the study provides the opportunity for the development of a theoretical understanding of the moral phenomena at the heart of nurses' experiences with workplace violence.

This research concerns the decisions that nurses make when the aggressive, abusive, or violent actions of a patient or others in the environment create conditions that could result in harm to the nurse, the patient, or others in the area. These situations place the nurse in the ethically tenuous position of needing to decide if they should remain in the situation to attend to the care needs of the patient, thus fulfilling professional commitments and obligations, or, if they should leave, avoiding possible injury in the line of the duty to provide care.

The questions this study aims to answer focus broadly on how nurses navigate the moral dilemmas that arise when they encounter workplace violence. Specifically, the work considers:

1. What ethical decisions do nurses face in the context of workplace violence?
2. What considerations factor into decisions about a course of action?
3. How is moral distress experienced when nurses encounter workplace violence?

To answer these questions, I take a qualitative approach, described through the remainder of this chapter.

Epistemological Foundations of this Study

The scaffolding approach to study design articulated by Crotty (1998) provides a useful framework for undertaking the work. To adequately describe the methodological choices made in this study, it is necessary to understand the underlying epistemological assumptions and theoretical underpinnings that form its foundation, in addition to the methodology and a detailed description of the study's methods.

The primary objective of this study was to explore how nurses navigate the moral dilemmas that arise when they encounter workplace violence. I became interested in the topic when working as an ethicist, providing decision support to health care teams that all too often faced choices related to the provision of care when there was a risk of physical, emotional, or psychological harm from patients toward the people who have professional duties to provide care, or toward other people in the environment. Speaking with nurses involved in these incredibly challenging situations, it became clear that the resulting dilemmas often come down to a choice between providing care, despite significant personal risk, or withdrawing from the situation and leaving a person without care. The decisions taken in these circumstances are deeply personal, and highly contextual. What may be a reasonable risk for one nurse is often beyond the threshold of acceptability for the next. The question was how best to explore the decision-making processes that nurses use to navigate these problems.

In her seminal article on the nature of nursing knowledge, Carper (1978), described four patterns of knowing in nursing: empirical, aesthetic, personal, and ethical. Empirical knowledge is the scientific knowledge necessary to provide nursing interventions safely and effectively. Aesthetics, or the art of nursing, is the embodiment of empathy in care. The component of personal knowledge is the relational actualization of the nurse's own personal knowledge in the caring encounter. Finally, ethics is the moral component of nursing knowledge. It is this latter pattern of knowing that primarily concerns this study.

Examining the moral phenomena associated with decisions around workplace violence demands a pragmatic, qualitative approach. As per the pragmatist foundations of constructivist grounded theory (Charmaz, 2006; 2017), the meaning of a moral concept changes depending on the context or situation in which it is applied. This resonates with the experience I had as an ethicist, where the care decisions that individuals or teams made incorporated innumerable contextual and situational factors, far more often than they included applicable rules or principles. This problem-oriented way of considering phenomena aims to identify processes for solving ethical dilemmas that evaluate a value judgment instrumentally, that is, in terms of whether it answers the question at hand. In the case of dilemmas of nursing practice, the contextual features of a problem are central to decision-making. Foundationally, these situational factors centre on the nurse-patient relationship, and the social interactions at its heart.

In this way, I start from the assumption that knowledge is constructed through social interactions with others and the world. Nursing is an inherently relational undertaking, and the moral conflicts that arise during its practice come from the connections nurses make with the people and communities they care for, and from the commitments that result. There is no nursing without relationship.

To grasp the relational phenomena that occur in the context of social interaction requires an exploration of the relationship and the impact of the event for all involved. The aim of this process is to understand the meaning of experience for each party, which is embedded in its significance for them, and closely tied to structures such as context that impact the resulting moral questions. Meaning and significance are highly personal phenomena, dependent on their impact for the individual (nurse or patient) and anyone they care about. Experiences occur and can only truly be mutually understandable if considered intersubjectively. Relationship and context are central to the experience of moral phenomena, and an approach to research that acknowledges the role of intersubjectivity is essential.

To that end, social constructionism is an appropriate epistemological standpoint to begin this exploration. This philosophical stance assumes that knowledge is a function of the interaction between and among people and the world (Crotty, 1998; Freire, 2000). Workplace violence, for example, exists within the boundaries of an interpersonal relationship. It can only occur when a person interacts with another person in their environment. As a person interprets and makes sense of an experience, meaning is created. Similarly, understanding the meaning that someone has assigned an experience can only be achieved intersubjectively, through social interactions that permit its exploration by someone who did not directly experience the event.

Social constructionism acknowledges all experience and interpretation as valid forms of knowledge. In this sense, meaningful reality, that is, knowledge, derives from the interaction with phenomena, on which culture and social institutions are indelible influences that guide and shape the creation of shared meaning. As noted above, interactions with phenomena are the sole source of our understanding of the world. This interaction may be a first-hand experience, which generates one type of knowledge, or it may be hearing about someone else's experience. Knowledge of phenomena comes to be through interaction with them. In this way, knowledge is socially constructed from experience (Crotty, 1998; Senehi, 2020). Furthermore, context matters. Each person's viewpoint is limited by their perception and positionality and generates a relevant meaning for that individual.

Subjectivity is a major challenge in this process. How do we come to have a meaningful understanding of what others know? How can we best create a reasonably representative, shared understanding of a particular phenomenon when we are bounded by our own perceptual limitations? These are crucial philosophical questions, because as close as we might get to a true understanding of another's perspective, it will always only be a representation.

The answer to the subjectivity problem, and the medium through which we overcome it, is human language. Language is the basis of communication and connection, a function of social interaction (Serpe et al., 2020; Powell, 2013), and the way we construct shared meaning and live in relationship to each other. Communication is a relational event that co-creates a mutually meaningful phenomenon. Understanding of personal, internal, subjective events such as experiences and decisions are only accessible through interpersonal communication.

As a function of communication, stories are an engaging medium for this type of study. Stories create meaning and shared understanding. They have a real-world impact that serves to unite people in new and different ways. As knowledge phenomena themselves, stories create new perspectives (Frank, 2010). A story is a reference to a past event that has relevance in the present for the teller and for the listener. Interpretation through the listener's own lens generates meaning for them, just as the act of telling augments the meaning of the event for the teller. The resulting mutuality of meaning flows from the narrative for both teller and listener, in terms of the event itself, and its telling. Story-telling is an interpersonal exchange that by its nature shapes how the teller and listener understand the experience and the meaning it has for each.

Ultimately, the result of this knowledge is a rich picture that generates an accessible understanding of the experiences of another person. In this way, the use and interpretation of language is the unit of analysis for making sense of the world from a social constructivist lens (Mills, 2004; Suurmond, 2005). An understanding of knowledge as socially constructed provides an epistemological foundation for research on moral phenomena. Given the philosophical centrality of language, narrative follows naturally as a theoretical perspective underpinning a methodology for exploring what are essentially subjective experiences that have real world impacts. It is to the theoretical perspective that I turn next.

Theoretical Perspectives: Nursing Ethics and the Narrative Paradigm

A study's theoretical perspective is based in its epistemological orientation and guides methodological design choices. Two main theoretical perspectives were considered in the development of this study. They are the framework offered by nursing ethics (Pilkington & Giuliante, 2023), and the narrative paradigm, proposed by Spector-Mersel (2010). Each of these acknowledges the social construction of knowledge in different ways: nursing ethics in the sense of its emphasis on relationality, and narrative in the sense of communication as a means of making sense of phenomena.

Nursing Ethics

Firstly, the choice of nursing ethics as a theoretical perspective follows naturally from the primary research question, the consideration of nurses' ethical decisions when faced with violence in the workplace. Ethical practice derives from moral theory, which, broadly speaking, refers to how we live in relation to each other. Theorizing about morality provides tools and referential frameworks for describing the normative structures that govern interpersonal interaction (Walker, 1989). Ethics is generally understood to be the application of moral theory in terms of the use of such frameworks for evaluating actions and decisions against relevant values and norms (Driver, 2022).

Nurses' ethical knowledge (Carper, 1978) considers these values and norms as based contextually and relationally and understood through interactions with those who are vulnerable to the nurse's choices and actions. Practices of responsibility (Walker, 1989) demonstrate the nurse's values and derive both from good character (Armstrong, 2006) and from consideration of the possible outcomes of a situation. This application of moral reasoning in nursing practice is ethics.

The practice of ethical analysis has been described for any number of normative systems and environments: for example, business ethics provides a means of evaluating the ethical permissibility of judgments and actions in the world of business; biomedical ethics refers to ethical appraisal of decisions

in the biomedical sciences, and so on. Carper (1978) recognized ethics as the moral component of nursing knowledge and argued that ethics goes deeper than the rules or norms of behaviour but speaks to the fundamental goals of nursing practice. As nursing theory in general examines questions of its purpose and goals, nursing ethics addresses questions of how we ought to achieve those goals. As it pertains specifically to the practice of nursing, nursing ethics bears significant differences from other branches of applied ethics (Fry, 1999; Pilkington & Giuliante, 2023).

To the present study, nursing ethics provides a natural theoretical fit for understanding the decision-making processes used by nurses in determining actions in the context of workplace violence. Nursing ethics describes the moral work of nursing and provides normative guidance about the purpose and goals of nursing as a practice (Fry, 1999). The nature of nursing work and the values on which it is based differentiate nursing from other health professions (although there are often commonalities). This philosophical orientation, as it has been conceptualized by Pilkington & Giuliante (2023), suggests that nursing ethics relies principally on the "deeply imbued relational emphasis that is the ethos of nursing practice." (p. 672). As Carper (1978) noted, nursing ethics goes beyond an understanding of the rules of conduct to recognize the foundational principles of service and respect that flow from the caring relationship. The relationality of nursing practice is fundamental: without the interpersonal connection between nurse and patient, there is no care. All nursing practice flows from relationship and the duties it confers on the nurse. When entering into a caring or therapeutic relationship, there is an expectation that the nurse will use their knowledge, skills and judgment in the other's best interests.

In this way, the moral angst experienced by nurses who are faced with decisions about whether and how best to care for people who may pose a threat to them (Copeland & Arnold, 2021; Beattie et al., 2020) comes from foundational, embedded values and the norms they inform. As such, the contemplation of these ethical decisions will naturally follow the frameworks that nurses use on a day-

to-day, moment-to-moment basis to make routine care decisions. Nursing values and norms, as described by nursing ethics, are not only relevant but highly influential in such fraught situations.

Considerations of the ethical responsibilities of nurses grounds all nursing intervention and is the measuring stick by which we determine whether a nurse has fulfilled their duty to care. Pragmatically, nursing codes of ethics are examples of frameworks for ethical reasoning in nursing practice. Indeed, the Canadian Nurses Association Code of Ethics for Registered Nurses (2017) reifies nursing ethics in that it has been adopted by Canadian nursing regulators as the standard of ethical practice (see for example, College of Registered Nurses of Manitoba, 2022). Nurses' knowledge, skills, and judgments are measured against the values and norms described in the Code, and complaints that a nurse's practice does not meet these standards are treated as violations of the norms of professionalism in the context of the caring relationship.

Of interest to this study, several of the nursing values delineated in the Code speak to the obligations that follow from the practice of nursing, and so must be considered in this discussion of theoretical influences. As examples, the Code urges nurses to provide compassionate care and remain accountable for their actions and permits nurses to take action to minimize risk and protect self and others when violence occurs. These are tangible statements that make explicit the expectations for practice and provide guidance in decision-making.

Far from being definitive answers to ethical dilemmas, however, these maxims set nurses up for ethical conflict when they are logically or practically impossible to uphold. The Code provides little comfort when withdrawal from a care encounter needs to be considered in order to protect the safety of the nurse or others. Decisions in such dilemmas then rely on higher order principles of nursing ethics, which are less tangible but no less internalized. Moral theory in general, and nursing theory specifically, contemplate the nature, purpose, and goals of nursing practice. As such, nursing ethics, more so than

other moral theories, provides a key theoretical orientation for this study. Returning to the premise that nursing practice derives from commitments to service and respect that are core to the nurse-patient relationship, the implicit and explicit values, norms, and principles described by nursing ethics are fundamental to nurses' decision-making processes.

Narrative Paradigm

The second theoretical perspective on which this study is based is the narrative paradigm. Given the underlying assumption that knowledge is socially constructed through interactions between and among people and the world (Crotty, 1998; Freire, 2000), access to that knowledge is a central question. From this perspective, narrative is the building block for socially constructed reality. Phenomena are uncovered through interaction with them, revealing knowledge as socially constructed from experience, interaction, and the stories thereby generated (Crotty, 1998; Senehi, 2020). Addressing the question of how nurses navigate the ethical dilemmas associated with workplace violence necessarily requires hearing from nurses who have experienced it. Their stories permit access into the person's internal environment. The meaning of experience and the implications for intersubjective understanding of its underlying norms, values, and thought processes can only come from social interaction, specifically, from hearing stories of workplace violence. Each person's experience generates a relevant meaning for that individual: both the teller, in the choices they make around what to tell and how to tell it, and the listener's experience in hearing the story and making sense of it in their own way. This is important because meaning is the source of actions and emotions, and narrative reveals patterns that help us understand the impact of phenomena in the real world.

The challenge is coming to understand the meaning that another person has derived from their experience. Although it is at best a representation, as all experience is filtered through perspective and as such remains subjective, human language permits the construction of intersubjective knowledge and

meaning (Serpeet al., 2020; Powell, 2013) through social interaction. Language and communication are the philosophical unit of analysis for making sense of the larger social context within which things happen (Mills, 2004; Suurmond, 2005). Knowledge is the product of these intersubjective experiences.

A narrative paradigm, proposed by Spector-Mersel (2010), is based on social constructionist epistemology, and recognizes narrative as the building blocks for reality that is a function of the ways we understand and interpret it. As a theoretical perspective, narrative is a function of language that is manifested in stories (Frank, 2010). Stories build connections between people and permit the perspective sharing necessary for knowledge exchange. They enable a mutually accessible understanding of events and experiences that are otherwise purely subjective. The interpretation and meaning the narrative has for teller and listener results in new perspectives (Kellett, 2011).

Specific to conflict, and to the present study, the process of examining a narrative of ethical conflict creates understanding of different meanings the conflict has for various parties. Narrative is an oral or written manifestation of experience, and research using narrative methods is a way of exploring and understanding that experience. Narrative reveals patterns and relational dynamics that underpin the conflict and create feelings and actions related to it (Kellett, 2011). As noted above, relationships are central to, and indeed they are the very essence of nursing practice, and a recognition of the ways those patterns and dynamics play out in ethical conflict is central to the mutual understanding of the impacts and meanings it has for those involved. As fundamentally subjective beings, collective understanding is the only means we have of making sense of the impact of events on the people affected by them. Narrative processes connect people by creating or illuminating shared identities (Dillon & Craig, 2022; Frank, 2010). This is to say that where intrapersonal conflict is subjective and inaccessible to others, narrative brings light by helping to elucidate meaning via the shared experience of story-telling and story-listening. Only then can knowledge be constructed from another person’s experience.

The theoretical contribution of the narrative paradigm to this study's methods and methodology cannot be overstated. The intersubjective examination of narrative through interviews and stories is the process of co-creating data that is the hallmark of constructivist grounded theory. Stories are the sole source of information we have about the perspective and meaning of an experience for another person, hence the choice of interviews and the development of a collection of stories to construct a picture of the ethical decisions facing nurses when they deal with violence at work.

The theoretical perspectives underlying this study include nursing ethics and the narrative paradigm. These are useful, and, indeed, necessary philosophical orientations for the examination of how nurses navigate the moral dilemmas that arise when they encounter workplace violence. Building on epistemological assumptions around the social construction of knowledge, nursing ethics and narrative provide a framework for the study methodology and design, and for building a theory of ethical decision-making that accounts for the stories of nurses who have experienced workplace violence. Nursing ethics, with its emphasis on the relational nature of nursing practice, establishes the behavioural norms and standards that govern nursing practice. These are the things nurses rely on to help with decision-making processes in situations where mutually exclusive goals create internal conflict and require contextual, individualized decisions about high stakes situations. Narrative practices are the ways in which we can access individuals' subjective experiences and make sense of actions and outcomes. Interpersonal communications, in this case stories, provide that glimpse into the person's motivations and thought processes that enables a shared understanding of the meaning of an event, and its connection to a larger discourse.

In the next section, I outline the study's methodology.

Methodological Approach

This study was designed with a constructivist grounded theory approach. This is a qualitative methodology that begins from the assumptions that knowledge is socially constructed, and that multiple realities co-exist and contribute to people's understandings of phenomena. Constructivist grounded theory develops concepts and theories that explain social phenomena through systematic analysis of qualitative data such as narratives. This approach offers a solid methodological fit for a study that is seeking the tacit meanings relating to values, beliefs, and decision-making processes.

Constructivist Grounded Theory

Constructivist grounded theory (CGT) is a qualitative research methodology that leverages the perspectives of participants and researchers through an iterative spiral of data collection and inductive analysis to explore and theorize around the research problem (Charmaz 2017; Mills et al., 2006). Where narrative inquiries seek to answer important questions about the nature of experiences, CGT extends the processes of interpretation and analysis to produce explanatory theories about them. These kinds of methods assume a relativist epistemology and require rigorous reflexivity on the part of the researcher, to situate the research and make sense of data in terms of the broader social context. The product of CGT research is theory that has been co-constructed through a connection between researcher and participant, and which integrates concepts to explain or make sense of data. CGT has been well-used in nursing research (Mills et al., 2006) because of its pragmatic guidelines for both completion of studies, and application of findings to practice and further research.

CGT is a cyclic, systematic process for collecting and examining data, and developing theoretical categories and connections that explain it. As a theory is formed, further data are sought to deepen analysis, strengthen connections and relationships, and solidify the theory. The constant comparison of data to the theoretical categories means that the resulting theory is grounded in the data. Importantly,

CGT also recognizes the role of the researcher as a part of theory development; CGT is not intended to discover truth in the positivist sense, as much as it is to create a meaningful interpretation of multiple realities, including that of the participant and the researcher. To do this well, the researcher ensures the priority of the participant's voice in the work and acknowledges their own positionality.

To complete a CGT study, the research problem is defined, and data collected to answer its central questions. The data is then reviewed, and an initial, open coding process takes place. A second, more focused coding process follows, and connections, categories and concepts within the data begin to take shape. The researcher then engages in theoretical sampling, either reviewing existing data or collecting more, to strengthen and solidify the developing theory. Sorting, writing memos, and integration of categories and concepts continue the process of abstraction and the development of a core theoretical category that unites and explain the data in a reasonable theoretical representation of the participants' reality (Lauridsen & Higginbottom, 2014). Analytic rigour is achieved through this cyclical process of data collection, interpretation and analysis, abstraction, and constant comparison.

Another important element of CGT is reflexivity, and the need for the researcher to continually acknowledge the ways their perspective is impacting and showing up in the work. While narrative data by its nature centres the participant's experience as the unit of analysis, all interpretation is filtered through the researcher's own lens. In order to develop a theoretical application that is grounded in the data and accounts for it, the researcher must be aware of how they have made sense of it. The result of this reflexivity is a theory that explains, describes, and predicts a phenomenon, grounded in data but with a sense of the commonalities that unite participants' unique experiences.

CGT was chosen for this study for several reasons. Firstly, I reject the positivist notion of an external reality waiting to be discovered, especially as concerns internal matters of the mind, such as decision-making processes. A methodology that imposes order on data through the application of a

theoretical model that makes sense of it appeals to my subjectivist, relativist understanding of reality. Secondly, a methodology that recognizes and reflects the intersubjectivity of knowledge was important for this work. The complexity of ethical dilemmas and the factors involved in their resolution could only be identified through collaboration with people who have had the experiences I seek to understand. Their stories, and the meanings they ascribe to their experiences, shed important light on how nurses think about the ethical dilemmas they face, and are inaccessible except when shared.

Furthermore, CGT permits a flexible approach to research. This is important because the inherent pragmatism of the methodology allowed for the use of multiple methods to help flesh out a theory of ethical decision-making. The story-telling approach supplemented individual interviews to build a coherent picture of the phenomenon in question, built through the iterative process of data collection, and recognized the logical inseparability of the researcher from the work: while the stories were told in the participants' voices, the conclusions drawn from them reflected the researcher's position and perspective.

Finally, CGT emphasizes the relevance of the context in which the research is conducted. This permits examination of such factors as values and norms, and the structural and cultural elements at play in the management of moral problems in nursing. While this is not to say that other methodological approaches would not have led to similar conclusions, the subjectivist/relativist epistemological orientation of CGT, the reliance on social interactions to construct the dataset, its flexibility in methods, and the emphasis on context in the interpretation and analysis of data all contributed to the development of a theory of nurses' ethical decision-making around workplace violence grounded in and supported by data.

Summary

In this chapter, I described the epistemological, theoretical, and methodological perspectives that inform the methods chosen for this study. Specifically, I noted the commitment to a social constructionist epistemology that recognizes the existence and validity of multiple realities, and the creation of knowledge through social interaction. The theoretical approaches I adopted were nursing ethics, which underpins all nursing practice, and the narrative paradigm, which describes narrative as the building blocks of reality and how we understand it. Where nursing ethics grounds the decision-making processes of nurses facing workplace violence, narrative reifies an experience and permits it to be examined in ways that are inaccessible via observation or other methods. Finally, constructivist grounded theory was a fitting methodological design informed by these philosophical approaches. CGT supported the development of a theory with sufficient explanatory value to explore questions of why nurses' ethical decisions related to workplace violence unfold they way they do.

The procedures I used to gather data and engage in a process of interpretation and analysis flowed naturally from these foundations. These methods will be described in the next chapter.

Chapter Four: Methods and Participants

As noted, this is a qualitative study, using a constructivist grounded theory methodology, and a story-telling approach. In this chapter, I outline the methods used to address the study's research questions. The research context, recruitment process, and the research ethics approval are described. I provide an overview of the participants, methods, and process for data collection and analysis. Finally, I offer a summary of the measures taken to ensure validity and rigour.

Research Context

This study was conducted in Canada and sought participation from Canadian nurses. The Canadian health care context is a system I know, and work within, and was a pragmatic delimiter for inclusion and exclusion criteria. Data collection occurred in the aftermath of the most acute phases of the Covid-19 pandemic, in the summer of 2023, influencing the decision to conduct interviews virtually, and expanding the inclusion criteria to participants from across Canada. I am located in Winnipeg, Manitoba, and I conducted all interviews from my home or University office.

Recruitment

Given the ubiquity of workplace violence and the sheer number of regulated nurses working in Canada, the goal of recruitment was to permit themes and theory to develop from the data, rather than attempting to achieve thematic saturation from a representative sample of nurses and their experiences. My goal was to recruit 20-30 nurses who practice(d) in Canadian jurisdictions, who self-identified as having experienced workplace violence, and who were willing to share their experiences in a 60-minute recorded interview. I did not specify a particular nursing designation, nor the duration of practice. I accepted practical nurses, registered nurses, nurse practitioners, and psychiatric nurses. I defined workplace violence very broadly, to include participants' conceptualizations of all types and experiences of workplace violence, and permit consideration of the contextual factors associated with participants' experiences.

To recruit participants, I took several approaches. I developed a study information document (Appendix 1), which I posted online via my university student account. I posted a summary poster with a QR code and link to the information document on my social media accounts, including Instagram, Facebook and LinkedIn (Appendix 2). I also circulated this information document to nursing professional organizations including the Canadian Nurses' Association, the Canadian Federation of Nurses Unions, the Association of Regulated Nurses of Manitoba, and the Manitoba Nurses Union, and via a postcard with the QR code that linked to the study information document that I distributed at the International Council of Nurses biennial convention in Montreal in July of 2023 (Appendix 3). I received offers from contacts and colleagues to share the study information on their own social media and with their networks, which I gratefully accepted. I also accepted referrals from participants and colleagues through word of mouth.

Prospective participants were invited to indicate their interest in participating by contacting me through the link on the information poster. Each person who contacted me received a reply email including the study information and an Expression of Interest questionnaire which was completed via a link to a Microsoft Forms survey (Appendix 4). This was to establish eligibility and collect contact information. I corresponded with those who completed the questionnaire to confirm a date and time for an interview (Appendix 5). The day before the interview, I sent each participant a copy of the Phase 1 consent form (Appendix 6), as well as a list of crisis resources, in case the interview raised negative or difficult emotions (Appendix 7). The interview guide can be found at Appendix 8.

As data collection progressed, and the topic of my research arose in conversation with nurses I encountered, I was able to share thoughts and impressions with people interested in hearing about this work. Woe be to the poor nurse who happened to ask about my research; through a number of these types of conversations, I invited individuals who told me they had experience with workplace violence to

participate. Several of these agreed and contributed richly to the data collected. Interviews were offered virtually or in-person (for participants in Winnipeg).

For Phase 2 recruitment, I contacted eight Phase 1 participants who had indicated interest in the additional step. I sent each of these contacts a Phase 2 Study Information document (Appendix 9). I offered each of these participants the option of writing their own story or editing a story that I had taken from their interview transcript. I offered several story prompts for those opting to write their own story, and for all participants editing a prepared document (Appendix 10). Six provided consent (Appendix 11) and completed a narrative document. These stories are reproduced in their entireties (Appendix 12).

Ethics

The study was approved by the Research Ethics Board of the University of Manitoba Fort Garry Campus (Appendix 13). The Research Ethics Board declined to permit demographic data to be collected via the Expression of Interest questionnaire, so any demographic data provided by participants was collected during the interview. To protect privacy and maintain the element of respect and safety, participants were not required to provide identification or proof of licensure, nor did I ask them to turn on their camera during virtual interviews. A list of trauma resources was provided to each participant prior to the interview, to maintain psychological safety and minimize risk to the participant. This was intended to set a tone of relational accountability, with control of the telling of the story firmly assigned to the participant. This was intended to demonstrate respect for the participant while recognizing their contribution to the work as representative of a traumatic event, acknowledging the role of power in the experience of violence, and deliberately avoiding the reconstruction of any power structures that may have been part of the trauma experience in the first place.

The consent form was provided several times and reviewed at the start of the interview. Participants were assured of the confidentiality of their responses, and their right to withdraw at any point without penalty.

Thanks to receipt of a Doctoral Grant from the Social Sciences and Humanities Council of Canada, I was able to offer a small honorarium to participants. Each participant was provided with a $20 honorarium by cash, e-transfer, or Amazon gift card at the time of consent. The honorarium was nominal and intended to demonstrate respect and appreciation for the participant's time and to cover any cost the participant might have incurred to participate. It was an amount that is intended to be too small to be an inducement or incentive. The honorarium was provided unconditionally to all interviewees, including those whose data was not ultimately included.

Confidentiality was maintained at all times. All identifiable data was kept on my university-issued laptop in a secure and password protected folder. Transcripts were redacted and identifiable only by the participant's pseudonym. Recordings were kept until the participant approved the transcript, and then were deleted. In describing the findings, I chose to use gender-neutral pronouns for all participants to minimize identifiable information.

Methods

This study involved multiple methods, including individual interviews and the development of a collection of first-person accounts of the experience of workplace violence.

Data Collection

This study was conducted in two phases: individual interviews (Phase 1) and the co-creation of narrative documents relaying the participant's experience with workplace violence (Phase 2).

Phase 1 interviews took between 20 and 60 minutes and were recorded for the purpose of transcription. The vast majority were conducted using MS Teams, two were done in person, and one via

Zoom, at the participant's request. At the beginning of each interview, I reviewed the study information and consent form, transferred the honorarium, and began the recording with the participant's permission. No one declined to be recorded. Recordings facilitated a conversational style intended to put participants at ease. As the interview followed a semi-structured guide, I added and refined questions, and discovered the ones that tended not to generate discussion. Once each interview was complete, I made field notes on a checklist document (Appendix 14) that I created for each participant, reviewed and cleaned up the transcript, and sent it to the participant for review. Most replied within a few days, indicating their approval, or providing any changes they wanted to make. For those who did not approve the transcript or provide a signed consent form, I sent up to three reminders before considering that participant's interview ineligible.

In Phase 2, select Phase 1 participants were invited to participate in the co-creation of a narrative account of their experience of violent patients/clients, to facilitate deeper analysis of themes and theory identified in Phase 1 (interview) data. I chose participants who (a) indicated an interest in participating in Phase 2, and (b) had relayed a particularly vibrant experience of workplace violence. I offered them the option of writing their own story or receiving one that I pulled from the interview data and wrote as a first-person account, for them to edit. One participant wrote their own story. The others were invited to take the draft I provided, and make the story their own, ensuring it fairly represented their voice and perspective. I included several story prompts in correspondence about Phase 2 as well. The result was a collection of rich, nuanced and deeply engaging research texts.

Throughout, participants' stories were foregrounded and maintain the most central position in the work. To that end, I kept a methodological journal, and recorded field notes on each interview to ensure that my thoughts and impressions were captured in the moment, but the review and revision

process generated the final research text. I ensured the participant had the final "say" in their story and prioritized their perspective and voice in each element.

Participants and Datasets

Given the ubiquity of workplace violence and the sheer number of regulated nurses working in Canada, the goal of recruitment was to permit themes and theory to develop from the data, rather than attempting to achieve thematic saturation from a representative sample of nurses and their experiences. In Phase 1, I received 65 expressions of interest. Individual interviews were conducted with 45 people, most via MS Teams. Those who were not interviewed either did not follow up after receiving the study information or were deemed ineligible by virtue of their location or professional designation. Participants were vetted through a short series of questions at the beginning of each interview, intended to confirm eligibility and gather what demographic information the nurse was comfortable sharing. Interviews were recorded and transcribed, and participants invited to review and correct transcriptions. Of the 45 interviews, 36 completed all elements, including review and approval of their transcripts, and their data comprised the Phase 1 dataset. Seven prospective participants were placed on a waiting list (with their permission), as I had over 40 interviews booked by that time. For phase 2, I invited eight participants and received positive responses from all eight. Ultimately, six completed Phase 2 and their stories are included in the dataset. Three stories concerned incidents that occurred in psychiatric settings and three in medical-surgical inpatient settings. Stories ranged from 500-1200 words.

The nursing experience of included Phase 1 participants ranged from two to 41 years, although seven did not specify how long they had been practicing. See Table 1 for a profile of Phase 1 participants. I chose not to summarize the demographic data on Phase 2 participants due to the small number and risk of compromising confidentiality.

Table 1

Profile of Interviewed Participants

Characteristic	Number of participants
Nursing Designation	
LPN	5
RN	18
RPN	4
NP	1
Nurse-Midwife	2
Unspecified	6
Location	
Alberta	4
BC	4
Manitoba	10
North	3
Ontario	14
Unspecified	1
Area of work	
Acute care	9
Specialty areas	8
Home care	2
Long-term care	2
Psychiatry	11
Rural/northern	3

Analysis

Analysis began at the point of the interview in the sense that participants were invited to describe their experience with violence, a concept which I purposely left undefined. This began the collaborative development of the ultimate dataset, which also included having the participant review and edit their transcript, and the invitation to add subsequent thoughts or observations to their data, which several participants did after the transcript was approved. As the data collection proceeded, my interview guide evolved gradually to incorporate observations and considerations raised during previous interviews.

Analysis was an iterative process that included development of field notes, co-creation of a narrative research text, and open and focused coding of interviews. The analysis considered both Phase 1 (interview) and Phase 2 (narrative) data. Constant comparison of new data to old, and to existing and developing theory facilitated analysis, as well as the evolution of the semi-structured interview guide. Codes developed organically through repeated examination of transcripts from the perspectives of the three primary research questions and the developing theoretical approach. Theoretical sampling was used once categories were developed from codes, and I considered the properties of each category, continually reviewing interviews with consideration of categories to ground the developing theory. Memoing proceeded formally to support the development of increasing levels of abstraction as categories, concepts, and their properties were defined and explicated. I wrote detailed memos on each of the six narrative documents included in the dataset. Throughout the duration of the study, I kept notes on method, progress, and my reflections on findings. I used Roam Research for these purposes.

Theoretical development proceeded from contemplation of categories and their properties, and from memos and field notes. This initially took the shape of a table of categories corresponding to each

research question, and was refined through continual review of transcripts, stories, and notes. As the core concept of vulnerability was determined, transcripts and stories were again reviewed to identify properties and supporting data.

Initial Analysis

With respect to examining and coding transcripts, this process was facilitated by nVivo 14 software. Open coding was the first stage of analysis of the Phase 1 data. Initially, this took the form of a review of each included transcript for general themes, making notes and comments on each. I then reviewed the dataset again, focusing in turn on identifying codes for each of the three secondary research questions. I made notes on process, thoughts, and general observations in a methodological journal throughout. As I developed a level of understanding of the data that permitted theorizing, I continually returned to the dataset to clarify and confirm categories, properties, and elements of the developing structure.

Secondary Analysis

Taking the codes for each question, I refined and grouped them into categories, identifying overarching patterns and concepts among the data. I repeatedly refined categories and labels. This permitted examination of each concept in terms of its fit with the developing theoretical framework. Throughout, I kept analytic memos that enabled me to continually reflect on and revise findings and engaged in theoretical sampling in the form of continually seeking evidence from the data to support the developing theory.

For the Phase 2 data, I read each approved story several times on its own. Next, I considered each, line-by-line, using open and focused coding. I sought connections between what was said and the impact the story-telling might have for understanding decisions on workplace violence. I considered the connections with the larger Phase 1 dataset to interrogate the fit with the resulting themes and

concepts. Finally, I read each story for its response to the research questions. I used theoretical sampling to re-examine the data from new perspectives, as I developed theory and further theoretical questions arose. Comparing and contrasting all data, themes, and categories, I identified common elements and derived a core category that formed the basis of the developing theory. As the theoretical framework took shape, I returned to the literature on workplace violence to identify ways it aligns with and challenges existing knowledge.

Rigour/Validity

Rigour in qualitative research is evaluated against the trustworthiness and authenticity of the study (Morse et al., 2002). Ethics approval was received, and the study proceeded in accordance with the parameters of that approval. Consistent with constructivist grounded theory methodology, this work was conducted with an explicit commitment to respect, openness, and mutuality that privileges the voices of participants. Verification of the analytic findings and developing theory was facilitated by the iterative nature of the methodology. Participants were vetted through the eligibility questionnaire and at the beginning of the interview, and all whose data was included shared relevant exemplars of the phenomenon of interest. The interview guide evolved over the course of data collection to include questions that elicited rich and thick stories of experience and explored emerging themes. Interview transcripts and stories were reviewed, edited, and approved by participants prior to inclusion. Importantly, the first-person nature of the data lends internal validity to the work, in the sense that the participant's voice is front and centre.

Given that this is a study of the internal landscape influencing decision-making processes, authenticity could only be achieved by adopting an emic perspective. I took measures to ensure that included stories reflected the participant's experience as they wanted it told. Data analysis proceeded in alignment with the methodological work of Charmaz (2006, 2017, 2021; Charmaz & Bryant 2016; Lindsay

and Schwind, 2016), and embedded reflexivity and constant attention to the theoretical and methodological foundations of the study. Phase 2 served as a check on resonance and credibility. Having participants create their narrative and aligning it with the initial codes and categories supported the developing theory. Practically, validation of the data took place through the constant comparison I did through the data collection and analysis stages of this work. The back-and-forth, co-creation of the research text was another important piece of the process which increases the rigour of the study.

Summary

This chapter has offered a detailed picture of the methods used to conduct the study. I reviewed the research context, ethics approval, methods, data collection, and analysis. The rich dataset and active process of analysis and theorizing yielded abundant findings. Over the next three chapters, I will unpack the results of each research question and frame the substantive theory that was ultimately developed. It is to these findings that I turn next.

Chapter Five: Research Question One - Findings

What ethical decisions do nurses face in the context of workplace violence?

In this chapter, I provide the combined findings from Phases 1 and 2[3] of this study that pertain to the first of the three research questions: how nurses navigate the moral dilemmas that arise when they encounter workplace violence. Participants revealed a subtle but complex process of weighing conflicting priorities, including a duty to provide care, and a need to maintain the safety of the patient, others in the environment, and themselves. These decisions crystallized around the question of how best to mitigate exposure to violence. Ultimately, participants described the primary ethical decision in terms of whether they ought to stay and provide care or leave the situation. Ostensibly a binary choice, to stay or leave, participants revealed that the moral problem was complex and often quite nuanced. When considering the appropriate response to a particular scenario, participants revealed a range of possible options that included remaining in the situation and continuing to provide care, pausing the care encounter for the moment, or withdrawing their services in a more permanent way. For each decision, the nurse considered how best to mitigate or minimize exposure to violence.

Preliminary analysis produced codes, which were subsequently collapsed, refined, and honed through focused coding and thematic categorization to comprise an overarching concept: vulnerability. Specifically, the core category of Managing Intersecting Vulnerabilities provided three subcategories related to the decisions that nurses face in the context of workplace violence: Getting the Job Done, Shifting the Dynamic, and Withdrawing from the Situation. I abbreviate these as Stay, Pause, and Leave. Table 2 summarizes the category and subcategories for this question. This chapter examines the findings for each of these subcategories.

---

[3] Illustrative quotations are drawn primarily from interviews. The attribution of each quotation is designated by the participant's pseudonym. Participants are referred to by non-gendered pronouns as a confidentiality measure.

Table 2

Summary of Question One Findings: Ethical Decisions for Managing Intersecting Vulnerabilities

Stay: Getting the job done	Pause: Shifting the dynamic	Leave: Withdrawing from the situation
I had no choice	We have some time	Ending the relationship
• Find a way	• Ultimatum	• Transfer care
• Bare minimum	• Safety in numbers	• Refuse to work with patient
• Brute force	• Back off/reapproach	• Leave the job

Staying: Getting the Job Done

Remaining in a care situation despite a clear and present risk was the default for most participants. They described a sense of professional responsibility that clearly reflected the values and responsibilities set out in the Code of Ethics for Registered Nurses (CNA, 2017). The decision to stay often reflected a basic sense of obligation or duty to meet the nursing care needs of the patient. One participant said, “I love the elderly. I think because they're very vulnerable. So, I just think they need that extra care.” (P2) Another, referring to a situation where they had to manage an aggressive, intoxicated family member, said “I was responsible for everybody in that room, and that's kind of why I stood up. It wasn't a choice, right? It was just, I stood up and did it.” (P45) Often, the sense was that there was no choice for the nurse but to remain in the situation and provide care in some way. This sentiment showed up repeatedly in three different ways: finding a way, doing the bare minimum, and using brute force.

Finding a Way

Participants often described continuing to provide care because of a sense of responsibility or professionalism. For example, P28 spoke of a passion for the work of nursing:

> I think you're scared because you don't want to engage with this person, but then you have to do your job. It's part of your job. You have to do your job. You love your job and you have to make this job get better no matter who is with them, no matter what's going on. If you can, you still do it. So, it was a little bit scary, but I'm still able to take care of myself. So yeah, [I] could just go back in there and do my thing.

This sense of professional responsibility appeared as a driving force for most participants as they explored their experiences.

Also reflecting professionalism, emotional regulation was noted as a priority in challenging patient care situations. P55 talked about managing their emotions in difficult encounters.

> Sometimes […] I try and say this is my duty […]. So, like I need to cope and I need like to adjust. Yeah, because like I will encounter […] such occasion from [sic] a daily basis. So, I just make myself doing it. Even if I feel like I'm not comfortable like that.

These examples of professionalism reflect the general commitment to nursing values and the trust relationship between nurses and the public.

Where some nurses may take a violent incident as a reason to stop providing care, P23, a psychiatric nurse, reiterates the commitment to invest in the person's welfare by taking a long-term approach to the care relationship.

> If you base your decisions on one incident, you're really missing out on what could be done over time with a lot of folks. So, what can be accomplished in the long term […] this area is all about the long game and [...] I think it was sort of that that made it possible to wait and see that it [the nurse-patient relationship] was really done.

This comment exemplifies the commitment participants have for their work and, more importantly, for the people that rely on them for care.

While they tended to acknowledge the risk, participants also often downplayed it, and proceeded despite fear or apprehension. P18 described intervening in a situation where other staff members were experiencing verbal aggression from a patient:

> You know, like I wasn't seeing this as something that would actually get out of hand, and I felt this was what made me actually intervene in the whole, the whole issue.

For this participant, as with many others, violence came up almost out of nowhere, and either the risk was not predicted, or it was downplayed, being overshadowed by various needs in the moment.

Several participants described tendencies to push forward with care, because the person needed it in that moment.

> I didn't think it would be fair to him to just be reactive […] and at least, you know, if it had gone that way and he was continuously acting that way and it didn't seem to be for any health reason, I'm also asking someone else to deal with it, right? So, it's like we're kind of the right place. And so, there's very few people that I've ended care with over the years. And it's always […] after a pattern, like a long-term pattern […]. I'm not easy to give up on stuff. (P23)

This is a recognition of the patient's needs and the indelible role of the nurse in meeting those needs, especially when there are no other options available to support the health and dignity of the patient.

Attention to patient safety and a desire to maintain the person's dignity were often identified as important drivers of the decision to remain in a risky situation. One participant, a psychiatric nurse, described the moral anguish of deciding to intervene when patients place themselves at risk.

> I think that where it made it the hardest was either when the patient was at risk. So, let's say they were ramming their head into the wall, you know, running from one end to the room to the other. Or they had a weapon, and they were threatening to hurt themselves. Or maybe choking themselves or something. Or if two patients were involved in a physical thing. That waiting

> would mean people getting hurt, like patients getting hurt. I think those were the tougher situations and that's where more of a fight or flight kind of response came in and it was like a split-second decision in which I didn't necessarily have time to weigh these decisions, and it was just acting in the moment. (P56)

Again, this comment reflects the sense of professional obligation and the commitment to the well-being of the patient and others that showed up time and again in participants' stories.

The prospect of leaving someone with dementia in a soiled brief also exemplifies this commitment to the safety and dignity of those whose care has been entrusted to nurses. P3 described attending to people with dementia who refuse care. "I've had patients where they're incontinent and they're sitting in a wet bed and it's just a mess. Well, you just can't leave a patient like that. That's an unsafe situation, unsafe, really". The risk to the patient and others in the environment is an important part of the decision to provide care despite the risk of violence.

Doing the Bare Minimum

While intervening or staying in a potentially volatile situation tends to be the default choice, many participants described ways of moderating their interactions, so that care needs could be met, without exposing themselves to any more risk than was necessary to get the job done. When it felt like the duty to care still outweighed the risk to the nurse – that is, when the patient was more vulnerable than the nurse – participants described attenuating care, so that they were doing the bare minimum necessary to meet the person's need, to reduce their own exposure to potential harm. For example, P1 was a unit manager, who described interactions with a long-term patient's particularly demanding relative.

> It affects the care of the patient because you don't want to go into the room and you're doing just minimal possible so that you can get in and get out and not have to have the three hour

> long conversation[...]. I think people just have gotten them through the system as quick as possible so they don't have to deal with it.

P1's dilemma was how to ensure the patient received care, without subjecting the staff to the relative's abuse. They did this by taking on the role of intervenor with the relative, accepting the difficult interactions as part of the job, to spare the staff, who were becoming less able to provide compassionate care to the patient because of the abuse.

Other nurses talked about disengaging from the care relationship when the person began to show signs of escalation. P19's practice of withdrawing emotionally from a care encounter also reduces their exposure to violence: "These are patients like I actually don't tend to, you know, be that friendly. I think I kind of feel like maybe I'm not close with them." Similarly, P40 commented on maintaining an emotional distance that reduces their risk.

> I always end up providing care in some way. The reason I'm having a hard time picking is because I often feel threatened at work all the time[...]. But no, I've never just been unable to provide care, or chosen not to. I might limit my interactions to the bare minimum that is safe for me and that patient and everyone else on the team, but I'm always, yeah, I'm always doing something for them.

This sense of backing off without withdrawing completely was almost universal among participants.

Strategies for minimizing exposure also included working as part of a team, so that it was not always the same person at risk. For example, P46 spoke of a team approach to caring for people with dementia who react to care as if threatened.

> Often being part of the team is key because there will usually be someone else on the team who will say 'it's OK, you don't need to go in. I'll go in'. Or 'I've got a good rapport with them already, I'll give them the med. They'll take it from me.' That kind of sharing of the load is really helpful.

The benefit of a team is that different approaches can yield different results.

Similarly, P3 described their strategies for approaching a patient with dementia who is known to be reactive.

> I always say it's a little bit of acting too, try to act friendly, don't act like you're scared or going to be threatening or bossy. Just act like you're going to be their friend even if you don't feel like you want to be their friend. Like just try to be [as] nonthreatening as possible.

This approach enables the care to proceed, if possible, while minimizing the exposure to a potentially aggressive response from the patient.

P23 also spoke of preparing for the potential of violence by minimizing time alone with a patient who had previously behaved inappropriately.

> We're just having short exchanges and not alone in a room. And he said, well, I want to come talk to you. I said, well, then I'll have to get someone else in the room and he left, […] but there's still a way to meet his needs overall.

In this example, P23 placed boundaries around the professional relationship that enabled the option of care while leaving the actual encounter ultimately up to the patient. This form of empowerment benefited both nurse and patient.

Unfortunately, this mutual benefit is not always possible. For P8, a medical-surgical nurse, the example of a particularly volatile patient posed a risk to their personal safety to the extent that the bare minimum was all they could do.

> I ended up with a patient that was HIV positive and he was withdrawing off several different drugs. So he was, uh, restrained to the bed, but he was yelling at me. He was threatening to bite me if he could get his restraints off [...]. And he was really wrestling around in the bed that I felt like if his restraints were let go, he probably would have done it […]. I tried to give him the care

> that I could […]. I basically had to do constant care with him, but I kept my chair probably as far away from him by the door as I could just to make sure I could keep an eye on him but not get any closer than I had to.

In this case, the nurse was able to stay in the room but could not safely deliver more than the necessities.

This idea of providing the bare minimum of what the patient needs serves to ensure their basic needs are met, without exposing the nurse to inordinate risk. This becomes more complex when the patient needs care urgently, but they are too volatile to intervene safely using common interpersonal interaction patterns. In these cases, the only choice is to provide care against the person's will.

Using Brute Force

The need to intervene to provide care when someone is highly vulnerable to harm but is for some reason also highly resistant, is a cause of many fraught situations. When a person is behaving in a way that places them or others in danger, there is an urgency to act, even when intervention is contrary to the person's wishes, or provided in a way that compromises the person's freedom. For these participants, this tended to take the form of using physical or chemical restraints or secluding the person so they could not harm themselves or others.

Participants who described witnessing or being part of forced care generally found it ethically problematic. In these scenarios, the emphasis on compassion and respect for autonomy as core nursing values rubs up against the need to use force in enabling the provision of care. Of note, for all participants who spoke of providing care in this way, it was a last resort, and force was used instrumentally, ultimately for the benefit of the person.

For example, P56 spoke of a particularly difficult situation with a person who had a psychiatric illness, who was unwilling to take medication.

> This one patient who had all sorts of like horrible trauma histories […]. He came from a war-torn country, had watched his family be slaughtered in front of him and forced to perform sexual acts on his siblings […]. This is kind of the last person that you want to lay hands on. But then as things happen, he had an order that required us to give him medication against his will. So then weighing the pros and cons of actually approaching this man with a bunch of security guards and a bunch of men essentially, something that would resemble a lot of what he had lived through, to do this intervention that ultimately, we thought would help them more.

This experience of intervention without the patient's consent was invariably morally distressing for participants, even when the ultimate benefit to the patient was clear.

Participants also spoke of imposing care when the safety of others was compromised by the person's behaviour. P40, also a psychiatric nurse, told the story of caring for someone who was so volatile, they needed to be physically restrained at all times.

> So, we had a guy who, [pause] and this is something I still, everyone struggles with to this day. He was so violent over a period of years; it got to the point that […] we had this man in mechanical restraints for 10 months […]. He was psychotic. And so, he had assaulted, brutally assaulted so many staff they needed medical procedures […]. We were like, we can't do this, we have to restrain him. And so, we ended up being able to put him in ambulatory restraints.

The act of restraining a patient is morally problematic at the best of times and tends to be used only as a last resort; in this situation, the duration of restraint multiplied the experience of moral distress exponentially.

The complexity of these kinds of interventions is magnified by the fact that decreasing the nurse's exposure to the risk of injury almost invariably increases the patient's vulnerability. The hazard of physical and emotional trauma is significant. As P56 notes,

> I have had patients who, in being restrained and things like that, they broken an arm or they've been tased, so then those patients that have more of a trauma history, you know how traumatic this is for them too.

Although these interventions are undertaken with the hope that the risks will result in long-term positive consequences, it doesn't always work out that way.

For P56, a particularly difficult intervention left the patient with physical sequelae requiring additional medical attention. "It was a bit of an unfortunate situation because then he developed side effects from the medication so we couldn't even then go in and say OK, now you're feeling better." Participants described the use of force as difficult at the best of times, but nearly impossible to reconcile when the desired outcome was not realized.

Fortunately, the use of force does not always have to be traumatic. Care that is necessary for the safety or comfort of the patient can be done in ways that minimize the invasiveness of the intervention, even when it requires the participation of many people. Often people with dementia and other cognitive impairments can experience these interventions as alarming and threatening, increasing their reactivity. For example, P46 described an approach to the provision of intimate personal care for someone with a cognitive impairment. They said,

> If they're having difficulty with [personal] care if I step in at the head of the patient and talk with them and just help reassure them and remind them, they're in the hospital and whatever it is that I can say to help keep them calm, so the health care aides can do their care, that makes a huge difference to the aides and the patient. Sometimes you need four people to do care, so the patient feels safe at a vulnerable time.

This benevolent use of force can reduce the exposure to violence for both nurse and patient, addressing the vulnerability of each in different ways. For the patient, necessary care is completed in a way that

does not compromise their safety or dignity, a consideration particularly crucial for someone whose cognitive capacity is insufficient to grasp a reasoned explanation for the uncomfortable or traumatic intervention. Their physical and psychological safety are preserved. For the nurse, the vulnerability to being physically hurt during the care encounter is reduced, as is the potential trauma of being party to the provision of care that causes harm to the patient, despite best intentions.

The preceding section has described the violence-related ethical dilemmas where nurses remain in the care encounter, and getting the job done in one way or another. The three categories of *stay* responses to contentious patient situations include finding a way, doing the bare minimum, and using brute force. These approaches are used when the patient is especially vulnerable, and to forego care would almost guarantee negative outcomes for the patient, nurse, or others in the environment. However, immediate intervention is not always required. At such times, a pause in care can provide a means for managing risk exposure for everyone. I turn next to the ethical decisions that nurses make to shift the vulnerability dynamic.

Pausing: Shifting the Dynamic

At first glance, the choice of what to do when a patient is violent appears limited to staying and leaving. However, the ethical options that nurses face in the context of workplace violence are far from binary. Rather, the decisions that participants described in this study exist on a spectrum, with remaining in the care encounter at one pole, and completely ending the nurse-patient relationship on the other. In general, participants describe staying when the patient would be at high risk of harm should the nurse withdraw care. However, when the nurse's vulnerability to injury increases relative to the patient's, the prospect of leaving a situation is more easily justified. Between staying and leaving, participants in this study revealed a liminal choice which keeps options open and reduces exposure to harm for everyone. I call this decision the *pause*. Participants reported pausing care when there was a

sense that there was time to allow a situation to settle or shift without risking the safety of the patient or nurse. For these nurses, the pause could take three different forms: finding safety in numbers, temporarily backing off, and issuing an ultimatum.

Finding Safety in Numbers

Calling for help was the preferred option for many participants. Often, they described calling a colleague to support the care plan. P39 described bringing in another nurse to try and explain to the patient what was going to happen.

> I called a colleague in to explain things to [the patient] slowly, like I had someone else. I did not tell someone else to take care of her, but I was there, and I called a colleague of mine who helped me in explaining.

As noted above, teamwork can often ameliorate a tense situation by offering options for addressing the patient's needs in ways that suit their health condition and state of mind and permitting the care to proceed in a slightly different way.

Similarly, P56, a psychiatric nurse, spoke of taking time to gather more people before attempting to intervene with patients who needed care, but were not in a position where they could harm themselves or others. "I think the situations were always temporary and it would be like, we're not going in until this happens or until we have more people or until police come". The availability of this type of support decreases vulnerability to harm by sharing the exposure to violence among more people.

Rarely, if ever, did participants choose to walk away completely. The pause in care served to reset the dynamic. P58 said,

> I don't think I have ever left and not come back. I have left, given it some cooling down time and returned but I don't believe that I'd ever left a situation where the patient did not get care. I have had circumstances where I've brought someone else in, […] bring a friend.

This temporary withdrawal to a safe distance was a technique that maintained the availability of care, while preventing a tense situation from escalating further.

Sometimes another nurse's way of interacting with the patient shifts the dynamic. For example, P39 described pausing the care interaction and calling for help, "I've had a patient once where I did not feel comfortable attending to them because they were like all over the place, shouting, so I called my colleague, and she was able to handle him properly and manage." P46 agrees, describing the benefits of bringing in someone with a different style.

> Approach really is key and stepping in to help other staff is really key because none of us have to do it on our own. And I think too it can be very humbling to know it's OK if you can't, if you're having trouble, it's OK for me to go ask [someone else]. 'This person will not take this med from me. Will you try?', or 'Oh hey, did you know that if you just put some medication in peanut butter and toast then they'll take it?' […] What I have appreciated most is a collaborative approach and we don't have to do it all. And if that patient just is not having it with us, it's OK to let other folks know and have them step in. Which again is awesome. It's not my way or the highway. And I really have seen approach do some very magical things with patients.

These examples again reinforce the importance of having a cohesive team approach to care, especially in environments where the prospect of violence is always close to the surface.

One participant told a particularly illustrative story about a patient who they knew would always require multiple staff to provide care safely.

> We had one particularly aggressive patient and so the management solution was to give us personal alarms. He knew where we carried the personal alarm, it was on a lanyard. And so, you didn't want to keep it on lanyard around your neck because of course, he could pull you and strangle you, so they would keep it in the pocket […]. And so, what he would do is go into our pocket and pull out the alarm and use it as a weapon to whip us. He would press the button to activate the alarm as a joke […]. And I remember, the doctor being there and being like, how come the alarm is going, and no one is going to respond to it? Well, because we knew that there was already two or three staff in there. They were caring for him and what I told the staff after I said OK, we know he plays with the alarm. I said, you guys, yell. Use your voice to call for help because you might not be able to activate the call bell either. OK, I'm listening. Use your voice because you can't. They can't always get the call bell. The personal alarm really ended up being a weapon more than anything. I said use your voice and seriously call me and call for help. And I'll listen for that. (P3)

This reliance on teamwork and the availability of others in the environment is crucial when the vulnerability dynamic is shifting. Were one person to go in alone to attend that patient, the risk exposure is vast. But when several people are there, and others on standby, risk to the nurse is somewhat mitigated. While the patient then becomes relatively more vulnerable, the duty to act in the best interests of the patient becomes more salient.

At times, family members can be called upon to support a pause in care that shifts the dynamic, although they may require support themselves. P8 described a patient with an intellectual disability who was quite volatile.

> She had her familiar person with her, but I think he probably needed some coaching on how to talk to her because he just got quite angry with her and I'm not sure if that's always how he was.

> So maybe some distraction techniques for her might have worked a little better just to take away from, you know, what was going on.

So, while sometimes, the behaviour of a family member is the bigger threat to the nurse, there are times when they can help temper the patient's reactivity.

Decisions to pause and bring in help are no less complex than decisions to remain in or leave a care situation, especially when concerns about privacy or the ability to maintain the care relationship are at play. P23 talked about a time when they felt they might have to completely withdraw their services to a patient of a psychiatric clinic.

> He has a sister who's like a very different person from him, very high functioning person who's put a bunch of boundaries around her relationship with him but does look out for his best interests […]. And so, without telling her what happened, I did share that there was the possibility that we might no longer be able to work together because if something changes, you're going to be wondering where to access care. So, I'll try to set something up for him if it goes that way.

In this interaction, the nurse is providing for care to be available, even if they cannot be the one to do it. Here, the pause enabled the nurse to repair the relationship and continue to provide care.

Many participants spoke of the option of involving security services when situations began to escalate. Most often, the presence of security personnel helped to shift the dynamic by absorbing some of the risk and reducing the nurse's exposure. Extra training in crisis intervention and the use of safety equipment provides this buffer. Often, the mere presence of security could neutralize the situation. As P18 noted, "I feel if the security had arrived earlier then probably that would have been, um, defused or something." P2 offered a similar sentiment.

> We would usually just call security like as soon as they started to get out of hand. I would, as the

> person that was being threatened, or I would say to them, I'm feeling threatened. And you need to back up a few paces [or] I'm going to have to call security. That would usually work, but not always, so I would either I would call security or one of my coworkers would.

The ability to call on security to intervene when needed was reassuring to participants, and most often provided a sense of increased safety that permitted them to provide care in situations where otherwise the exposure to risk would have been too great.

However, security was not always a positive. For people with a significant trauma history, as have many people with mental illness, the presence of intimidating people in uniforms increases agitation and accelerates the violence trajectory. Similar to the anecdote relayed by P56 under Brute Force above, P23 talked about the risks of calling in security forces.

> We do have the ability to call on security. We often actually don't, because for a lot of folks that tends to escalate things […]. I feel like if I had called security within the first 5 or 10 minutes, I think it would have been a code […]. if someone had laid hands on him, it would have been anybody's guess.

These risks, associated with a show of force, were noted by several participants.

While the decision to call for help is a go-to response to escalating situations, the decision to involve security services is one which is weighed carefully. Finding safety in numbers is an important option for reducing the exposure of nurses to the risk of violence, and there are several ways to do it.

Backing Off and Reapproaching

It may not always be necessary to call in extra people for support. Several participants described temporarily leaving a situation where the patient's behaviour made it challenging to provide care. Especially with people who have cognitive impairments such as dementia or brain injuries, the pragmatic and ethical choice is to back off when they are not receptive and reapproach later. For

example:

> I've had incidences where you go in and right away, they're throwing something at you or. Well, then, of course, you're not going to. You're going to reapproach, right? […] Especially I find with dementias because they totally forget like it's a brand new thing when you come back maybe 5 minutes later […]. The brain injuries are little different. So yeah, reapproach if it seems right off the bat, they're throwing things or angry and aggressive and that works. (P3)

This technique is an option for nurses when the person is not in urgent need of safety-critical care and serves to allow the situation to settle. This can be challenging when the care interaction starts well, but the dynamic shifts and the person becomes agitated. P3 continued, "Yes, lots of times I've had, they'll start lashing out all of a sudden and we'll just have to leave them half dressed […]. And maybe be able to come back later and get finished." While this pause does not always feel great, it can help to reset the dynamic and permit care to be completed in time, and without violence.

This, of course, becomes more ethically challenging when the required care is time sensitive or critical to the person's safety. For patients who do not have these types of cognitive impairments, waiting for the patient to request their care is an option. As P40 explained,

> It can be something like […] as simple as someone is very irritable and doesn't want to be approached for anything, they'll just come to me […]. So, I'll limit my interactions with that patient to kind of like sneakily eyeballing them to make sure they're alive, and if they have medication, I'll often either wait for it […]. I always wait for my patients to come up to me until it's apparent that they won't for their medication, but either I'll wait for them to come to me, or I will call security to administer their medication.

Although this option requires a certain amount of therapeutic flexibility, for patients who can absorb a pause in care, backing off can mitigate or alleviate some of the risk to both nurse and patient.

Issuing an Ultimatum

Issuing an ultimatum can be another way to have a positive impact on a situation's volatility. Although this is a decision that requires the perpetrator of violence to have the capacity to appreciate the implications of their choices, it does preserve their ability to act autonomously. An ultimatum can shift the risk dynamic by permitting the nurse to walk away from a situation that has become dangerous for them, while ensuring that the patient is informed about what will happen if their behaviour does not change. For example, P58 told the story of working in a nursing station in the North and dealing with someone who was under the influence of substances and requiring sutures.

> And finally, I just said to him, look, like you're here. You came to get my help. You are behaving in a way that is making that impossible. So, you have a choice. You can either let me do my job and stop being a jerk, or you can choose to leave. And I think that was probably the most direct and probably rude that I've been to a patient in my entire career.

Similarly, P8 talked about working on a labour and delivery unit where emotions can run high. They said, "It's like, well, you know what, if you're not going to settle down, then you're not going to have a nurse." This type of communication makes the potential consequences of behaviour clear to the patient and provides them with the information necessary to make a choice about how they want to interact with the nurse.

A dialysis nurse provided an example of using an ultimatum to help a patient de-escalate their behaviour.

> And he started getting mad. He goes, why can't I just go on [the dialysis machine] first for once? And then he started carrying on and I said, when you calm down, I'll put you on. And he's carrying on and carrying on and carrying on [...]. I finished and he was still going off […]. So, then

> I went and sat down at the nurse's station, and he said, aren't you going to put me on? I said, are you calm? And he looked at me and goes, yes. I said, okay, I'll put you on. (P45)

These anecdotes show that decision to use an ultimatum can help to prevent a situation from escalating, but participants acknowledged that it can also place people's health, safety, or comfort at risk. P1 spoke of a situation that was particularly ethically problematic when the behaviour of a patient's family member made it difficult for nurses to provide care.

> [I told her] if you're not able to conduct yourself in a in a in a reasonable way, then it's a privilege that you get to visit. And we will remove that privilege. And so, we've, we've shortened her visiting hours during management hours so she can only be there from 8 till 4 […]. Since it's a family member like how like is there opportunity to separate the family member and just say like I'm sorry you can't, you can't attend like you can't come again or you can't come visit at all because you're impeding our care of your mother […]. If I tell that person that they have to stop yelling at me and I'm not going to come back and until they can, you know, get themselves together or whatever, like, at what point are we risking the patient's health and safety?

Clearly, even the act of issuing an ultimatum is morally challenging for the nurse. The risk, of course, is that the person will continue to exhibit problematic behaviour, and the nurse will need to follow through and implement the consequence. The prospect of a negative impact on the patient must be considered when deciding to issue an ultimatum.

Like the use of security services, an ultimatum can shift the dynamic in a situation and tip the balance of vulnerabilities back in favour of the nurse. Where nurses remain in a care setting to attend patients whose vulnerability strengthens the duty to care, a pause is used when the risk to the nurse becomes less manageable. Often, it means time to summon reinforcements, provide the patient with a break that enables them to reset their behaviour, or offer choice in the form of an ultimatum moves the

situation back towards the *stay* end of the spectrum of ethical choices available to the nurse. This shift permits the nurse to continue to provide care in relative safety, balancing the best interests of themselves and the patient in a constructive manner.

Next, I move further along the *Stay-Pause-Leave* continuum, as I turn to the decision to end a nurse-patient relationship because of violence.

Leaving: Withdrawing from the Situation

Moving along the spectrum of ethical decisions available to nurses working in situations where there is actual or potential violence from patients or their family members, we reach the space where a nurse may decide they need to end the nurse-patient relationship to preserve their safety. While infrequent, this tends to occur when the risk to the nurse of remaining involved in the care of a person begins to outweigh the therapeutic benefit. For participants in this study, this reduction in exposure to violence could mean refusing to work with a particular patient, transferring care to someone else, or leaving the job entirely.

Refusing to Work with a Patient

For nurses who have been harmed by a patient, a common response was to withdraw from providing care to that person again. While some took the time and effort to transfer care, others simply refused and placed the responsibility for finding another provider onto the manager or charge nurse. Sometimes, this was because the nurse required medical attention, and other times, it was because of the mental toll of the violence. For example, P2 simply refused to look after a patient who had cornered them with a knife. “I said. You know, I'll look after everybody else, but I'm not looking after him.” This had the effect of separating the nurse from the patient and reducing their exposure to his potential for violence.

Participants did not make these decisions lightly. Unlike the previous situation, P23 described a conversation related to the decision to end a nurse-patient relationship that was no longer beneficial for the patient. “We reached an impasse about his treatment plan […]. Like it was going nowhere and nothing beneficial was happening for his mental health anymore. It just became like a power struggle.” It was clear that this decision was not a knee-jerk reaction to a single incident, but a long-considered response, reluctantly reached.

Some participants described reaching a threshold, before which they could manage the demands of the job, but after which, their tolerance for abuse and aggression dropped precipitously. P8 felt comfortable taking care of a particular patient until they were attacked and bitten. They said,

> I refused to take care of her after that because there was another altercation with another nurse, and it was worse than what happened to me and so I flat out refused to take care of her the next day when I was at work.

Similarly, P4 described a pattern of racial violence that escalated before they felt justified in refusing care.

> I have choose [sic] not to attend to certain patient because of how the person reacted towards me not once or twice, more than three times. This is because the argument didn’t end on a good note. So, I just didn't want to have any further issue [with the] person.

These stories offer examples of the point at which the nurse felt it was unsafe to continue providing care, and permanent withdrawal was justified.

There was acknowledgement that while withdrawal of care restores the safety of the nurse, it results in increased vulnerability of the patient, so tends to be used as a last resort. Although some participants described being supported by their manager to refuse care, others provided examples of their employers looking unfavourably on them for refusing to attend to a patient. P39 said that their

manager downplayed the violence they had experienced at the hands of a patient. “Yeah, they be like this is part of your job. This is your job. This is what you do, like violence is part of the job which it’s not supposed to be.” P45 reported a scenario that required intervention by their union, when their manager disagreed with a decision to banish an aggressive family member from the unit one night. “Well, the manager tried to blame me for causing her grief […] and the union put their foot down and said, ‘listen, give me a break, what was she supposed to do?’”. While there is general agreement that nurses need not work in unsafe conditions, the realities of the workplace do not always support that principle.

Some participants reported instances of absenteeism. After a physical assault in a patient’s home, P35 required a sick leave. They said, “Yeah, especially on that day. That guy hit me back on my head. I just left. I never provided any care so just left after I recovered myself. I could not return there again”. Even where there is no physical injury to the nurse, the psychological impact takes a toll. P40 recalled a scenario where they decided to take a leave from work after a violent incident on the unit.

> And I took some time off work because, I think things just accumulated. I took time off work last year and the thing that kind of triggered me to be, OK, I need to take some time off was a patient was in his room, in a seclusion room because he was well known to be very, very verbally aggressive and intimidating and aggressive to the environment […]. I went to his room, and I was like, hey, you have a phone call and he just, shot out of bed, straight up and started screaming at me that he was going to fucking kill me. And then a bunch of others, just, you know, calling me names and stuff. And then he started coming at me really fast. And I remember in that moment being, oh, this is where my career ends.

These narratives demonstrate the point at which the nurse recognizes their need to remove themselves from the workplace for a time. The dilemma is no less acute for nurses in leadership positions. P1 was

the clinical manager of an acute medicine unit. They described staff refusing to report for work due to ongoing abuse from a patient's family member.

> I think some of the things that make me really, yeah, that do make me really sad for my own, like for my team. Is that they just don't really know how to respond. And so, they either [take] the verbal abuse. They leave crying, right? Like it affects how they do their job. They don't want to come to work. They're calling in sick, if they know that that's the assignment they're going to have.

This adds complexity by placing the manager in the difficult position of assigning work that they know will cause harm to a team and its members.

Many participants described learning from experience when it was time to withdraw from a situation that seemed to be escalating. P8 said that after being attacked and savagely bitten by a patient, they developed a very low threshold for tolerance of aggressive behaviour, stating, "Whenever I even got the hint of feeling threatened, I would kind of back off." P2 agreed. When asked if their experience of being held at knifepoint by a patient changed their approach to people, they said, "I guess it did, if I felt threatened in the future, I would back right off." Their experiences with violence reduced the threshold for tolerance of aggression and provided an unfortunate benchmark for withdrawal from situations that look to be moving in the same direction.

Handing the Patient Over to Someone Else

Most of the time, participants who described withdrawing from the situation were able to hand their patient over to the care of another nurse. In the case of a long-term psychiatric patient whose aggression in the clinic forced the nurse to cut ties, P23 said, "I did set him up with other follow ups, they were keen to have him and he kind of fit exactly into what they had to offer." The sense of obligation remains, even after terrible experiences at the hands of an aggressive patient. Even after

receiving verbal and physical threats, P31 still felt compelled to find someone to take over the care of the patient. P35's workplace, a home care agency, had a process for this type of scenario. When they were attacked by a patient in the patient's home, they reported it to their manager. "Like that time, I was beaten up, I would not go back to there. After I report to the office, they'll send somebody different there." This dedication to ensuring the patient's needs are met even after being seriously harmed by them is commendable, and nearly universal among participants of this study.

However, some participants described feeling like after a certain amount of violence, they were absolved of the duty to care, in a sense. For example, P4 said, "But your patients, I believe when they are very rude, those ones don't even deserve to be calmed, do you? They I believe they just deserve to be walked out, like sent out of the hospital." P58 noted that there were even patients banned from accessing anything short of life-and-death emergency care at certain facilities after they had committed acts of physical violence against staff. P1 and P45 both considered the implications of banishing an aggressive relative from the hospital after harassment and abuse of nurses. P19 went so far as to have a visitor removed from the hospital. When asked if they were ever allowed back to see the patient, P19 replied, "Nope, no they were not. They had to request like another relative come pick the patient up due to the fact that he was way too violent. He wasn't actually allowed back in." Although far from a simple decision, the sense of absolution seemed to ease some of the moral angst related to the choice.

It was clear from participants that decisions to stop providing care or banning family from visiting were never made easily. While it may have protected staff, the patient was certainly disadvantaged as a result, so most of the time, care in some form continued. As noted, complete withdrawal of care was rare. P46 summed it up well:

> What's good, is that we usually do come to a better place eventually. Sometimes it takes a while and sometimes figuring out the meds takes a while, and I think what's hard is that because it

> takes time, or sometimes we just get so fatigued, it's like the patient just sort of sits there and there's no movement in the plan. Meanwhile, we're like, please get this patient out here, which is not appropriate either. It's like wanting to pass the buck because you're just so tired and it is so hard to give care and maintain professionalism and a high standard of care.

As noted previously, the sense of caring and professionalism leads nurses to try incredibly hard to manage patients' needs before resorting to withdrawal, either temporarily or permanently.

Leaving the Job

Even among nurses who self-selected for a study on experiences of workplace violence, complete withdrawal was not often described as an option. However, several participants spoke about reaching the far end of the *Stay-Pause-Leave* spectrum, and a point where they felt they could no longer do the job. Some, like P54 and P55, actively sought another job after a violent encounter with a patient. As P56 described, the ongoing and cumulative effects of frequent violence in their work environment began to cause significant physiological and psychological symptoms, leading them to seek employment elsewhere:

> I think eventually for me it was also making the decision that the level of violence and how often things were happening, how they were affecting me to the point that I could see other things developing like, I would go to Walmart, and I would hear a beep that sounded just like the beep from Code Whites. And I would get an autonomic kind of response, my heart was racing. I get all sweaty and I almost get bordering on that PTSD response that I was like, OK, this is not normal. This is not something that I should be experiencing at Walmart, so making the decision eventually to move from that environment and seek something else.

These anecdotes suggest that there is an upper limit to nurses' tolerance for managing these ethically fraught situations, and they manifest in multiple ways.

Summary

Nurses face a moral question every time they encounter a situation where a patient is or could become violent. In response to these dilemmas, participants' decisions ranged from staying and getting the job done, to pausing, and finding ways to shift the dynamic, to leaving, and withdrawing from the situation. When the nurse stayed, they described finding a way to provide necessary care, doing the bare minimum to meet the person's needs, or using force to provide care that was in the best interests of the patient and/or those in the environment. When they invoked the pause, participants found safety in numbers, backed off and reapproached later, or issued an ultimatum. When they absolutely had to, participants described transferring care to another nurse, refusing to work with the patient, and some even resorted to leaving their job for one that was safer.

These decisions were inherently ethical, raising questions for nurses about the right thing to do. Participants balanced considerations of patient vulnerability against their own physical and psychological safety, moving toward the *leave* end of the range of options as the situation became increasingly volatile. These acts of weighing conflicting priorities enabled participants to manage their exposure to violence and decrease the external influences on their vulnerability in the face of patient aggression.

On the surface, these ethical decisions may seem simple – to stay, pause, or leave. However, the reasoning behind the choice goes well beyond a simple question of who was more vulnerable in each moment. In exploring the considerations that factor into decisions about a course of action, the internal conditions impacting the vulnerability of nurse and patient offer a much more nuanced explanation of how nurses navigate these moral dilemmas. In the next chapter, I explore the factors that nurses consider when balancing vulnerabilities to determine the right course of action.

Chapter Six: Research Question Two - Findings

What considerations factor into decisions about the right course of action?

In the first research question, I explored the moral dilemmas that nurses face, and the ethical decisions they make in response. The decisions themselves crystallized around the reduction of exposure to violence and took the form of a *Stay-Pause-Leave* continuum or spectrum. To delve more deeply into the question of how nurses navigate the moral dilemmas that arise when they encounter workplace violence, my second research question concerns the considerations that factor into decisions about the right course of action.

Reflecting the core category of *Managing Intersecting Vulnerabilities*, the findings under this question are concentrated in two areas: factors that increase vulnerability by increasing exposure and sensitivity to violence and its impacts, and factors that mitigate vulnerability and improve the adaptive capacities of nurse and patient to deal with violence. Risk-multiplying factors that affect a nurse's decision to stay, pause or leave include elements personal to the nurse and their circumstances, patient-specific factors that may increase the impact of the nurse's decision, and environmental or contextual factors. Risk-mitigating factors include the results of the nurse's risk assessment, the availability of support, and the skills and tools available to the nurse at the time. All of these contribute to the nurse's prioritization of needs and the balance of vulnerabilities in the situation. Table 3 summarizes these findings.

Table 3

Summary of Question Two Findings: Determining the Right Course of Action

Factors that Increase Vulnerability	Factors that Mitigate Vulnerability
Personal factors	Risk assessment
Risk of harm	*Observations*
Fatigue and resilience	*Patient population*
Values	*Past experiences*
Patient factors	*Receiving information about a patient*
Cognitive capacity	Availability of supports
Risk to the patient	*Adequate staffing*
Risk to others in the environment	*Security services*
Other factors impacting the person	*Leadership support*
Environment	Skills and tools
Proximity to other people	*De-escalation and communication techniques*
Layout of the unit	*Approach*
Availability of spaces to de-escalate	*Ultimatum*

Factors that Increase Vulnerability

As a core element of the functional definition of vulnerability, sensitivity to violence is an important consideration in the decisions that nurses make. Sensitivity goes both ways. While nurses are at risk of being harmed by a patient's actions, patients are particularly susceptible to the nurse's decisions, especially when they are dependent on support of their basic needs and activities of daily living. These factors are informed by previous experiences as well as the nurse's personal circumstances.

Personal Factors and the Impact of Potential Consequences

In terms of the nurse's vulnerability, personal factors play a role in decisions on when and how to intervene when there is a risk of violence. Being in a state of providing care, that is, being at work, creates exposure to risk generally, but decisions around intervention are individual and contextual, and affect the extent to which a nurse is willing to be exposed to violence in the name of fulfilling a duty to provide care. Participants described considering factors such as the impact of potential consequences when determining whether it was safe to remain in a care situation. Furthermore, potential consequences were affected by the person's circumstances.

Risk of Harm

Most commonly, the nurse's risk of physical injury was a consideration. For example, P2 described their thought process while backed into a corner by a knife-wielding patient: "I actually remember backing up against the wall and thinking to myself, should I relax my abdomen, or should I tense it up? Like what's going to do the least amount of damage when he stabs me?" Bodily safety was a significant factor in decision making. Gender was also noted to be relevant. P28 described feeling that their gender made them less of a target:

> I think the thing that only saved me was the fact that I'm a man, […] if it was a lady or someone he thought he could actually take down or uh, boss around or he had a slight authority over, […] it could have ended with physical assault.

P49, too, found gender to be a factor, but in a different way. They described having to tolerate more risk and choosing not to report incidents of violence, because the response (or lack thereof) from hospital leadership was not supportive of women. "Sometimes when you are reporting a case, some men tend to feel like you are overreacting. Or you're being too emotional because you're a woman. I feel like some of them don't put our feelings in consideration." These quotations show that the role of gender was

multiply relevant to how violent or potentially violent situations played out for some of these participants. Although as noted in Chapter Two, the literature on the impact of gender on the experience of workplace violence is mixed, there was certainly a perception among many of these participants that their gender was a factor in their experiences.

Racism also played a role in nurses' decisions around care. P6 was one of the nurses who described anti-Black discrimination from patients. They said, "Sometimes I kind of like feel scared if there will be any discrimination[...]. Sometimes I asked (the patient) which of the nurse would they like to attend to them. Do they prefer a black or white nurse?" Identification of racial discrimination was unfortunately common, and its prospect clearly impacted the decisional processes of several participants.

The risk associated with physical injury is also more significant for a nurse who was pregnant. P1 described the impact of workplace violence as being more substantial because of their pregnancy. For example, they described having to decide whether to begin prophylactic treatment for bloodborne pathogens after a needle stick injury where the patient refused consent for bloodwork.

> I feel like [my partner] and I did have an opportunity to talk about what we were going to do, and I just said, like, I think I have to [take the prophylaxis] because I don't know. And as soon as you add another person into that, the baby that I'm carrying that it just, it just felt like way too uncertain.

This decision that resulted from an encounter the participant identified as violence, had considerable implications for the participant and their family.

Fatigue and Resilience

Other personal circumstances noted by participants included factors such as fatigue and the level of resilience at which the nurse is operating. P46 provided a particularly poignant story that shows

the ways fatigue influences care, describing a time on their unit when there were several challenging patients at the same time:

> So, with those four patients plus the usual kind of variation in between, it was exhausting, and I think all of the staff at that time had honestly some, and I don't talk about this frivolously, some low grade trauma after the winter because there was no safe place in the unit and we were constantly helping each other and fielding for each other. Plus, the noise level of the patients calling out, the distress, it affects you. I found it affected me. When you're hearing patients who are in distress, and sometimes you can go and help attend to that distress and other times you can't. Because you do have to finish your work, or you have to attend to your other patients […].
>
> You're just trying to maintain your professionalism and do your work safely, and then to be hit by a patient, and also feeling that kind of loss of control, I had to just leave the room, because I could feel myself losing control […]. I think that's kind of an undefinable heaviness when you work in a workplace where there could be violence, you have to be vigilant with many of the patients. As they do start to get better, we still must know where they are in the hallway when they're walking by you, just in case. Just to be mindful like that takes energy and effort and that's kind of exhausting in and of itself. It's necessary and it's appropriate, but it's exhausting.

These comments demonstrate that vulnerability is not limited just to a risk of physical injury but encompasses moral injury as well. Emotional and psychological consequences held as much sway in participants' decisions as the prospect of being hurt by a patient.

Other potential consequences described by participants included concerns related to legal vulnerability. Some participants spoke about being named in or threatened with legal action, and many described pushback from management. For example, P49 chose to leave an escalating situation because

they felt they would be held responsible for any harm, due to the patient's health condition. "Him being a mental health patient, let's say he does something to me, it wouldn't have been have taken seriously because he's a mental health patient." Several others expressed similar sentiments, reflecting the ways that patient precarity increases the nurse's responsibility to care, without necessarily mitigating the nurse's own sensitivity to harm.

Values

Another personal factor that played into a nurse's vulnerability to workplace violence was values that, paradoxically, tend to place the nurse in harm's way. These included the nurse's sense of professionalism, their desire not to make a situation worse, and the drive to ensure a patient's needs are met.

Many participants cited professionalism as a factor. The sense of duty imposed by the existence of a professional relationship led many participants to enter or remain in a high-risk situation. P23, for example, rationalized the decision to continue providing care for a long-term client despite an incident of sexual violence in the clinic.

> I actually want to keep eyes on it like I have a sense of responsibility and for his overall health and stuff like that. And because of the acuity of his injuries still, […] I just, I didn't think it would be fair to him to just be reactive, […] and at least, you know, if it had gone that way and he was continuously acting that way and it didn't seem to be for any health reason, I'm also asking someone else to deal with it, right?

This recognition of the nurse as one of the few, if not the only, option the patient had for meeting their health care needs, took on significant weight in the decision-making process. Similarly, P10 described staying in a care situation due to a sense of professional responsibility. They stated,

> But most of the [times] I did experience physical violence was as a result of cognitive impairment. So, I just kind of did it even though I was scared. [Sometimes] I did leave, and I had to call for assistance because that was above the threshold. Other times, because of this idea that you just have to do it, I don't really recall leaving. I just sort of pushed through it.

Again, the sense of responsibility kept them from leaving a situation they knew to be risky.

This sense of being accountable for the impact of a decision led several participants to describe similar decisions to remain in a volatile situation, even to the extent that they compromised other principles. P29 described their strategies for defusing a situation after receiving verbal abuse from a patient's family. They said, "I completed the care, […] I just applied my good communication skills. I had to cool down [the family member] so that I can finish my work and […] at a point I even had to lie." They felt they could not leave the patient without care but were worried for their own safety in the moment. In this case, remaining in the situation felt like the only available option, although they had to violate a different ethical norm to do so safely.

Responding with decorum and respect, even when it was not reciprocated, was a common finding. Participants cited the need to maintain professionalism for many reasons, including not wanting to damage their own reputation or that of their employer, and wanting to demonstrate excellence. Several also commented on not wanting to exacerbate a situation, or cause harm to a patient in the process of providing care or defending themselves.

Ultimately, participants in this study described prioritizing the patient's needs, even at the expense of their own safety, again and again. Their commitment to providing care, and the recognition of the person's dependence on the therapeutic relationship signaled a value orientation that at times placed the nurse in harm's way. This, in combination with the nurse's personal circumstances and the impact of potential consequences, informed many decisions relating to whether a participant would

stay, pause, or leave a violent situation. Another important consideration was the patient-related factors that impacted their sensitivity to the nurse's decisions and actions. This is discussed next.

Patient Factors

Several patient-specific considerations were referenced in relation to participants' care decisions when workplace violence was present or anticipated. They include the patient's cognitive capacity, the risk to the patient or others in the environment, and other factors impacting the person. The patient's state of needing care, of having needs that must be met, were considered in connection with the associated level of vulnerability, forming an important element in the process of the nurse's decision making.

Cognitive Capacity

The patient's cognitive capacity was noted frequently as relevant to a decision to intervene or to step back from a situation. Participants were likely to become or remain involved in a scenario where the patient's health condition rendered them less able to control their own behaviour, as compared with people who were presumed to be capable of reasonable interactions, and still behaved aggressively. Nurses described using effortful and persistent approaches with patients living with conditions like developmental disabilities, psychosis, and dementia, whereas they felt justified in leaving interactions with people who had difficult or challenging personalities in the absence of an organic health condition requiring immediate intervention to save life or limb.

For example, P56 spoke of the distinction between intervening with a patient who was behaving aggressively due to their particular health condition rather than an oppositional personality:

> Another factor is whether the patient's behaviour was related to illness or more of a behavioural issue. I think it made it easier for us to make a decision of not responding if it was a behavioural issue, as opposed to like, this person's truly unwell and tortured by their experience and their

> symptoms […]. I think it made me more willing to put myself at risk, if I knew that the person was suffering because of their illness as opposed to, [the patient thinking] I don't like that person and I want to hurt them, or you're not giving me what I want, so now I'm threatening.

This distinction carries moral weight and is connected to decisions to leave a care encounter even when the patient's care needs have not been met. P46 concurs, referring to caring for people with dementia or cognitive impairments.

> Sometimes you need four people to do care, so the patient feels safe at a vulnerable time. Otherwise, they're wild and out of control, putting themselves and staff under duress and threat of physical harm. One person really needs to attend to their emotional needs. That isn't a luxury, it's a necessity. Because, again, at the root of it is our clients with dementia feel they're being attacked, that they're not safe. They're vulnerable, and that's why they're behaving the way they are. We don't deal with the population that typically is rational and abusing us. They do not have the capacity to be rational. I think that helps a little bit.

These differences, between a person acting out because they are confused and scared, as compared with someone who can understand social norms around incivility but chooses to act contrary to those norms, was a central factor in participants' assessment of patient vulnerability, and their decisions about whether to stay, pause or leave an unpredictable situation.

Risk to the Patient

The risk to the person was also an important factor. When the patient was not behaving in a way that compromised their own health and safety, it was easier to pause and reapproach, or even to end the relationship. For example, P3 spoke of working with people who have cognitive impairments, stating,

> Where I really see the problem is when there's a risk to themselves, the patient or a risk to other patients in the environment like I have had incidences where a patient is zipping around [in an

> electric wheelchair], and other patients are at risk and then you're not in a position to just leave them and reapproach. Like it's a, it's a safety thing.

Reapproaching is an example of the process generally used for people who would not be in immediate danger if the nurse leaves for a time. In contrast, P56 talked about jumping between two patients, knowing one was more vulnerable than the other.

> I remember one of the very first times that I got hurt at work. It was just, you know, two patients fighting each other. And I pressed my alarm. I know that no one's going to come for the next, like, 3 minutes. That's a very long time.

This type of decision was not always made in the moment. The same participant spoke of the decision-making process where they had to impose a treatment on a patient who was not in a state to consent.

> He had locked himself in a room, but it was the interview room, so there was windows all around so we could see what was happening. But he had taken apart a table. He had legs of a table, and he had all the threatening gestures, nonverbally and that he had taken off his shirt. He had wrapped his arms to fight, and he had these legs of a table, and then he's yelling profanities at us and telling us how he's going to hurt us in all these kinds of different ways [...]. And I think that was an example of we decided we're not going in, he is not going anywhere, he's not hurting himself. (P56)

In this case, the participant and their team decided not to intervene, until help could be summoned.

Several participants talked about the traumatic nature of health care, especially for people with cognitive impairments due to dementia or mental illness. P23 spoke about how their patients' past histories influence how they engage during health care encounters. They said,

> My patients are a lot of big scary looking dudes, and they get treated the worst in the hospital. They spend the most time in seclusion and restraints and overmedicated, and for some people

> it's completely traumatizing even to come to an appointment in the building like there's numerous people who do not sleep the night before […]. And so, I think just really being aware of not wanting to be a part of trauma.

A trauma-informed approach helped participants rationalize their decisions, when pausing care was an option. In the same vein, P56 expressed a feeling of moral compromise in having to manage a violent patient through force.

> And in that situation, the police came, and they tased the patient and then we put him in restraints because we didn't want that to happen again […]. Even restraining him was quite difficult. You know, as a young man of colour and I think it was around the time that there was a lot of like George Floyd things online and physical asphyxiation and all those things kind of in the forefront of our mind. And as I see, you know, like 10 people piled up on top of this guy.

In this case, a pause was not an option, but the patient's vulnerability to potential trauma was never far from the nurse's mind.

The risk to the person also factors heavily in situations where the violence was perpetrated by a family member or someone not in need of immediate care. P1 and P45 spoke of the angst associated with the decision to restrict a visitor's access to a patient because of their aggressive behaviour toward the staff, recognizing that the decision was also going to impact the patient, possibly quite negatively. The prospect that solutions to the family member's behaviour would affect the patient weighed quite heavily on these participants.

Risk to Others in the Environment

The risk to others in the environment played a role in participants' decision-making processes as well. Participants described the urgency to intervene in situations where others in the vicinity were being affected by an aggressive person. The risk of physical injury to bystanders was a primary focus, as well as

concerns around infection prevention and control. P45 related an example of a situation where a family member's aggression on a dialysis unit put others at risk.

> I'm responsible for everybody in that room and the safety of everybody in that room. And so that's why I was like, you know what? You don't get to put everybody at risk for that […]. I was responsible for everybody in that room, and that's kind of why I stood up. It wasn't a choice, right? It was just, I stood up and did it […]. Everybody's got a full unit of blood out of their body at any given time in that unit when they're on the machine, it's 300 mL and it's running at 300 mL a minute. So, all it takes is a needle to slip. It doesn't take long for someone to exsanguinate. All he had to do was freak out and attack a patient, and someone would exsanguinate. So, it was a matter of trying to de-escalate it as quickly as I could.

Likewise, P40 provided an example of decision making on a psychiatric unit for a patient who was known to be aggressive.

> We had a patient brought in from jail who according to report was very, very sexually aggressive, shouldn't be alone with females at any point. We had some female patients on the unit and obviously the majority of the staff were female […]. The guy ended up being put on a security status because he was extremely sexually aggressive.

Similarly, P23 noted that the protocols that are implemented after an incident are often focused on protecting others who were peripherally affected.

> I do have to think of the whole team. Right. Like I can't. It's not just my safety, it's the secretary [who] is their first point of contact, it's everyone, right? So, I can't just handle it from what I would like to do, or what you know, go by my judgment day to day, like there has to be some kind of process.

These three situations show how the risk to others often seemed to be weighted more heavily for

participants than even the risk to the patient or nurse individually.

Other Factors Impacting the Person

Finally, participants described taking other patient-related factors into account when deciding whether to remain in a care encounter with escalating risks. As noted above, the patient's diagnosis played a significant role in determining the nurse's next steps, as did the patient's history, especially when there was past trauma contributing to the behaviour. In addition, the nurse's approach changed depending on their knowledge of a history of aggression, either due to personal experience, or communication about an incident involving others.

For example, P2 told the story of a patient who attacked them with a knife. They stated that their approach would have been much different if the patient's history of aggression was known to the hospital staff.

> If we had known he was that violent [in his home community], that would have been a huge help […]. I honestly think that the powers that be [in the community] felt if they informed us of that, that we wouldn't have taken him. We wouldn't have allowed him to be a social admission and he was there for ages.

In this case, the situation may not have happened if the nurse had been advised of the person's violent history, permitting them to anticipate the risks and identify a mitigation plan.

P23 also spoke of the factors impacting a patient who went on to be sexually inappropriate while receiving health services.

> Umm, so it's basically a guy I've been working with. I've known him for the whole 20 years, so I always had a really good rapport. He's pretty rough around the edges, you know? Precariously housed most of the time. And he's been stabbed. Almost died twice in the last two years and he has a diagnosis of schizophrenia, but he has been very well from that point of view. It's more

> and I hate the word antisocial, but it's sort of those traits and that cause the most problems for him in the community and in following through on things that could maybe make life a little different.

There were numerous such patient-related factors that impacted this nurse's decision around whether to intervene or step back.

While personal factors and nursing values were important elements in the care-related decisions of participants, patient-related factors were also significant. The final group of considerations under the category of decision-making factors related to multiplying the risk of harm is the structural impact of environment. These findings will be discussed next.

Environment

Participants described important considerations related to the context and structural circumstances where care is taking place. Environmental elements such as the physical proximity to other people during a volatile encounter, the layout and physical space, and the availability of spaces to contain, mitigate, or de-escalate and prevent violence were all cited as essential pieces of participants' decisions to stay, pause or leave, as they altered the vulnerability of both nurses and patients in the moment.

Proximity to Other People

A major environmental consideration was whether others were at risk from the behaviour. As noted previously, the welfare of those individuals in the vicinity was a concern for participants. Distinct from the risk to others in the vicinity noted above, from an environmental perspective, the proximity of bystanders was considered because of the challenges that they pose for the management of a situation. Participants described protocols and processes for ensuring that bystanders would not be harmed in the process of managing another person's behaviour.

P50 noted that training and practices for de-escalating and protecting bystanders is a central part of their work. They provided the story of having to leave the room of an aggressive patient quite abruptly and commented on their decision-making process.

> You kind of have to be trained on how maybe to tackle and how to avoid the whole closing the door, that training. I mean, if I didn't get the [training], maybe I wouldn't have closed the door or just left and leaving the door open, exposing more people to a possibly dangerous situation, which is what you're trying to avoid. So, there is one protocol that you have to follow when there's an aggressive patient around you, like clearing the area, calling for help. It's all part of the training to defuse the situation.

In addition to the potential for the exposure of others to violence, the practical implications of working around those in the vicinity clearly factored into decisions about how best to manage a difficult situation.

The ability to control where ambulatory patients can go on the unit was also cited as an important influence on the level of aggression overall, and particular incidents as well. P40, a psychiatric nurse, noted,

> And yes, there are times where patients are usually […] when they're psychotic and they become unpredictably violent, […] that we can't really help. But if we had environmental measures in place where we could control where they can go, even would be so helpful. So many less people would get hurt […]. A big time where people get injured is giving a patient meals because you have to fully open the door.

The exposure of others to the aggressive person increases the ambient risk, and correspondingly factors into decision making in the moment.

Layout of the Unit

As noted above, physical space was also important. Several participants noted serious safety deficiencies directly attributable to the layout of the unit and proximity to environmental hazards. Options for containing or isolating a patient who was behaving dangerously received mixed reviews. While it was seen as good to have a space where a patient could be placed where they would be safe while the team waited for support, the reliance on seclusion and restraint was recognized as often being unhelpful. P40, for example, spoke about the layout of their psychiatric unit.

> We wouldn't have to put patients in seclusion if we could prevent the whole situation to start with […]. Our seclusion rooms don't have toilets or water fountains in them, like a jail seclusion. It's just a locked room with white walls […]. If we just had a safer way to give [a volatile patient] his food and let him go to the bathroom, have a toilet in the room and a meal slot, and then you're not necessarily physically interacting with him. Or it's very, very limited, but instead people were getting hurt all the time, having to open that door.

Well-designed units were described as more conducive to healing and recovery, and as safer for both staff and patients. Several participants spoke about being conscious of always having access to escape routes, in the event that a situation becomes volatile. The layout of the unit also determined how easy it was for a nurse to avoid a patient after an incident.

Availability of Spaces to De-Escalate Issues

Especially in psychiatric settings, nurses described ways that the physical space tended to increase the risk of violence, for example, being in close quarters with others, or having no safe place where a psychiatric patient could go to be alone and practice self-regulation. These structural elements were seen not only as safety issues, but as compromising the dignity of patients, increasing their vulnerability.

P40 again shared their perspective on how environmental measures could decrease the incidence of violence in psychiatric settings.

> We have no comfort room. Very distressingly, the program got rid of comfort rooms to build seclusion rooms […]. We try our very best not to seclude someone unless someone is an imminent threat of violence to other people and to an extent themselves, we'll let them hurt themselves to a certain point. But, if they're an imminent risk of violence, yeah, we'll put them in there. But when someone is in that stage where they could escalate and we could still prevent it, having the ability to give them a quiet room that isn't locked has a couch or something, a bean bag chair, some sensory things just to calm down, would be really valuable. Right now, all we have to offer them is going to their shared room.

These kinds of environmental factors clearly played an important role in participant decision making. The setup of the unit and the proximity to others reflected vulnerabilities that factored significantly in decision making about whether and how to intervene when a patient's behaviour was escalating.

Summary of Factors that Increase the Risk of Violence

Navigation of the ethical decisions around whether to remain, step back and reapproach, or leave a volatile care encounter entirely is driven by several considerations. In this section, I examined the factors cited by participants that related to sensitivity to the risk of harm. These included personal factors individual to each nurse, such as their own life circumstances, and the impact of potential consequences, and the ways in which their internalized professional values influenced their decisions. It also included relevant patient-related factors, such as the patient's capacity to control their own behaviour, the risk to the patient and others in the environment, and other factors impacting the person. Finally, participants described how the physical environment in which care was being provided impacted their risk of harm from a violent or potentially violent person.

The other category of considerations factoring into participants' decision-making processes concerned their capacity to mitigate risk. In the next section, I examine findings that provide insight into these critical influences on decision-making in the moment.

Mitigating Vulnerabilities

While some considerations focused on the ways in which people (nurses, patient, or others) became more or less vulnerable to harm as a result of violence, other factors related more directly to those things that helped the nurse anticipate and respond constructively to an increased risk of harm. The category of considerations that comprise the ability to evaluate a situation, identify strategies, and deploy resources to maintain the safety of everyone who could be affected by an incidence of workplace violence is what I am calling Mitigating Vulnerabilities. These factors included risk assessment, the availability of supports, and the skills and tools available to the nurse to manage the situation.

Risk Assessment

Risk assessment is the evaluation of a situation to determine the level of vulnerability, and resulting concern or expectation the nurse has for the development of a violent situation. This was described in terms of the nurse's situational awareness and derived from a constant level of vigilance for patient behaviours and contextual information. Often, participants described their risk assessment as observations of cues gleaned from the patient's behaviour.

Sometimes, the situation can escalate rapidly, without a great deal of warning. P18 was a nurse that stepped into a confrontation between another nurse and a person who had been waiting for care for a long time. They said,

> So honest, it wasn't looking, it wasn't looking so dangerous in the beginning, and I felt that was what motivated me to just go the way I went. You know, like I wasn't seeing this as something

> that would actually get out of hand, and I felt this was what made me actually intervene in the whole, the whole issue.

Indeed, it was when the nurse was taken by surprise that the most serious incidents arose. P2 had been attacked by a patient wielding a knife. They said, “My mistake was I didn't know what was going on, so I backed up into a corner, not realizing now I can't get out.” Many participants described being constantly vigilant for a quick change in someone’s demeanour.

Most often, however, participants described specific cues that suggested a person might become aggressive. Often, familiarity with the patient and their usual manner, a raised voice, being visibly intoxicated, and other nonverbal cues, such as pacing or increasing agitation indicated that the person was likely to lose their temper. P8 described their assessment criteria.

> A lot of times it's like, how are you talking to me like? Are you giving me verbal threats? Are you giving me physical indicators that you might be violent? You know in other scenarios I've had agitated patients start swearing at me or telling me things, and then the verbal threats kind of come with it. And then it's like, you know what? I'll come back. I'm not doing this with you right now because, but I've got a life to live. Um other ones are like, you know, when they start shouting […] you know, something more is going to come out of it. Like it's going to, there's always going to be something worse after somebody starts shouting at you.

These cues alerted participants to the impending escalation of behaviour and allowed them to reduce risks by taking precautionary measures.

Participants noted that some patient populations were more prone to outbursts than others. For example, people experiencing symptoms from mental illness, or people living with dementia or other kinds of cognitive impairment were deemed to be at higher risk for reactivity or violence, so

higher vigilance for escalation was required. P10 spoke of overcoming the fear of managing care for people with cognitive impairments. They said,

> I remember there was one patient this when I was a newer nurse was hesitant about a lot of things. And any time I saw that I was assigned to this patient, I was scared. Like I would go in in the morning being like, please don't assign me this patient. I'm scared of what this patient's going to do. They're going to, they would lash out, like physically they would hit. We had to have multiple people in the room any time you were doing anything. So, any time I would go in that room, my senses were heightened. And yet I knew that this patient had cognitive impairment. They could not help what they were doing. And yeah, so that's what I struggled with my own fear. I knew I had to provide care, but I was also scared of getting hit and I would never want to hurt the patient either. Like there's things you have to do but they don't understand. They might be acting out violently, like physically, violently, and you still have to provide the care. So, it's like balancing my fear, the care you have to provide and not wanting to hurt the patient.

Participants suggested this was important, not only for the completion of the task, but for preserving the patient's dignity and comfort as well.

Several psychiatric nurse participants described the unique challenges of managing the care of people with mental illness. After being attacked by a patient, P50 noted,

> I try to check the background to see if they are manipulative and how they interact with other nurses. If I'm dealing with the patient, I try to know the kind of interaction the patient [has] with the people in the hospital. So, if you hear a complaint, even if it's one, you got to be careful because these are highly manipulative individuals. So, if, uh, even if it's a single person who [says] that, yeah, you should be careful with this patient.

Clearly, communication among the health care team provides information that is central to the care planning process.

Similarly, participants who had previously experienced violence with a particular patient or found themselves in a situation similar to one where violence had occurred described having a heightened awareness of cues that presaged a violent outburst. Seasoned nurses described the ways that previous experiences with violence changed their approach thereafter. P8 stated, “Whenever I felt like I was getting backed into a corner by a patient or felt threatened or I thought I was going to get hurt, I just backed off with some of my nursing care.” This was a common theme.

In general, being alert to the possibility of violence became second nature to participants, as they gained experience in dealing with challenging behaviour. As noted by P46,

> I think that’s kind of an undefinable presence and when you work in a workplace where there could be violence, you do have to be vigilant with some of our patients. When they do start to get better, it's even knowing where they are in the hallway when they're walking by you.

This process of constant observation is self-protective, and quickly becomes part of the way a nurse goes about their day.

Participants noted that receiving communication about a patient’s tendency to escalate was helpful for preparing and planning strategies to manage their care. When it was mentioned in shift report, for example, participants described using different tactics for approaching the patient. Conversely, not receiving information that a person might become violent meant the nurse tended to be less prepared and more likely to be hurt. P8, for example, was bitten by a patient who subsequently went on to seriously hurt another nurse. They had not received information about the patient’s aggression, which would have caused them to alter their care plan.

This is particularly problematic with float staff, who do not know the patient. P3 said,

> And then and the other thing that I've noticed too is when they have, when they float staff and you get staff that are unfamiliar with a patient that's volatile, that's usually when a problem arises too, because not only are the staff unfamiliar, but the patient's unfamiliar, and then it just escalates the situation and that's when people get hurt.

Familiarity with the patient can have a protective effect by reducing the nurse's vulnerability to injury through knowledge of the patient's behaviours. This was conveyed by a sense of confidence in dealing with patients with whom they had had prior encounters, so they would know the ways to approach them to minimize risks. Receiving information in handover reports from other nurses was also helpful in allowing nurses to prepare a care plan that permits care that is safe for both nurse and patient.

Several participants described being acutely conscious of having access to escape routes when entering the care environment. Strategies such as ensuring the door to the room was not blocked, and not permitting the person to back them into a corner were key risk mitigation procedures. P3 suggested, "So, open the door and keep the door open so you have an exit. Don't block your exit. Even with a medication cart or something, keep that exit clear and just slowly in a nonthreatening way." This awareness is again engrained in the nurse's thought processes from an early stage as they go about their work.

Risk assessment provided key information to nurses making decisions about whether to stay, pause or leave. Knowledge of the tendencies of the patient population in general as well as communication about individual patients' histories, and situational awareness of the physical environment allowed participants to evaluate and mitigate threats.

Availability of Supports

The availability of support helps to prevent situations from escalating and to de-escalate situations when they become volatile. Commonly cited supports include adequate staffing levels, security presence, and the backing of leadership when challenging situations arise.

Adequate Staffing

Participants described the benefits of adequate staffing as permitting sufficient time with patients to provide care in the way that best suits the person's health condition. Several participants talked about how providing care at the speed a patient tolerates, rather than rushing to get tasks completed, took far longer, but resulted in less escalation. One psychiatric nurse described being able to take the time for a therapeutic conversation with a patient who was becoming agitated, rather than taking them straight to a seclusion room.

> I remember the first time I was working with another nurse and a guy started to get pretty agitated, and we're looking at each other like we're really not supposed to put him in seclusion[...]. It took a lot of work, but we didn't, and we had all these situations where suddenly things took 45 minutes to talk through, but we didn't use seclusion […]. Anyways it was exhausting, but there was not one time I cleaned up poop off a wall, you know? […] So anyways, we went three months without using seclusion even one time, and so that to me really drove home that it's not them, it's us. Because they didn't change. The patients did not change. We did, and yes, it took a different kind of work, but it was so worth it. (P23)

This approach, however, depends on the availability of staff to manage the care needs of all patients, especially when one is demanding the undivided attention of the nurse.

Similarly, P46 described the need for multiple staff to provide basic daily care to people living with dementia.

> Having appropriate staffing levels makes a very real difference in our safety and the safety of our patients, and our ability to create behaviour care plans quickly and move patients through the hospital system more efficiently. If we don't have proper time, the behaviour of patients keeps them in limbo in the hospital. Appropriate staffing and care means safety AND efficiency.

This example shows the critical role that staffing ratios play in the ability of nurses to provide compassionate and timely care. Adequate staffing permits the nurse more opportunity to assess and monitor for escalation, makes fomenting issues more visible, and makes prevention more likely.

Security Services

Having security services or police on the unit can be both helpful and harmful. While the presence of trained people who can intervene in volatile situations can be reassuring to staff, it can add an element of retraumatization or risk, especially when the patient has a history of trauma. Several participants talked about calling in security when someone was becoming reactive. Often, this resolves the situation, because the show of force tips the balance of power and helps the patient to recognize the need to re-regulate their emotional state. Other times, forcible restraint and sedation is required, which necessitates the use of trained security personnel.

Sometimes, though, the presence of people in uniform makes things worse, so participants reported encouraging them to stay nearby but out of sight. P23 described a situation where they were barricaded alone in a room with an agitated person experiencing symptoms of a mental health crisis. They chose not to call on security, expecting the presence of uniformed guards would make things worse.

> And anyways, it all ended peacefully with him walking out of there peacefully. And you know, [it] wasn't a great day for that guy, but it was a result. And I feel like if I had called security

> within the first 5 or 10 minutes, I think it would have been a Code [White] […]. If someone had laid hands on him, it would have been anybody's guess.

So, while trained supports are good to have, there is also an element of discretion required for their effective use.

The reassurance that access to trained support provided to participants was considerable, and, not surprisingly, the impact of not having security close at hand resulted in several participants describing decisions in the moment that they might not have made were there supports nearby. For example, P56 described being hurt at work intervening when there was no security support immediately available.

> I remember one of the very first times that I got hurt at work. It was just, you know, two patients fighting each other. And I pressed my alarm. I know that no one's going to come for the next, like, 3 minutes. That's a very long time […]. And so, it's just me and my colleague trying to peel them apart from each other. So, I got a couple punches thrown to my head. These are things that if I were to think back, it's like, yeah, maybe I shouldn't have stepped in the middle. But in the in the in the split second, I just made that decision.

So, while having security services available can itself cause some situations to escalate, it can also help to control volatile situations when force is required.

Leadership Support

Another factor that participants described as an important consideration in decisions to stay, pause or leave a care situation was the knowledge of whether they would be supported by their organizational leadership. Having a manager back them up provided participants with a sense of validation of their decision to intervene (or withdraw) and reduced their own vulnerability to the personal consequences of their decision.

P23 described feeling well supported in their decision to continue treating an outpatient who had been sexually aggressive toward them in an outpatient clinic setting.

> I think if I'd said, I'm never working with this person again, I think I would have been supported. I think they followed my lead on what I was comfortable with and the process that we had in place and the other side of any incident of this nature, whether it's threats or violence or this kind of thing.

P2, on the other hand, considered quitting their job when their employer refused to back their decision not to continue working with a particular patient after they were attacked with a knife. They said, “I think, you know, what hurt the most was that the hospital was very blasé about the whole thing and actually questioned [my colleague] and I separately, like we were criminals.” The experiences of P23 and P2 noted here clearly impacted decisions about patient care they made later in their careers.

A lack of support manifests as victim blaming, or a reluctance to support necessary interventions such as Code White. While this did not always cause the participant to make a different choice, it certainly gave reason for second thoughts about how best to handle a similar situation and tended to make the aftermath of the decision more difficult. Not infrequently, it resulted in the participant considering leaving the job.

Commenting on the same situation, P2 described feeling betrayed by their colleagues and other witnesses after the attack. They said, “[Other witnesses] also saw what was going on and they denied it. So that really that really hurt. Then I was asked I don't know how many times what I did to provoke that attack.” Gaslighting like this was concerningly common among participants.

While leadership support was not cited as a significant consideration by all participants, those who mentioned it found it to be an influential factor in their decision-making processes.

Skills and Tools

The skills and tools available to nurses can help them assess and mitigate their own vulnerability and that of the patient. Their confidence in the intervention being considered helps with decision-making.

Several participants talked about de-escalation and communication techniques to defuse or prevent escalation. These tactics played a significant role in managing patients with cognitive impairments. P3 tells new staff,

> Don't come straight on. Go sideways to them and maybe back against the wall […], and also with your hands, keep your hands kind of loose […]. Like just try to be [as] nonthreatening as possible. I find especially with dementias that helps because the language isn't there sometimes, but they can kind of sense behaviour, your face and your body language.

Numerous participants spoke of the importance of these kinds of communication techniques.

Often, the use of humour could serve to de-escalate a situation, as did offering the patient as much choice as possible. Open communication and gestures that demonstrate respect for the person's autonomy tended to go a long way. P23 talked about strategies they use to support people in an outpatient mental health setting, where outbursts are common.

> I've had enough times where I've dealt with really agitated people. But the principles are kind of the same, as like always offer people choices. Always. You know, people usually feel really good after they can have a good vent, right? So, if they're really upset, umm, I'll sometimes say like if they're like, I'm going to kill that guy in the store or whatever. And I'm like, I need to know if you're venting or if you're serious. And then it's like, OK venting, go ahead, like and there's even times where, like, if people are yelling in my face, I've found that saying like, you know, 'you're actually really freaking me out right now' is a little bit disarming. They're like 'oh really? Sorry'.

> And then dial it down a notch, right? […] Umm but to let the person know how their behaviour is kind of impacting the situation. […] So, I don't know. Humour. You know, trying to keep things light when you can.

P23 also talked about ensuring they are trustworthy. This is central to caring for people whose illnesses manifest as paranoia, but also applies to many situations. If a person knows the nurse can be relied on to fulfill promises, the likelihood of escalation tends to drop. Similarly, techniques for approaching a patient that acknowledge the patient's experience of fear or sense of threat can prevent the patient from reacting aggressively.

Occasionally but still significantly, a participant described the use of an ultimatum that clearly communicates the consequences for continued behaviour. These are effective when the patient has sufficient cognitive capacity and ability to regulate emotions to make an informed decision. P58 related an incident where they were attending to a person who came into the nursing station in a remote community for care of an injury.

> He was intoxicated. He was being an ass. He wasn't really letting me assess him, saying some completely ridiculous things. And finally, I just said to him, look, like you're here. You came to get my help. You are behaving in a way that is making that impossible. So, you have a choice. You can either let me do my job and stop being a jerk, or you can choose to leave. And I think that was probably the most direct and probably rude that I've been to a patient in my entire career. He kind of muttered for a bit and then he let me suture him up, and then before he left, he pulled all the sutures out. And then he left in a huff. And I'm like, well, that was just two hours in the middle of the night that I'm never going to get back.

As noted previously, issuing an ultimatum can be difficult if the patient calls the nurse's bluff, and they need to implement the consequence. However, this example illustrates that not only is communication *about* the patient important in mitigating the risks of violence, so is communication *with* the patient.

Summary

The participants in this study offered two broad categories of considerations regarding the question of how nurses make a determination about the right course of action when faced with an ethical decision about workplace violence: considerations that increased vulnerability to risk and harm, and considerations that mitigated vulnerabilities and improved capacity for managing the situation. Within the category of multiplicative factors, participants described personal factors, nursing values, patient factors, and environmental conditions that impacted the susceptibility of the nurse, patient, or others to harm. In terms of mitigation, participants cited the value of risk assessment processes, the availability of supports, and the skills and tools at their disposal as central to their decision-making around whether to remain in a volatile care situation, pause and reapproach the patient, or withdraw altogether.

The decisions that participants described were not simple or without consequence, irrespective of which choice was made. Often, a significant element of moral distress was apparent. It is to this question that I turn in the next chapter.

Chapter Seven: Research Question Three - Findings

How is moral distress experienced when nurses encounter workplace violence?

The third research question concerns how moral distress is experienced when nurses encounter workplace violence. In this chapter, I will review the working definition of moral distress, and examine findings related to this question.

During the analysis of interviews and participant stories, it became clear that moral distress is a significant issue when nurses make decisions about how to manage a patient or visitor who is violent. The data on this question again coalesced around the concept of vulnerability. For this question, I have called the core category *Vulnerable Healers*. Under this category, participants described the experience of moral distress via four subcategories: *Choosing to Disengage, Living with Moral Residue, Witnessing Patient Impacts,* and *Working Under Structural Constraints*. I will describe the results under each subcategory in turn. I will start by outlining the idea of moral distress itself.

Vulnerable Healers: The Experience of Moral Distress

Much of the reason for the moral angst of participants when considering the right course of action in a situation of workplace violence is the mutual exclusivity of providing good care to a reactive or aggressive person and also remaining safe at the same time. As noted in the previous chapters, the choice in a volatile situation amounts to staying, pausing care, or leaving entirely, and the decision among these limited choices reflects the relative vulnerability of the patient and nurse. Whichever decision is made, the ideal of care is not being met. Even when care continues because the patient is more vulnerable relative to the nurse, participants described doing the bare minimum, or resorting to forced intervention to protect the patient and others. None of these options feel good, yet no perfect option exists, and a sense of moral angst results.

Moral distress is a condition of psychological anguish resulting from the experience of a moral event (Morley et al., 2020). As noted in Chapter Two, moral distress occurs when personal or professional integrity is threatened or violated. This happens in situations where an ethical dilemma has

no solution that does not compromise deeply held moral ideals. Often, morally distressing events occur when there are constraints on the person's ability to carry out what they believe to be the morally correct action, resulting in lasting physical, psychological, emotional, and spiritual sequelae (Rushton, 2018). It is largely a negative experience that tends to motivate the person to address either the source or the impact of the discomfort.

Participants in this study identified four ways in which they experienced moral distress related to workplace violence, all of which contributed to the identification of nurses as *Vulnerable Healers*. I categorized these themes as *Choosing to Disengage, Living with Moral Residue, Witnessing Patient Impacts,* and *Working Under Structural Constraints*. Table 4 summarizes the categories and themes for this question.

Table 4

Summary of Question Three Findings: The Experience of Moral Distress

Vulnerable Healers

Choosing to Disengage	Living with Moral Residue	Witnessing Patient Impacts	Working Under Structural Constraints
• Shifting responsibility to someone else • Avoidance • Issuing (and enforcing) an ultimatum • Leaving the situation when care is required • Doing things poorly due to lack of leadership support	• Questioning my identity • Decreased resilience • Lasting trauma	• Compromised care • Impact of causing trauma • Imposition of unwanted care • Compromised dignity	• Unable to meet patient needs • Advocating to no avail • Balancing the needs of one vs many • Watching colleagues suffer • Lack of effective solutions

Choosing to Disengage

I describe the first subcategory of participants' moral distress experiences as Choosing to Disengage. This takes the form of withdrawal from the therapeutic relationship, either physically, or emotionally. Some participants described stepping away from the care encounter even when care was still required either because they had been harmed, or because the situation was escalating, and they could no longer be confident about their safety. P8 said, "Whenever I even got the hint of feeling

threatened, I would kind of back off. I probably wasn't giving the greatest attention to the patient that I could because I was afraid that they were going to hurt me." This nurse's sense of professional regret at the necessity of disengagement from a situation where their own vulnerability tipped the response toward leaving was clear.

On the other hand, P58 spoke of deliberately pausing during urgent treatment of a patient whose level of intoxication and demeanor caused them to be concerned for their safety. They said,

> At night when you were on call, you were the only person in the building with your patient, […] realistically speaking, […] you were truly alone. So, this one patient, I had seen him before, always pretty good, but this particular night he'd had a laceration, and it was his ear and sort of behind his ear. So, it was suturing and close, because he's got his ear and I'm at his face, suturing. And I just remember looking like looking up from suturing and seeing a look on his face. And I can't tell you exactly what it was or how it was different from his normal demeanor. But you know you've got the smell of gas coming off of him. You've got all of that context and I'm like fine suturing and just that look, and I thought to myself, this feels really oh […]. So, I ended up stopping for a minute. Just like, oh, I need to stretch my hands, you know, got him sitting up for a minute. Change the position. Changed the dynamic of what was going on in the room. I'm like I need like a 2-minute break. I just felt like in that moment had I continued, I wasn't sure that he wasn't going to have grabbed me and done something stupid.

This way of disengaging temporarily shifted the dynamic and diffused the risk for the nurse in that moment.

Shifting Responsibility

While P58's story just noted did not convey the same sense of regret as that of P8, above, the example required only a pause in care, whereas other participants described leaving the situation

entirely. P35 described leaving a patient's home after being viciously attacked while providing care. "Like that time I was beaten up, I would not go back to there. After I report to the office, they'll send somebody different there." Similarly, P23 related the story of ending a care relationship that was no longer beneficial to the patient.

> We reached an impasse about his treatment plan. […] But he just got so frustrated that he could not be in our area without getting super threatening and intimidating. And in the end, it's like we had a breakup conversation.

P31 offered a comparable story. After being verbally abused by a patient who did not want to take medications from them, they disengaged by finding someone else to manage the patient's care.

> I requested someone else to take because for me it affected my mental health. […] It disturbed me a lot because I was like, if I can't help someone who really needs it, like I can't tell this person like you need to take this medicine and they take it nicely. (P31)

In this case, the nurse felt conflicted not only because their approaches were ineffective, but because the withdrawal represented an inability to provide necessary care.

While decisions to withdraw contribute to the nurse's safety, ultimately, they compromise the patient's care, at least temporarily, by delaying it either until the situation is more stable, or someone can take over the nurse's responsibilities. A basic expectation of nursing care, handing over responsibility, was a common way of disengaging. With reference to the same patient mentioned just above, P23 described finding other providers to manage his care when they could no longer work together, "I did set him up with other follow ups, they were keen to have him and he kind of fit exactly into what they had to offer." This story is an example of how the transfer of responsibility can be a salve to a morally distressed nurse, an opportunity for the patient to receive care the participant was unable to safely or effectively provide.

P46 provided a similar example of how teamwork can address the needs of everyone in the situation:

> I think all of us are recognizing that approach really is key and stepping in to help other staff is really key because none of us have to do it on our own. And I think too it can be very humbling to know it's OK if you can't, if you're having trouble, it's OK for me to go ask [someone else]. 'This person will not take this med from me. Will you try?', or 'oh hey, did you know that if you just put some medication in peanut butter and toast then they'll take it? […] We don't have to do it all. And if that patient just is not having it with us, it's OK to let other folks know and have them step in.

This sense of a team effort also serves the purpose of sharing the moral and emotional load and creates a collective experience that helps those involved feel more connected and mutually supported, perhaps assuaging some of the moral distress that this difficult work produces.

Issuing (and Enforcing) an Ultimatum

Shifting responsibility for the patient's care to another nurse was common. Another type of disengagement was to issue an ultimatum. This was a way for the patient to receive information about the impact of their behaviour, enabling the nurse to continue care, or justify withdrawing from the situation, on the understanding that the patient was aware of the limits of the nurse's duty. For example, P8 stated, "Umm, when there were more threatening situations? I just flat out told the patients. You know what? If you continue with your behaviour, then you're not going to have a nurse." This helped the nurse feel less guilty when they decided they needed to step away from a patient.

For patients with cognitive impairments, the threshold for disengagement was higher. But as P10 noted, patients who had the capacity to know that their behaviour is putting people at risk, it is easier to demand the person behave more appropriately.

> I would imagine if they were cognitively intact, that might look different. Like if I've had someone angry, I said, I'm going to come back. Like when you can speak to me nicely because they know what they're doing. I think that's only happened once. Every other time. It was like they didn't realize.

This nurse is describing a different experience of moral distress when the patient is aware of the impacts of their actions, as compared with patients whose behaviours are a result of their health condition.

P1 related issuing a directive to a patient's family member who was being abusive towards staff. They shared the story of confronting the family member and informing them the behaviour was not acceptable. They stated,

> And so, you can't come in here and yell at yell at staff, and like, if you're not able to conduct yourself […] in a reasonable way and collaborative way, then it's a privilege that you get to visit. And we will remove that privilege. And so, we've, we've shortened her visiting hours during management hours so she can only be there from 8 till 4.

While this could be effective in terms of permitting continuity of care, it also caused its own moral distress. P1 also noted,

> It affects the care of the patient because you don't want to go into the room and you're doing just minimal possible so that you can get in and get out and not have to have the three hour long conversation.

This nurse also observed that having to enforce that ultimatum could have a negative impact on the patient, who would suffer if not able to see their daughter. An ultimatum could be morally distressing in more than one way: for some participants, it felt manipulative, and like it compromised the dignity of the patient to have to use coercion to secure the nurse's safety. For others, the distress came in the form of negative consequences for the patient or family member when the directive was enforced.

Avoidance

More often than either complete withdrawal or providing an ultimatum, disengagement took the form of avoidance, minimal interaction, or care that was perhaps rougher than it needed to be. Again, participants noted feeling conflicted about this. While they recognized it might be important in terms of keeping people safe from violence, it also compromised their ability to meet the needs of the patient in a compassionate and respectful way, especially when there was no realistic choice about handing over the care to someone else, or if withdrawing meant the person would not receive care. P10 said, “Sometimes people become more callous, too, right? […] It's just like, well, if I have to do it, I'm just going to do it. But kind of go through the motions. Or maybe it's not the most gentle way.” This emotional disengagement offered protection from physical injury as well as emotional harm. This was also the case for P1, a clinical manager who was dealing with an aggressive family member. They said, “I think the avoidance is still happening. […] When the daughter's there, I think we're doing like kind of minimal amount possible.” None of these nurses took pleasure in the need for avoidance but felt it necessary in order to get through the situation and rationalize the distress that would be caused by any decision they could have made.

Doing Things Poorly Due to Lack of Support

Support from management was a factor that mitigated moral distress when it was present and exacerbated it when support was lacking. P3 talked about providing care in a way they felt was suboptimal, because their manager did not support necessary interventions such as temporary restraint, or a group response like a Code White. They said,

> I didn't really feel I got support, to be honest. In fact, my manager didn't want us calling Code Whites […]. I know we had a few volatile patients and she said just open the door and let them walk out, which I really didn't feel that comfortable with doing because they were cognitively

> impaired. And [the facility] is right by the river […]. I wrestled with like that, I didn't feel comfortable with that either. Yeah, I don't know what the solution is sometimes, but you can't always just let people just go, they need care.

The result of this lack of support, and the sense of having no choice about providing care was that staff felt they had to push through situations where they were in danger, requiring them to provide a substandard level of care in order to remain safe. P3 spoke of this as well.

> Lots of times I've had, they'll start lashing out all of a sudden and we'll just have to leave them half dressed […]. A lot of the philosophy now is just to leave […] if they refuse care. So, umm yeah, we are doing that a lot more and it doesn't feel good, it runs into problems with skin integrity and just yeah. Yeah. You can't. Yeah, yeah, it runs into other problems.

These data indicate that choosing to disengage from volatile care situations was both a cause of moral distress and a source of relief from it for participants.

The act of disengaging may protect the nurse from some of the impacts of managing an aggressive person, but it also compromises their ability to provide care, even when responsibility for the patient was handed over to someone else. This perpetual catch-22 is a barrier to fulfilling the nursing role, leading to moral distress. Living with this sense of injustice can also lead to moral residue. This is the second way in which participants experienced moral distress. I will explore these findings next.

Living with Moral Residue

Moral residue is the painful impact of moral distress, and the sense of fear, uncertainty and shame that results from acting, or failing to act in such a way that the nurse's values have been compromised (Webster & Baylis, 2000). For many participants of this study, the experience of moral distress manifested as a lasting emotional impact from the way a violent care encounter unfolded. For some, this was a sense of betrayal or violation of professional values that caused them to question their

identity as nurses. Many spoke of decreased resilience, lasting trauma, and regret at how something was handled. These were longstanding consequences. Participants recalled morally distressing events with a clarity and level of emotionality that indicates a significant and continuing negative outcome.

Questioning Identity

One of the main ways that moral residue manifested for participants was that the violent incident caused them to question their identity as nurses. Experiences left a sense of failure, and many reported feeling a great deal of self-doubt. P46 talked about the dismay they experienced after being assaulted by a patient.

> I think in some ways it was more my own internal reaction that was so distressing, rather than violence at me. It was more my needing to contain my own instinctual reaction or just the feeling of 'I'm so done with having to deal with this kind of behaviour' and wanting to strike out myself, even though I knew I couldn't, of course, but it's still you're having a human response to the situation, I think that's the challenging part of violence in the workplace. Is that whatever reactions are happening to you, you can never have in some ways an honest response because it's not appropriate. But then you still have those feelings. And that energy to cope with.

This self-doubt was described by a number of participants and was exacerbated by the denial of the nurse's expertise, either by the patient themselves, the patient's family, or even by their own manager.

For example, P29 described an upsetting encounter with a patient's daughter, who questioned their care in a way that P29 described as abusive. "I was very disturbed for like even six months. Every day I had to think about this situation. What would happen next? How are the family members are [sic] thinking about me?" This negative self-image contributed to the moral distress associated with having to interact with a difficult family member that caused them to doubt their own abilities.

Similarly, P49 considered leaving the profession.

> Um, after my first incidence of facing violence, I decided to find a therapist to talk to. Not about the details, but you know how it has been […]. Uh, that has helped me a lot because at that point my mental health was like shattered. I was rethinking about my career choice and all.

P10 related a situation where a patient obtained a weapon, and it was only then that their management acted on nurses' warnings that the patient needed a different level of care. They said,

> I think had they listened to our concerns like this, this behaviour is escalating. It's erratic. We don't feel safe […]. So, I think had they listened to us, yeah, maybe that would have been prevented. A more appropriate care facility or unit might have mitigated that. But again, when you're just sort of told it's just part of the job, it's hard to vocalize for yourself or I mean, you try to speak up, but you're sort of brushed aside.

Reconsidering their career choice was an unfortunately common consequence of violence-related moral distress.

Moral residue led several participants to question their very identity as a nurse. P56 talked about a challenging situation where a patient had to be treated against their will in a scenario that required significant force on the part of the health care team. Processing the incident was very difficult. They said,

> Well, I think after the fact, it was hard to go back to work the next shift. I think we all had to stay late that shift. It was hard to go back to work thinking, am I doing more harm than good? Is this caring? Is this the thing that I went to school and why I wanted to do this job? So, I think it really kind of got me questioning my identity as a caregiver.

The experiences of morally distressing events created fissures in participants' self-concept and challenged the principles on which their nursing identity was based.

Decreased Resilience

Moral residue also showed up in the form of decreased tolerance and resilience for managing aggressive patients. Several participants talked about feeling depleted or having a lower threshold for dealing with the emotional fallout of continually navigating challenging behaviours. For example, P46 felt that their response to the aggression of a particular patient had been exaggerated by the accumulation of lower-level stresses:

> It's cumulative, you know, death by a thousand cuts, where all of a sudden, you're feeling on edge. My reaction to this patient that I dealt with, the hit, was worse because of the whole scenario on the unit at the time with those four to five patients, that feeling of helplessness like you're just barely getting through the shifts helping these people and feeling like […] wishing you could do better for them […]. I have found even now that if I have a patient who is more reactive or comes in with dementia, the failure to cope, the exacerbation of symptoms at home, I'm not at the same level of coping, so instead of being kind of like up here, I'm already down here, so it's easier for me to feel teary or defeated, or yeah, just like it's hard, hard work. Whereas before I could roll with it and it was OK […]. Cumulatively, again, I am starting to think I'm not sure that it was even that specific hit, but maybe it's kind of a time thing, where one can only work in these sort of workplaces for so long before you have to go somewhere else. Because, the consistent effort and traumas, you have to just remove yourself from it to be able to ultimately cope. I think that's kind of what I'm trying to figure out.

P46's comments here speak to the experience of moral residue in the forms of self-doubt, identity crisis, and the impact on resilience, as well as the crescendo effect (Epstein & Hamric, 2009) of accruing consequences.

Lasting Trauma

Many of these participants spoke about the lasting trauma that managing violence and aggression at work caused. This residual impact was significant for many. P56 talked about the lasting emotional impact of having to provide care against the will of a patient with a significant trauma history.

> So then weighing the pros and cons of actually approaching this man with a bunch of security guards and a bunch of men essentially, something that would resemble a lot of what he had lived through, to do this intervention that ultimately, we thought would help them more. So yeah, that was pretty hard, I think traumatizing for everybody. I still think about that guy.

Clearly, this participant was dealing with vicarious trauma and moral residue from that incident, despite the passage of time, demonstrating the insidious influence of moral distress on those who experience it.

Moral residue also showed up in a sense of regret for how things played out or were managed. P19 expressed sorrow for how they managed a situation with a distressed family member. They said that in retrospect, “I felt more like the bad person in there because I do understand what he was feeling at that moment. Cause it's it isn't quite that easy as a family member to […] lose someone.” Others offered similar sentiments.

Overall, moral residue is a highly influential force. Participants described self-doubt, questioning their identity, feeling depleted and less resilient. There was significant trauma associated with managing aggression and abuse, and a sense of regret at what happened. This is closely aligned with the next category of moral distress experiences, witnessing patient impacts.

Witnessing Patient Impacts

In addition to disengagement and moral residue, the experience of moral distress can stem from the unpleasant reality of witnessing negative impacts on the patient without an ability to prevent or

mitigate them. For participants of this study, bearing witness included providing compromised care, causing or being part of trauma, the imposition of unwanted care, and compromised dignity.

Compromised Care

One of the most morally challenging scenarios for participants was the inability to maintain a high standard of care, either because the patient's behaviour made it impossible to safely intervene, or because workload prevented the nurse from meeting the standard. P3 described the anguish of having to leave someone without addressing basic needs because their behaviour was too volatile and providing them with a sedative to facilitate the completion of necessary care is no longer considered best practice. They said,

> We usually end up just leaving them until the bed is totally soaked. The pad is on the floor and it's a real mess. In the past, we could kind of, yeah, give them a medication and settle them down and then do the care. Yeah, that has changed.

Other participants agreed that this inability to meet obvious patient needs is a significant source of distress for nurses. P46 said,

> When you're hearing patients who are in distress, and sometimes you can go and help attend to that distress and other times you can't. Because you do have to finish your work, or you have to attend to your other patients […], that feeling of helplessness like you're just barely getting through the shifts helping these people and […] wishing you could do better for them. Wishing you had more staff, so you didn't feel so stretched thin.

The sense of having clearly compromised their standard of care was clearly incredibly problematic for participants.

The problem of having to make concessions in care delivery becomes even more challenging when the perpetrator of violence is a family member or visitor rather than the patient. While it would be

ostensibly easier to banish a family member than a patient from hospital premises, the very act could compromise the health care team's ability to care for the patient. P1 described the moral distress associated with managing a problematic family member:

> Since it's a family member how is there opportunity to separate the family member and just say I'm sorry you can't, you can't attend like you can't come again or you can't come visit at all because you're impeding our care of your mother. But […] because she's the health proxy, I don't know. I don't even know if we can do that. It's different than if it was [pause], see if the patient was violent then I think then it would be a little different.

So, while the team may be relieved of having to deal with an abusive person, the patient is also deprived of access to someone they love, which may be problematic for the patient, and is certainly a cause of moral distress for the nurse.

Impact of Causing Trauma

Participants also described feeling incredibly conflicted about playing a role in causing trauma to patients during the care decisions that had to be made when someone was abusive or violent. Often, the means necessary to keep someone from harming self or others are themselves highly aggressive. P50 related the story of admitting a patient who did not believe he needed care. They said,

> So, the father came and with the help of the uncle, and they had to help him, and the process of admitting him was really hard. I personally, […] and you're trying to be as delicate a person as possible. You don't want to hurt him. Realize that he's not in control of his body, so you're trying to minimize the damage you're causing to him, and so it's a process of you're gaining the trust of this person so that it will be more easier [sic] for them to open up.

They recognized that the process required to help this person was likely to cause them additional harm in the short term, in the name of providing a long-term benefit.

P56 described similar distress, when working with a psychiatric population that occasionally required police intervention to enable the health care team to provide the care the person needed to recover from their illness.

> So, then that would be something that I think would weigh on our minds, too, when we were making this decision of should we call police because we know that there's the potential of the patient getting hurt as well. I have had patients who, in being restrained and things like that, they broken an arm, or they've been tased, so then those patients that have more of a trauma history, you know how traumatic this is for them too. So, I think we would always try to deescalate things as much as possible to verbally tell the patient what we needed from them, reassure them, validate them. But sometimes that can only go so far if they're wanting to leave, or they're not wanting to take their medication. And maybe they're not, from the Mental Health Act perspective, in a position to decide if they can take the medication or not.

These scenarios show that while the intervention is traumatizing to the patient, the staff also leave the situation feeling distressed about their part in it.

Imposition of Unwanted Care

Even when it is not outwardly traumatizing for the patient, the imposition of unwanted care can be difficult for nurses who have been socialized to respect patient autonomy and prioritize the patient's informed preferences for (or against) treatment. However, at times, the patient is not in a state of mind to receive and act on information. This, in combination with behaviour likely to harm them or others, requires intervention. P50 explained the process of medicating someone so it is easier to provide care.

> Umm, sometimes we sedate them so that they fall asleep, and you're able to, you know strap them onto their beds, wherever they are so they even when they wake up, they don't have the freedom to move around and break things. (P50)

The use of physical or chemical restraints was never described as an easy decision, and indeed, is no longer considered good practice in most situations. P40 described struggling with the treatment of a patient whose behaviour was so dangerous they needed to keep him physically and chemically restrained for nearly a year. The moral and logistical complexity of caring for this person left a lasting impact on the nurse.

Compromised Dignity

The final category of bearing witness that participants described as it related to the experience of moral distress was the ways in which patient dignity was compromised through the necessary choices made when dealing with violence. As noted by P40, many of the conditions under which care must be provided would be human rights violations under other circumstances. Furthermore, these factors tend to increase aggression, contributing to a vicious cycle. They said,

> Our unit is overcrowded. We have 21 patients but one of the rooms is so small that you can't even have a curtain between the beds… these are people who are often acutely agitated and going through shit. They don't need to be having a roommate who is up all night pacing and talking to himself […]. The jail won't even let us put people in our forensic courtyard because one guy escaped a long time ago. So, we're violating people's human rights by not letting them have fresh air, sometimes for months, so that increases agitation.

The inability to provide privacy is a significant driver of moral distress.

Similarly, dependency on the health care team to provide help with basic needs such as toileting is compromised when a patient's behaviour prevents them from safely attending to them. Not only is patient dignity curtailed by dependency, but also by lack of access to ways of meeting needs. This has the effect of infantilizing the patient. P58, working in an isolated community where there was only one place to access health care, described requiring certain people to ensure they had someone with them if

they needed to attend.

> I wouldn't say that we ever had someone told that they could not come back, but what we did on more than one occasion, we actually said you cannot come back unaccompanied by a responsible adult… We are not going to decide whether you're intoxicated or not and need to be supervised. Anytime you are coming to the clinic, you must have a responsible adult who can help you moderate your behaviour.

While this serves to support the safe provision of care, it effectively treats the person as if they were a child and feels in important ways to be disrespectful.

Added to disengagement and moral residue, bearing witness to the impacts of violence on the patient, as borne out in the form of compromises in how care is provided, causing or exacerbating trauma, forcing care in the absence of consent, and compromised dignity, contributed to the experience of moral distress for participants. In the next section, I unpack the final element of moral distress for these participants: working under structural constraints.

Working Under Structural Constraints

Structural constraints were an additional source of moral distress for participants of this study. As barriers preventing the right course of action, structures were perhaps the most frustrating of all, as there was no human element with which they could attempt to rationalize. Under this category, participants described being unable to meet patient needs, advocating to no avail, balancing the needs of one against many, watching colleagues suffer, and having a distinct lack of effective means of preventing violence in their workplaces.

Unable to Meet Patient Needs

For several participants, the work environment itself makes it difficult to meet patient needs. As noted elsewhere, the physical layout of the unit was frequently seen as a barrier to preventing

escalations, and indeed, had a tendency in many areas to exacerbate violence. Participants also identified policies and procedures as blocking their ability to choose what they felt was the right course of action. P3 and P58 both, for example, noted that anti-restraint policies effectively tie the hands of providers, who then need to find other ways of managing behaviour. Furthermore, although there is a violence prevention program in their facility, it has largely been ineffective. P3 said,

> I think it really just labels people to tell you the truth. Like I don't know. I don't. I wouldn't say it's something that really helps. It's a label. I thought we were supposed to get away from labeling people […]. So, I don't know if that's necessarily a good thing, although I understand the reason, they're communicating that the person has tendencies to be violent and abusive. But umm yeah. I don't know. I don't know about that.

Frustration arises when structures such as policies prevent people from doing what they feel is the right thing.

Advocating to No Avail

Several participants described how their efforts to advocate on behalf of themselves, their patients, or their colleagues fell on deaf ears. A lack of support from management impacted the ability to prevent violence, and to process an incident once it had happened. One participant mentioned that ongoing conflict between them and their supervisor created its own kind of moral distress. Another described reporting being assaulted by a patient to their manager, who downplayed the event. “Yeah, they [are] like this is part of your job. This is your job. This is what you do, like violence is part of the job, which it’s not supposed to be…” (P39). Another participant described a scenario where they had tried to advocate for a patient’s transfer to a more appropriate care setting, only to walk in on the patient who had found a weapon.

> We were worried about the patient's escalating behaviours as a result of their underlying illness. And we tried to verbalize it multiple times. Like something's not right. This the person's acting erratic. Maybe isn't the most appropriate place. And the patient found an object they shouldn't have found. And I was the one who walked into the room, and the union got wind of it the next day and was like, that is completely inappropriate. And then that's what caused the patient to be transferred to a more appropriate [unit]. But it took an even more scary situation to prompt that change, because I think a lot of times it was like, well, part of the job, you just do it. (P10)

For these nurses, the employer or manager functioned as a structural constraint against pursuing their preferred course of action. Especially when preventable violence occurred, this lack of support for advocacy invalidated the nurse's experience and efforts and caused moral distress.

Balancing the Needs of One Versus Many

Resource limitations were also described as barriers to action by many participants. Where there is almost infinite need in a health care environment, finite time and human resources force choices and compromises in the provision of care on a daily basis. Ideally, staffing is adequate to ensure each patient gets the care they need, but realistically, choices are made that balance the needs of one against the needs of everyone else in the unit. P3 framed this well.

> I know why it's like that because, people have their rights, and they shouldn't be forced to have care. I do understand that. Umm I think it's just it's a problem when they're in with a bunch of other people on, especially if they're ambulatory and walking into people's rooms. That's not good. Like if they can just be by themselves and their room, well, then, that's OK. If they don't want the care, but if you know, for instance, they're incontinent and they're walking around touching everything and other people, that's a problem for safety, for other people. So, I feel like it's kind of swayed that it was more about managing the unit in the past and now it's more

> about the individual and what the individual wants. And their rights. And that doesn't always work when they're on a unit with ten other, twenty other people.

The tension that arises when one patient places others at risk is one piece of this concern. The other is, as noted above, the structures that limit the ability to manage such situations.

Watching Colleagues Suffer

The inability to prevent or mitigate the suffering of colleagues was also cited as a source of moral distress that I have included under structural constraints, because that suffering was so often attributed to the structures in the workplace that failed to prevent violence. P56 puts it very poignantly:

> I think watching people around me get burnt out because of the violence or coming to a shift and hearing that this colleague or this other colleague got hurt, and how things went down and just the level of acuity and the violence that came with that was those were the difficult things that made the day-to-day and the big picture of being a nurse hard […]. I've seen violence in the workplace just chew and spit out some really good clinicians, and some really good nurses […]. I think it got to the point that I was seeing myself as kind of like a punching bag that here I am taking these punches and making decisions that are putting myself at risk, and then potentially, my life at risk, and I'm off work and then feeling guilty that I'm off work because now my coworkers have to deal with the same situation. But also, that I'm replaceable and that another punching bag will just come in my place.

This description of the suffering that unprevented and unaddressed workplace violence causes was heartbreaking. In a similar sentiment, P1, a clinical manager, described feeling regret for their inability to mitigate the impact of an abusive family member for the staff that had to be involved with her.

> I think some of the things that make me really […] sad for my own team is that they just don't really know how to respond. And so, they either [take] the verbal abuse. They leave crying,

> right? Like it affects how they do their job. They don't want to come to work. They're calling in sick if they know that that's the assignment they're going to have.

This was a common refrain among participants, and one that participants felt could be mitigated, were appropriate structures in place to provide support for decisions that enabled nurses to take what they felt was the morally correct action.

Lack of Effective Solutions

The final observation related to the structural constraints impacting participants' experiences of moral distress is the lack of effective solutions for preventing violence or addressing it once it has happened. For one participant, the complex composition and reporting structures of their team has a bearing on how critical incidents are managed. They said,

> I'm [a hospital] employee. The doctors are sort of [hospital], right? The community mental health specialists are [employees of the health authority]. The secretaries are [hospital employees]. The psychologists are [university employees] like so, nobody has the same boss and so there is no one way that these situations can be addressed… it's a team, but it's not a team, right? Uh, it's kind of fragmented in terms of like a formal [debrief], and it wasn't a critical incident, and nobody got hurt or anything. But it's probably an example of where we could have maybe debriefed and learned something going forward. (P23)

This complexity in organizational structure resulted in a tangled web that made caring for each other in the aftermath of an incident unnecessarily difficult. This shows how the nature of the employment environment complicates the creation and deployment of policies and procedures that could help people heal from traumatic events that happen at work.

Beyond debriefing as a team, which was consistently described as happening rarely, there were not seen to be many effective ways to achieve a kind of restitution or closure after a violent incident.

Especially in the case of someone with a cognitive impairment, legal remedies are essentially unavailable. Several participants described being concerned about being sued or charged for their involvement in a care encounter that turned violent. P2 described wanting to press criminal charges against a patient who had assaulted them, telling their employer, “I want charges against this lady. And that's when [the employer] said, well, she has dementia, and she doesn't really know what she's doing. And yeah, so that went nowhere.” Legal structures were thus not seen to be helpful in managing violence or its consequences.

Organizational policies, while in place to prevent violence, do little to manage volatile patients. As P1 noted, “I've pulled out our policy. We have respectful workplace [posters] all over the place… the respectful workplace thing is more around staff-to-staff [violence].” Not only is there little structural support for preventing violence, but there are also few remedies available to people once an incident does occur.

Structural constraints were noted to be a significant source of moral distress for participants. These included institutional barriers to meeting patient needs, advocacy that was ineffective, balancing the needs of one against the collective, watching colleagues suffer due to the job, and lack of effective solutions to the risks and problems inherent in the work environment. All told, these limitations on nurses’ ability to take what they felt was the morally correct action added up to significant and lasting moral distress, the consequences of which could be seen to affect participants long after the event.

Summary

Moral distress is an inherent part of nursing work and unlikely to ever be completely eliminated. With respect to the ethical decisions relating to the management of workplace violence, participants in this study described four categories of moral distress experiences. When *Choosing to Disengage*, participants spoke of shifting responsibility to someone else, avoiding the patient, using an ultimatum,

and leaving care unfinished. *Living with Moral Residue* led to participants questioning their professional identities, depleted resilience, lasting trauma, and regret. Moral distress also arose from *Witnessing Patient Impacts* of violence, such as compromised care, the impact of causing or being part of trauma, imposing unwanted care, and the compromised dignity of patients whose care had to be managed differently due to their behaviour. Finally, *Structural Constraints* including being hamstrung by policies, ineffective advocacy, resource limitations, watching colleagues suffer and lack of effective prevention or remedy led to the experience of moral distress.

This concludes the findings of this study. In the final chapters, I provide a theoretical approach to understanding how nurses navigate decisions related to workplace violence and consider the implications of the findings in light of this proposed theory.

Chapter Eight: Managing Intersecting Vulnerabilities

Salient Vulnerability Theory

In this chapter, I build a theoretical approach from analysis of the study's datasets, using participant stories to illustrate the ways that vulnerabilities influence the ethical decisions that nurses make in response to violence from patients and bystanders. To do that, this chapter proceeds in three sections. First, I set the stage by describing the use of stories to ground and support the development of the theory. I then use one of the participant stories from the Phase 2 dataset to define and outline the problem, and another to introduce a conceptual model for Salient Vulnerability Theory. Finally, I look at how this theoretical approach to the problem of the ethical decisions required in the context of workplace violence addresses identified gaps in the literature. To begin, I offer an introduction to the role of stories and an overview of the theory itself.

Development of the Theory: Using Stories in Research

Story-telling transforms lived experience into interpersonal knowledge by making it accessible (Senehi, 2002, 2020). Story amplifies voices and privileges the perspectives of people with lived experience of a phenomenon. It creates shared understandings, builds connections, and uncovers the structural factors that impact an issue. Stories provide resources for addressing and resolving conflicts and serve "…as a rationale for action" (Senehi, 2002, p. 43). It is this potential for moving an issue toward resolution that drew me toward stories as a tool to investigate and theorize on the ways in which nurses navigate the ethical dilemmas that arise in the presence of workplace violence.

In the following sections, I present the categorical outcomes articulated in the previous three chapters as a theory of ethical decision-making for nurses experiencing violence. Where the quotations illustrating findings in the three previous three chapters were drawn from micro-stories told in interview, the theoretical approach I have taken to understanding the problem is here illuminated by the narrative documents developed in the second phase of the study. To that end, I offer a story to focus this

identification of the problem, and one to introduce the emerging theory. All six stories are also provided in full in Appendix 12. I will begin by explicating the problem itself.

The Problem

P8's Story: My Livelihood Shouldn't Impact the Rest of my Life

I was working at one of the community hospitals, and I had a patient that had some mental capacity issues. She was like a five-year-old in a 40 year old's body. Nobody had told me that she had a tendency to be violent. On this day, I had come in to give her some medication. She was quite agitated and out of control, and she bit my finger, latching on to it and growling at me. Her elderly father was standing in the background, trying to tell her to back off. She growled longer and harder, shaking her head like a dog. It took a while before she finally let go. It sparked a trip down to emergency to make sure that there was no damage, and I had to have blood work drawn and get a tetanus shot.

I wonder if the incident could have been prevented. Maybe her family could have brought in some things that gave her greater comfort, because she was in an unfamiliar environment. It was hard to get medications into her. It was hard to keep her under control. With a child, you can calm them down by hugging them or using soft words or teddy bears. But that's not appropriate for a 40-year-old lady. She had her familiar person with her, but I think he probably needed some coaching on how to talk to her because he just got angry with her. Maybe some distraction techniques for her might have worked a little better.

I refused to take care of her after that. There was an altercation with another nurse, who was badly hurt by this patient, so I flat out refused to take care of her the next day when I was at work. The cognitive ability of the patient doesn't make a difference in my risk assessment. It's still a threat to me. I'll think, what can I do differently to get them to calm down? In the end,

though, it's still a threat, whether the patient has full cognitive ability or not. So, I'm not going to go in any further than I have to, if I feel like they're going to hurt me.

This incident changed how I practice nursing. Now, whenever I get the hint of feeling threatened, I back off. I know I might not be giving the greatest attention to the patient that I can when I'm afraid that they are going to hurt me. I pay more attention to how they talk to me. Are they giving me verbal threats? Are they giving me physical indicators that they might be violent? When there are more threatening situations, I try to keep calm, and leave the situation. At that point, I just flat out tell the patients, 'if you continue with your behaviour, then you're not going to have a nurse'. I decided that my livelihood shouldn't impact the rest of my life, and one violent incident can do that. So, whenever I felt like I was getting backed into a corner by a patient, I just backed off with some of my nursing care. I'll come back later. I try and move my care around to see if they'll be calmer in a while, and if they're not, then I go ask for a patient assignment change. I've got a life to live. (P8, Story)

As noted throughout this thesis, the problem of violence in the nursing workplace is widespread and prevalent. Initially brought to my attention while I was working as an ethics consultant, the people who contacted me for support at the time articulated deep angst about their experiences with patients whose care was complicated by behaviours which made it unsafe to attend to them. They described a true dilemma: a choice between providing necessary care and remaining safe when it was not possible to do both at the same time.

While there is general agreement that work should be safe and no nurse is expected to accept unreasonable risks on the job, in reality, this is far easier said than done. The fact remains that patients access health care services because they have needs that can not be met otherwise, and which are often life-threatening. The nurse's position, knowledge and skill generate the expectation that they can and

will intervene in the patient's best interests. In other words, nurses have a duty of care. When the patient's behaviour makes it impossible to intervene without the nurse being injured, a decision-making process must be navigated that often leads either to an inability to fulfill the duty to provide care, or to providing care in a workplace that is unsafe.

P8's story of workplace violence illustrates this problem well. Their default choice is to provide care, and this nurse proceeded as they normally would because they recognized the patient as vulnerable and were responsible for providing the interventions the patient needed. After being assaulted, however, the nurse had to decide whether to maintain the therapeutic relationship in the context of a very real possibility of serious injury at the hands of this patient.

The incident changed how P8 practices nursing. The situation made them acutely aware of their own vulnerabilities, and provided them with a threshold of perceived safety, beyond which they are now more likely to withdraw from a care encounter that moves into a category of personal risk that surpasses their comfort zone. The identification of that line, and the nurse's response to situations that push them beyond it, is the subject of this study. The practical and ethical choices that nurses make about these kinds of fraught situations are contextual and deeply personal because no matter which option they choose – staying or leaving – they compromise ideals, values, and beliefs about themselves, their role, and the moral priority of caring for others.

The theoretical model of ethical decision making that developed from the data collected in this study coalesces around the concept of vulnerability: that of the patient, balanced against that of the nurse. The core category, Managing Intersecting Vulnerabilities, captures the multiple ways in which patients experience vulnerability, and the counterpoint vulnerability of the nurse who is facing harm at the hands of that patient. I provide the model next.

The Conceptual Model

P56's Story: Am I Doing More Harm than Good?

I can't think of a situation in which we said we were not going in to provide care at all. The situations were always temporary. We would decide we're not going in until we have more people, or until police came. At the same time, we sometimes have to make decisions in a split second.

One situation that comes to mind is about a person who was unwell, but there was also a personality and behavioural component. It was a young man of colour, and it was around the time of the George Floyd protests. On this day, he had locked himself in a room. It was the interview room, so there were windows all around and we could see what was happening. He had taken apart a table. He was making threatening gestures with the legs of the table, and he had taken off his shirt. He had wrapped his arms to fight, and he was yelling profanities at us. He screamed at us how he's going to hurt us in all kinds of different ways. "I want to see your brain splatter all over the walls! I'm going to find you when I get out of here and I'm going to hurt you and your family! I remember your face!". This was one time we decided we were not going in. He was not going anywhere; he was not hurting himself. We decided just to hold off until we had more staff, and security came. Then collaboratively, we made the decision to call the police in.

We called 911, and it was incredibly invalidating, because the people at 911 said, if this person's locked in, why can't you just go and grab them? If you have security, why can't you just use that resource? Why do you need police there? We needed to advocate for ourselves and for the patient. We had to tell them we don't have the expertise to go in and de-escalate the situation. We don't have the means to get the weapons away from this person, to move them away or give them their medication in a safe way. We also had to consider that we didn't want

our security guards in harm's way either. Just because they are security or we are front line staff, it doesn't mean that we are punching bags. Then, we needed to wait 20 minutes, 30 minutes, 40 minutes until police showed up.

Then when the police came, they went in and tased the patient. We put him in restraints because we didn't want it to happen again. We can put them in a seclusion room, but if we need to take them to the bathroom or give them supper, it could happen again. Even restraining him was quite difficult. Because of the patient's ethnicity and the current context, things like physical asphyxiation were in the forefront of our minds. And there were 10 people piled up on top of this guy. It was difficult.

Afterwards, it was unfortunate because he developed side effects from the medication. We couldn't even say OK, now you're feeling better. So, it wasn't great. He was more settled, but he had these terrible side effects. The family was not happy that police were called. The family was not happy that he got tased, and I don't blame them. You leave your family member in the hospital. You don't think that they're going to be getting involved with police.

Eventually I think the patient got the message that violence is not the way to get things, and if he behaved like this, then we would have to respond with injections and him being tied down to a bed. We were able to get him to see that if his goal was to get out of the hospital, then we needed to see certain behaviours. Eventually, patients need to get to a point of accepting their situation, which is not easy. (P56, story excerpt)

Salient Vulnerability Theory

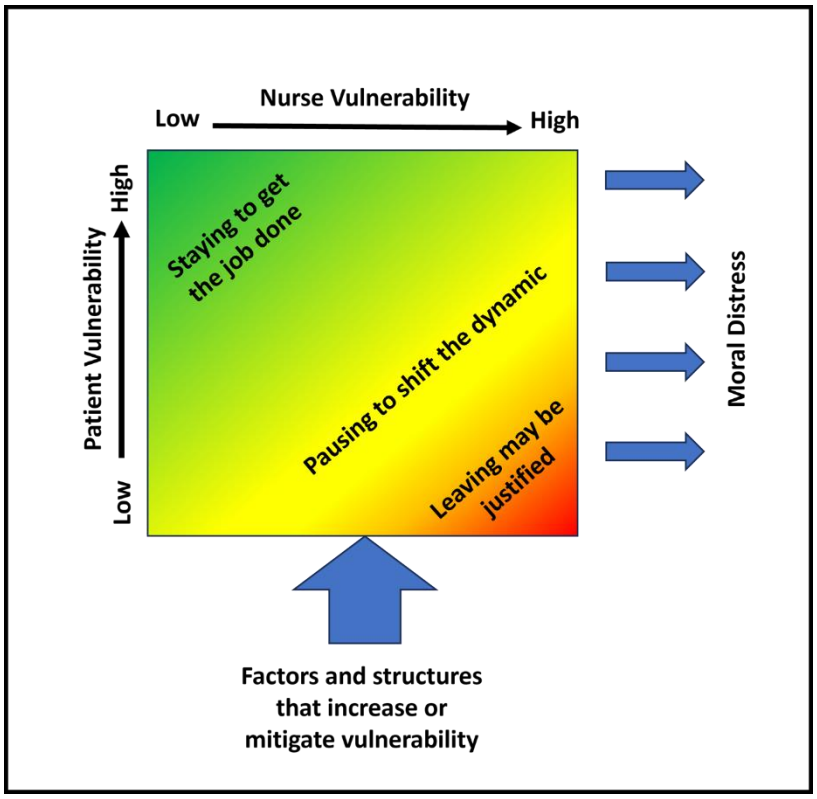
The concept of vulnerability plays a significant role in nursing practice. Vulnerability is expressed in the patient's susceptibility to damage, and dependency on others to address a threat to their health. By virtue of their need for health care, the patient is vulnerable to the possible impacts of their health

condition. This provides the nurse with an obligation, by virtue of their skills, knowledge, and position, to intervene and prevent the potential harm from occurring. At the same time, the nurse is vulnerable to the impacts of the patient's health condition, including, for example, risks from communicable diseases, and, of course, behaviours that threaten safety.

Salient Vulnerability Theory is a framework for understanding how nurses navigate decisions around patient care when their safety is compromised by violence from patients or bystanders. Figure 1 provides a conceptual model demonstrating the core concepts and linkages between and among the three research questions explored in this dissertation. Vulnerability is a function of the intersection of risks and threats to patient and nurse that determines whether it is reasonable for the nurse to fulfill their duty of care. The core data category that captures this dynamic is *Managing Intersecting Vulnerabilities*. This core category reflects the multiple, layered ways that patients can be vulnerable (Luna, 2009), while at the same time acknowledging that the act of providing care places nurses at risk of harm as well. The theory proposes that nurses make decisions about whether they ought to enter, or remain in, a volatile situation by assessing and prioritizing the relative vulnerabilities of patient and nurse at a given point in time. This provides a standard for the nurse to evaluate their obligation in that moment and establishes criteria that form the justification of their choice. The person seeking health care is vulnerable to their health condition and their lack of knowledge or means to address the resulting threat to health or safety. There is an asymmetry in risks such that the patient is more likely to experience harm, that is, they are more vulnerable to threat, under ordinary circumstances, than the nurse, providing the nurse with a baseline or default duty to provide care. Where a nurse has the skills and knowledge to address the vulnerability, and where there is not a strong corresponding risk to the nurse, there is a general expectation that they will intervene.

Figure 1

Conceptual Model of Salient Vulnerability Theory



As noted previously, vulnerability functions through the intersection of three conditions: exposure to a threat, sensitivity to the consequences of the threat, and a capacity for responding positively to the threat (ten Have, 2016). Nursing interventions serve to reduce patient vulnerability by addressing one or more of these conditions. For example, a psychiatric patient vulnerable to the suicidal ideations that are a feature of their illness is at greater risk when they are actively suicidal (exposed), particularly susceptible to a compulsion to act on their symptoms (sensitive) and are unable to reduce their symptoms to a manageable level (adaptive capacity). Nurses can provide a safe and protective environment and medications to reduce the patient's vulnerability to suicide.

Interpersonal violence in the care setting upsets this dynamic by increasing the nurse's vulnerability. The prospect of injury resulting from a patient's aggression also meets the three conditions

of vulnerability: the nurse's exposure to a situation where a patient is volatile, their sensitivity by virtue of proximity and normal human vincibility, and their capacity for overcoming the threat (which is affected by personal circumstances such as knowledge, health status, physical stature, perceptual acuity, etc.) all impact their level of vulnerability. The nurse's vulnerability is mitigated when they are not in proximity to a violent patient, when they have the means to protect themselves from an attack, and/or when they are able to overcome the threat by escaping or de-escalating it.

The vulnerability of the party who is more likely to be harmed and/or for whom the harm, if actualized, would be the most significant is the salient vulnerability. Most of the time, the patient is relatively more susceptible to the conditions and circumstances that threaten their well-being than the nurse is, meaning that under normal circumstances, the patient's is the salient vulnerability, and the normative force of their vulnerability compels the nurse toward the provision of care. Nurses are expected to be competent, knowledgeable and fit to practice (College of Registered Nurses of Manitoba, 2018), so the threshold at which their vulnerability becomes more salient than the patient's tends to be quite high. Although there is always a risk that a nurse could experience a threat during the provision of care, they are less likely to be harmed, and they have tools, strategies, and resources at their disposal to mitigate risks, resulting in an asymmetry of vulnerabilities.

Under normal conditions, the patient is more vulnerable than the nurse, so the nurse's actions support the patient's needs. However, violence increases the proximity and magnitude of a threat to the nurse. Relative to inherent vulnerability that derives from the patient's health condition, violence renders the nurse vulnerable as well. At a certain point, the nurse becomes more vulnerable to harm by entering or remaining in the situation than the patient would be from the prospect of the nurse's departure. In that moment, the nurse's vulnerability is more salient. It is at this point that the nurse is

justified in either leaving the situation or acting to restore the salience of the patient's vulnerability, which re-imposes the baseline duty of care.

The story that P56 relates in this narrative poignantly illustrates this theory. They describe a patient with several factors that made him sensitive to risks, including being a young man of colour who was experiencing symptoms of mental illness. While he would evidently benefit from medical intervention, a decision to force treatment on him would almost invariably cause harm, making him very vulnerable indeed. However, he had a weapon and was expressing intent to hurt anyone who attempted to intervene, meaning that the risk of injury to staff was very high. Because the patient was relatively safe and unable to hurt himself or anyone else while contained in the room, and the staff were proportionally more vulnerable to harm than the patient while in his presence, they decided to remain outside, reducing their exposure, until additional resources could be gathered. When police arrived, the vulnerability of the staff was diffused among more people with additional ability to manage the risk, so the patient's vulnerability became more salient in that moment, and it became safe to intervene and provide the person with the medical attention he required.

The result of an assessment of salient vulnerabilities is that it provides the nurse with a framework, or a means of weighing the conflicting priorities in each situation. It permits the consideration of context, and accounts for the nuances that make the outcome of one event different from another. P56's story shows how this process of calculation provides guidance on the best course of action. For this nurse, the assessment revealed that although the patient needed care, there was a risk to staff that could not be ignored. The relative safety of the patient in the moment permitted evaluation of the balance of vulnerabilities that determined the plan of care. The theory accounts for the distinctiveness of the decisions in each circumstance, as the best course of action may be different at

another time, with another patient or team, in the presence of contextual factors that comprise a different balance of the relevant vulnerabilities.

Addressing the Gaps in the Literature

Salient Vulnerability Theory is a conceptual approach to understanding nurses' ethical decision-making, especially in the context of workplace violence, and is supporting of and supported by extant literature. As noted in Chapter Two, I identified only two studies that consider nurses' ethical decision-making in the context of workplace violence (Beattie et al., 2020; Copeland & Arnold, 2021). In the Copeland and Arnold (2021) study, nurses viewed violent acts from patients as criminal behaviour when the nurse was injured and the patient was competent at the time of the assault, or as a risk of the job when the nurse was not injured and the patient was incompetent. An ambiguous space where remedies were unclear and ethically fraught was identified between these interpretations.

Salient Vulnerability Theory addresses this haziness by providing an explanation for nurses' interpretive ambiguity in these situations. When the patient is cognitively impaired and the nurse is uninjured, the salient vulnerability (the patient's) is clear. Similarly, when the nurse is injured and the patient is competent, it is the nurse whose vulnerability provides the impetus to take an action such as pressing criminal charges against the perpetrator. However, in those liminal spaces, the balance of vulnerabilities is unclear, and the path forward is much more difficult to define, leading to the unsatisfying polarization of perceived options, that is, to either pursue criminal charges, or to let it go. The consideration of salient vulnerabilities permits the nurse to justify their decision to stay, pause or leave. Similarly, it explains nurses' reluctance to enact zero-tolerance policies, especially for patients whose health conditions made them vulnerable to the impact of the nurse's actions and reactions in response to aggression (Beattie et al., 2020). It is consideration of relative vulnerabilities that provides a path forward for nurses operating in that ambiguous middle space.

Likewise, the models of ethical decision-making offered by Benedetti et al. (2020), McDougall et al. (2020), and Dunsford (2021) prompt consideration of the probability and magnitude of the impact of the nurse's choice, either to stay and provide care, or to leave and remain safe, for both patient and nurse. Where legislation and blanket policies such as the zero-tolerance policies are blunt instruments that do not encourage contemplation of the nuance and contextuality of such situations, consideration of the relevant vulnerabilities provide pertinent and definable criteria for determining the path forward. The factors that participants in this study identified as relevant to the determination of a course of action, that is, those things that increase or mitigate risk, are relevant because they have a direct bearing on the intersecting vulnerabilities of nurse and patient. Indeed, I suggest that the *Stay-Pause-Leave* continuum of decision-making described in Chapter Five is a clear manifestation of this phenomenon.

This study and the resulting theoretical approach to our understanding of ethical decision making and the roots of nurses' responses to workplace violence offers a foundation for future research, and recommendations that have the potential to address a ubiquitous and persistent problem. Equally importantly, it provides a glimpse into the role and impact of nursing ethics for practice, with wide application well beyond this issue.

Summary

In this chapter, I have outlined the research problem, provided the conceptual model, and situated it within the literature on vulnerability. Ultimately, participants described making decisions around attending to a patient who was exhibiting violent behaviour by considering the manifestation of the patient's vulnerability in the context of their own vulnerability. That is, they weighed the patient's level of exposure and sensitivity to harm, and their capacity for managing any negative consequences that might result from their decision, against their own risk in terms of likelihood and severity of harm, and their ability to cope with the physical or emotional sequelae of a violent encounter. While the

patient remained more vulnerable, the nurse provided care. Once the balance tipped, and the nurse's vulnerability became salient, they withdrew, temporarily or permanently, from the situation. Irrespective of the decision, the event generated some level of moral distress for the nurse.

In the next chapter, I offer a discussion of the theory in light of the study's findings, and present four recommendations deriving from the data and emergent theory.

Chapter Nine: Discussion and Recommendations

In this chapter, I build on the presentation of Salient Vulnerability Theory by offering a discussion of its application to each of the three research questions examined in this study. I again focus the chapter on the stories gifted to me in the second phase of the study. I conclude the chapter with four recommendations derived from the findings and developing theory.

Discussion: The Research Questions

Question One: Ethical Decision Making

P40's Story: Constant Vigilance Takes a Toll

> I love working with patients who come in really sick. They come in often in a terrible mental state. Seeing them get better and get back to their normal is really rewarding. Sometimes they are coming from the lowest point in their life, and we help them get back to a meaningful life that they're happy with. I find it very rewarding to be there for people in the worst time of their life, and then see them get so much better.
>
> I feel threatened at work all the time, but I've never had to choose not to provide care at all. Even when it's dangerous, I always end up providing some kind of care. I might limit my interactions to the bare minimum that is safe for me and that patient and everyone else on the team, but I'm always doing something for them. I've never been physically seriously injured, to the point I needed to take time off work. I have been punched in the face. I've been spit on and I've been grabbed and pushed. There are patients who just have a threatening aura. Mentally, the constant need to be vigilant takes a toll.
>
> I took some time off work last year because things just accumulated. The thing that triggered me was a situation where a patient was in a seclusion room. He was well known to be very verbally aggressive and intimidating to people and the environment. He was a big guy with

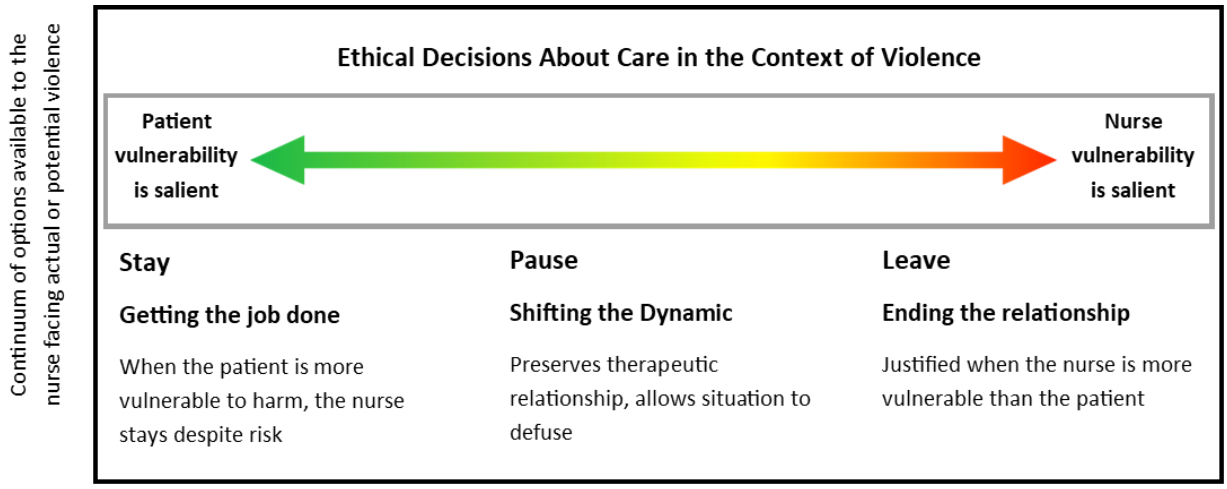
> a very loud, deep voice. He was always very angry. He had a diagnosis of schizophrenia and did not want to take any medications. I took a phone call from a family member who wanted to talk to him, and so I went to his room to let him know. He shot out of bed, straight up, and started screaming that he was going to kill me. Then he started coming at me really fast. I remember in that moment thinking, oh, this is where my career ends. I jumped back and started speed walking down the hallway away from him. He followed me, still screaming and swearing at me. And at this point, I knew that he wasn't going to hurt me. He was just really angry, but the way that he just exploded was so scary. He was the kind of person where he would come to you if he wanted something, so I knew I was taking a risk telling him he had a phone call. I knew not to go to him because if you disturb him, he blows his top.
>
> Afterwards, I remember sitting at the nursing desk, and I kind of dissociated. Even though he didn't touch me, it was still very, very stressful. That's when I knew I needed to take some time off. (P40, story excerpt)

What Ethical Decisions Do Nurses Face?

Considering the question of how nurses manage intersecting vulnerabilities when workplace violence erupts, I identified three primary decision categories on analysis of interview and narrative data. They form a range of choice options: *Getting the Job Done (Stay), Shifting the Dynamic (Pause),* and *Withdrawing from the Situation (Leave)* (Figure 2). P40's story illustrates this spectrum.

Figure 2

What Ethical Decisions Do Nurses Make in the Context of Workplace Violence?



The nurse begins by describing the satisfaction of providing care to people who are in an incredibly vulnerable state, and seeing the person get well. This is established as the nurse's priority; however, it is constantly balanced against their own safety. This nurse states that they have never chosen to completely leave a patient without care, because there is always something that can be done, even if it is the bare minimum that is safe for everyone. Their default response to stay and provide care is based on their assessment of the person's state of health – their vulnerability - unless or until there is reason to think it is not safe to do so. This decision depends on assessment, observation, and constant vigilance. This nurse pauses to shift the dynamic when that is needed to maintain their own safety in the moment. They also recognized here that their ability to continue to provide good care was at risk due to the accumulation of stresses and chose to take time off to recover. The *leave* element of this story is therefore twofold: literally vacating the room to address the immediate threat to their safety, and the more metaphorical response that was less immediate and more general, the dissociation and disengagement caused by the trauma of the verbal attack and physical threat. The nurse then had the presence of mind to recognize that processing the trauma was affecting their fitness to practice, their

ability to meet patients' care needs without judgment or bias, and without curtailing their engagement due to fear. The immediate physical threat of the aggression, and ongoing psychological threat from processing trauma made this nurse's vulnerability highly salient.

P40's default *stay* response, attending to a patient known to be volatile, is based on their assessment of the patient's vulnerability, and the consequent duty of care that the nurse-patient relationship, forged by the nurse's knowledge and skill, confers. The therapeutic relationship central to nursing practice holds at its core the recognition that a threat to the person's needs or integrity demands a response. Respect for human dignity drives this connection and leads the nurse to remain in the situation due to their responsibility for attending a person in need, when they have the means to meet those needs. Nurses rationalize the decision to stay by finding a way to get the job done as safely as possible, by doing the bare minimum, or by using the amount of force required without causing more harm than benefit. They conduct risk assessments and use strategies to minimize the chance of harm. Nurses persist, even as their safety is threatened, when there is no one else who can assume responsibility, and the prospect of leaving means the person would be without care. P40's story shows how the nurse stays as long as the patient is more vulnerable.

The *pause* happens when the relative vulnerabilities shift. This does not mean that the patient becomes any less vulnerable, but that the threats to the nurse have become problematic: their exposure to violent behaviour places them at higher risk of injury. P40's story shows the point where the balance tips as the negative implications for the nurse become more salient than they are for the patient. Self-protection makes it difficult for the nurse to provide care. When this happens, they call for help, back off for a while, or move to a safe distance and wait for the behaviour to de-escalate. These actions have the effect of rebalancing the risks, which can put the nurse back into a less vulnerable position. In this case, the nurse physically left the patient's room and retreated to the nursing desk, a physically safer space,

then psychologically withdrew by dissociating. Eventually, they completely left the care setting by taking time off work to process the trauma of the encounter and the accumulation of other stresses from threats and constant vigilance required to stay safe, and to replenish their capacity for managing threats.

When the conflict between risks to the patient and nurse cannot be reconciled, and the nurse faces near certain injury due to the patient's behaviour, the choice to leave becomes justifiable. Withdrawal from a nurse-patient relationship, temporarily or permanently, happens when the implications of remaining in the situation are profoundly more negative for the nurse than the fact of their departure would be for the patient. Generally, this takes the form of handing the patient's care over to someone else, and only at a time when to do so would not cause greater harm to the patient.

At the extreme of the *Stay-Pause-Leave* spectrum is the abandonment of someone whose behaviour makes them too dangerous to attend. Notably, participants identified no situations where a person would be completely denied care, short of triaging in the event of a disaster. Several participants spoke about the fact that they would always find a way to do something for the person, even if they were so volatile that no one could be in the same room with them. Even the participants who spoke of refusing to look after a particular patient after being assaulted by them did so in the knowledge that there was a pathway for the person's most critical needs to be met, either because other willing staff were available, or because there was a way to guarantee staff safety, even if it meant forcibly restraining the patient during the provision of care. This commitment is a recognition of the inherent dignity and worth of every person and counts on the resources and strategies available for re-establishing the salience of patient vulnerability and the resulting duty of care.

Of course, these are not discrete options. P40's story demonstrates the full continuum of choices available: attending to the patient when they are most vulnerable, stepping back from the situation when it becomes dangerous, and taking time away from work to heal from the accumulated stress and

trauma when the nurse's compromised state begins to interfere with their ability to do the job. The decision will be different for different nurses at various times because the factors that comprise vulnerability are highly contextual and nuanced. This is the subject of the second research question. I explore the question of considerations that factor into decisions about a course of action next.

Question Two: Factors and Considerations

P2's Story: Nurses Have Been People's Punching Bags for Years. It's Got to Stop

> When I was working up north, we had two long-term patients, a husband and wife. They were sent to us as a social admission. We had this couple for a long time. One day, I was doing rounds with a coworker on the combined med/surg/obstetrics unit. I went into the man's room, and he was attempting to sew a button on a pair of pajama bottoms that came from the hospital. I told him he didn't need to do that, and I went out and I got a new pair of pajama bottoms for him and brought them in. I was tidying the room, and I heard something behind me. I turned around and he was coming at me with a buck knife. It was pretty scary. I didn't know what was going on, so I backed up into a corner, not realizing that then I couldn't get out.
>
> As nurses we're told, just be calm, don't yell, but I realized I was going to be hurt really badly. I remember backing up against the wall and thinking to myself, should I relax my abdomen, or should I tense it up? What's going to do the least amount of damage when he stabs me?
>
> I yelled for my colleague. He came running down the hall right away. He saw what was going on and grabbed the patient by the shirt and threw him onto his bed. That's how I got out of there. After that, I said I would look after everybody else, but not that patient.
>
> What hurt the most was that the hospital was very blasé about the whole thing. They questioned my colleague and I separately, like we were criminals. What also upset me was the

security guard. My colleague yelled for him. He saw a lot of what happened, and then later denied it. I saw some of the ladies that were in the maternity part of the hospital watching what was going on, but they denied it too. That really hurt. I was also asked what I did to provoke the attack.

My husband at that time was a police officer. He wanted to have this fellow charged with assault, but the hospital told me that if we pursued that, that it could affect my job. I agreed to continue working there, and not to press charges, but I told management that I wanted him out of the hospital. We had had a report from his home community that he had never done anything like this, but his granddaughter came down and apologized and told us that one of the reasons he was sent to us was because he was so violent.

The incident affected how I provided care after that, because if I felt threatened in the future, I would just back right off.

Nurses have been people's punching bags for years. It's got to stop. (P2, story)

Determining the Right Course of Action

When confronting workplace violence, nurses can choose to stay and get the job done, pause to shift the dynamic, or leave, and withdraw from the situation. I have argued that these options are based broadly on the vulnerabilities of the people involved in the encounter. But how exactly do nurses identify and assess intersecting vulnerabilities? What are the things that make someone vulnerable, and how is that moral calculus conducted? This is the subject of the second research question: the considerations that factor into decisions about a course of action (Figure 3).

Figure 3

What Considerations Factor into Decisions About a Course of Action?

The story told by P2 exemplifies the considerations involved in determining the right course of action. The categories of relevant factors identified during data analysis consist of those things that increase risks, and those that mitigate risks. P2 describes a patient in precarious health who could not be supported in his home community, so was dependent on the staff in the facility to support his basic needs. The nurse also describes being backed into a corner at knifepoint, in imminent danger of serious injury. The nurse was exposed and sensitive to the attack, with the only means of overcoming the assault being yelling for help: in that moment, the threat to the nurse was clearly the salient criterion for the course of action. The availability of the colleague to intervene was a mitigating factor that decreased the nurse's vulnerability in that instant, enabling them to escape the threat. These factors modified the salience of the nurse's vulnerability and provided the justificatory basis of the physical removal of the patient and the nurse's subsequent refusal to provide care.

Study participants described several factors that multiply the risks of harm from a violent encounter: the magnitude or likelihood of a bad outcome for the nurse, patient or others in the area, the patient's health condition and associated behaviours, and environmental factors like the ability to safely leave the area all figure in to the process of deciding whether to stay, pause or leave. The obligation to provide care in a situation where someone is dependent on the nurse generates the default response of intervention, until such a point as those situational considerations accumulate and the nurse's

vulnerability to harm outweighs the patient's need for care. Some participants commented on the fact that health care is not recognized as an inherently dangerous profession, unlike, for example, law enforcement, despite the frequency with which health care providers are required to manage aggression and violence. Although the goals of nursing and law enforcement are different, the incidence and prevalence of violence provides an apt comparison. The difference, however, is the fact that police receive special training and equipment like stab vests to protect them, meaning they are less sensitive to the impacts of violence than nurses are, at least physically. This suggests that training and safety equipment may help make nurses less susceptible to harm when violence occurs, so the balance of vulnerabilities can be maintained. In a balanced state, the patient's vulnerability remains salient, because the nurse is proportionally less vulnerable.

Where the things that increase the risks of incipient violence address the sensitivity to vulnerability, the strategies and resources used to mitigate risk shift the capacity for a positive outcome. Conducting a risk assessment to inventory the human and environmental factors that increase the probability of violence or negative outcomes enables the nurse to employ tools and supports to diffuse it. Ensuring there is help available before entering a potentially challenging situation can ensure the encounter is as safe as possible. Similarly, the nurse's approach and communication techniques may help to de-escalate a situation, maintaining the balance of vulnerabilities in favour of providing care.

One finding relevant to mitigating risks that P2's story exemplifies well is leadership support, or, in this case, the lack of it. Participants described thinking about whether their supervisor would support them while deciding to intervene in or leave a volatile situation. P2's experience was a distinct lack of support, even gaslighting, which impacted not only their willingness to continue working with the patient, but also their commitment to the organization, and, indeed, how the nurse responded to feeling threatened in the future. Concern about the level of support the nurse can expect from their leadership

increases the nurse's vulnerability and can either intensify the justification for pausing or leaving a high-risk care encounter or motivate the nurse to stay in a dangerous situation longer than is prudent. It is an interesting thought experiment to consider whether this nurse may have been willing to continue providing care to similar patients in the future, if their supervisor had responded differently.

The *Stay-Pause-Leave* framework is the set of options that nurses consider when they are threatened by violence. I have proposed that the decision to leave is justified when the nurse's vulnerability surpasses that of the patient. The salience of vulnerabilities is determined by assessment and consideration of the factors that multiply and mitigate risks. Collectively, this model permits the nurse to manage the intersecting vulnerabilities and fulfill their duty to care, while maintaining a level of personal safety. Irrespective of which choice a nurse makes, however, they are likely to experience moral distress, because they cannot logically or practically meet all these mutually exclusive goals at the same time. In the next section, I examine how Salient Vulnerability Theory accounts for this.

Question Three: The Experience of Moral Distress

P23's Story: Reckoning with Myself

The following is my account of an incident in my workplace that affected me differently than other, more typical, instances of verbal aggression and potential violence. I have chosen this story for its particular nuances and for the difference in how it made me feel compared to other situations.

For 20 years, I have worked with this patient in inpatient and outpatient settings. Despite many instances of verbal aggression and unpredictability, we had forged a type of understanding and rapport that allowed us to work together through the many exceptional circumstances he has faced throughout the years. Most verbal aggression was directed at others, and until the day this incident occurred, I had been able to help de-escalate and redirect him so that he could still

obtain the care he needed. He had, unfortunately, alienated family and had limited tolerance for situations that required patience or predictable attendance. By the time this incident occurred, he had no other care providers or supports. He had also recently been stabbed, not for the first time, and with sutures, staples and the beginning of an infection, and had come in for wound care, although my role is in his mental health care.

That day, we went to our department's treatment room, which is small, away from the main area and behind a closed door. I began removing the old dressing from the ER and cleansing the wound. I was assessing the extent of his significant injuries when I suddenly realized he had begun to masturbate. It took me a minute to process this; I was so shocked and it was so out of character – and bizarre for a moment when his other mangled hand was on the table and quite grotesque. I asked him to stop; instead, he stood up, exposing himself, and continued. I backed away and assertively told him to stop. He barely reacted apart from sitting back down. I didn't feel I had a choice but to quickly re-bandage his hand and send him on his way, asking him to return in a few days to have the wound reassessed.

What surprised me more than the incident itself was how angry I was. It felt, at that moment, like more of a violation than if he had begun screaming at me. After all these years, with no one else providing health care to him, and at a time when he was in serious need of care and support, this. I suppose there were also thoughts of what would have happened if he had become physically sexually aggressive at that time. Without wanting to seem dramatic, in general, I think, women live with fear of moments like this, and it reminded me of my vulnerability in that setting. It disturbed me, on some level, that I would need to keep my cool, be professional, not act in a way that would let him know I was upset. This is always the job but this time I was rattled.

Things have changed since the incident. A report was completed and a plan for having another person in the room going forward was implemented. Security was called to stand by every time he came to the clinic for the next 1 to 2 months, until he was able to demonstrate consistent 'appropriate' behaviour. He still gets irritable but hates having security present so things don't seem to escalate anymore. I felt conflicted, even though I wanted to prioritize the safety of the team and myself, because the presence of security often re-traumatizes those who have had incidents with them, especially 'back in the old days.'

I did try at the first subsequent appointment to explain the reason for these changes and referenced "what happened the other day". He glared at me intensely then abruptly left, swearing and yelling about how this was "bullshit." We haven't talked about it since.

His wounds have healed. He still lives in a dangerous setting where a similar incident could easily occur. He is getting older; he is developing other physical health issues. His mental illness is treated but his capacity to care for himself is deteriorating. I am not able to help him as I would many others, in part because of long-term challenges, and in part because there is now an unspoken barrier.

I am a champion of preventing violence rather than just being reactive. I preach about it, and I formally teach about it. My approach to my role is wholly focused on respecting where people are at, rolling with the changes in people's presentations, collaborating toward solutions or recovery in general. As much as possible, I try to keep things light, use humour, offer hope and a place to unpack difficult emotions. I don't like that I felt a sense of betrayal in this moment. I couldn't land on an excuse or reason for it. His symptoms weren't poorly managed, he wasn't intoxicated. This wasn't a known possibility. I felt like he forced me to treat him differently, be colder, more detached. There wasn't a way to properly debrief.

> I don't want this to colour how I interact with people going forward. I don't want to become jaded or cynical. I want to continue to have unconditional positive regard for people, to be empathic and to keep my sense of humour. I think a lot of job satisfaction comes from how we view ourselves in our roles – what we give to nursing can really determine what we get out of it. This situation didn't shake all of this to its core, but it did lead to initial anger, some careful planning, and a bit of a reckoning with myself. (P23, story)

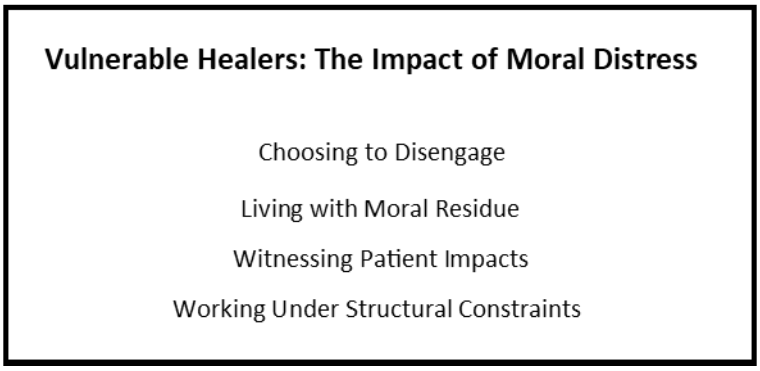
Vulnerable Healers

Salient Vulnerability Theory proposes that patients are by default vulnerable, resulting in a duty of care on the part of nurses who have the relevant skills and knowledge and who have been charged with the responsibility of providing interventions to improve the patient's situation. When a patient or bystander commits violence, the risk of injury to the nurse is significant, so the nurse faces a decision about whether the duty of care overrides their own personal safety. The answer to that question lies in the calculation of who is at the greatest risk: the nurse from violence, or the patient from the nurse's need to withdraw from care to preserve their own safety. The greater risk, which I have called the salient vulnerability, provides the decisional impetus.

A result of these invariably fraught decisions – to stay, pause or leave – is moral distress, stemming from the nurse's inability to fulfill all obligations simultaneously. Moral distress manifests in disengagement, moral residue, witnessing the suffering of others, and the need to work under structural constraints (Figure 4), each of which in turn have relevant ties to vulnerability. P23's story demonstrates this well.

Figure 4

How is Moral Distress Experienced When Nurses Encounter Workplace Violence?



The primary theme of P23's story was moral distress, developing when the nurse put boundaries around their relationship with a patient who had been sexually inappropriate in the clinic. While acknowledging their own vulnerability as a reason for the boundaries, the nurse's distress was also a reaction to the patient's exponentially increased vulnerability from his lack of other options to obtain necessary care. The nurse described feeling conflicted because the need to prioritize safety for self and others meant possibly causing harm to the patient through retraumatization, even more likely due to his history. There is a sense of regret that the salience of the nurse's vulnerability means they need to treat him differently, sub-optimally. They are acutely conscious of the fact that this incident has impacted them deeply and want to guard against it colouring future practice. It raised questions on the nurse's role and their approach to their profession. This incident resulted in disengagement, regret, worry about the impact of causing additional trauma, and compromised patient dignity - all of which affect the patient, the nurse, and the rest of the health care team. This is difficult because the patient is no less vulnerable than he was before he incident; indeed, he is perhaps more so due the damage to the relationship with his sole remaining health care provider. He still needs care, and the nurse is now worried they will not be able to provide it.

This example shows how moral distress has roots in vulnerability. Moral distress is born of the inability to meet responsibilities arising from the nurse-patient relationship. I suggest that it is in fact an actualized harm from vulnerability. The categories of experiences related to moral distress, that is, disengagement, living with moral residue, witnessing patient impacts, and working under structural constraints, all derive from the ways in which vulnerability functions in the clinical setting. The nurse disengages to protect themselves from risk and reduce exposure to physical and emotional harm. The experience of moral residue comes from the sense of violation and betrayal of compromised values and contributes to the crescendo effect that decreases the nurse's capacity for managing violence. The anguish that comes from witnessing negative patient impacts from violence, like the inability to meet patient needs, is a recognition of the actualization of preventable harm from vulnerability. In addition, structural constraints like short staffing and lack of supervisor support make it difficult to avoid violence and multiply the impact when it occurs.

It needs to be recognized as well that not only are nurses vulnerable to violence, but they are also vulnerable to moral distress. The experiences nurses have that lead to moral distress have a lasting impact and form a part of their toolbox for managing subsequent situations that are difficult, positively and negatively. When moral distress and moral residue are outcomes of workplace violence, the resulting emotion is a response to the inherent vulnerabilities of both nurse and patient, and the impossibility of meeting all the duties and goals that exist for the nurse. Given the myriad consequences of both violence against nurses and moral distress, it is critically important to nurses, to the nursing profession, to the health system, and to the very functioning of society that the prevention and management of workplace violence is a priority. To that end, I next consider what is needed to address the problem of workplace violence, and the resulting moral conflicts it invariably produces.

The Implications of Salient Vulnerability Theory

P3's Story: Can This Patient Really Hurt Me?

There are always the patients that you know from their history have a tendency to be aggressive, and so, I'll just ask them if they need care, and if they don't, I leave. I've had incidences where I went in and right away, they're throwing an item at me. Well, then, of course, I'm going to try to leave the room and re-approach later. That works to a certain extent. People with dementia often forget that they have been aggressive so it's a brand new thing, when they are offered care again maybe five minutes later.

Where I really see the problem is when there's a risk to themselves, or a risk to other patients in the environment. I have had incidences where a patient is zipping around in an electric wheelchair. It puts themselves and other patients in danger of a collision. Then I'm not in a position to just leave them and re-approach in a few minutes. It's a safety thing. So that's when I'll end up having a call a Code White, to try to contain it somehow. Calling the code brings the help to de-escalate the situation. From experience I have a sense if people are going to be volatile and even then, there are times that I have misread the situation. I have learned that you never know what's going through someone's mind.

There was a time when I went into the room to give a patient their medication. I talked to the patient. They kind of knew who I was. I said, 'here's your medication'. And then all of a sudden, out of the blue, they hit the medication out of my hand. The tablets and med cup went flying and ended up on the floor. I tried to be nonthreatening and unfazed by it to not inflame the patient more. I thought, 'Can this patient really hurt me?' and decided I had to leave the room and hopefully not get hurt. When I would interact with a patient that had unpredictable, violent behaviour I thought about if they could actually hurt me. It is difficult to make a safe

decision when unfamiliar with the patient. I would just say, ‘OK, I'll just come back later’, and leave the room when confronted with an angry patient that is refusing a medication.

Now, if it was a medication that was not really all that important for their health and they could miss a dose without ill effect, like PRN Colace [a laxative given as needed] for instance, I would leave it. I would write ‘refused’ on the MAR [medication administration record] and document that the patient refused. I respect that a patient has a right to refuse a medication or treatment. It gets trickier if it's an anti-seizure, analgesic or time sensitive medication as an example. I think about the outcome of a missed medication. If there is a potential for a serious side effect, I would go back later to the patient. I know that continued refusal and aggression from a patient would mean a conversation with the doctor and team.

In the instance I’m thinking of, the patient refused an anti-seizure medication. He had a brain injury as well as some other cognitive deficits and was not fully orientated to his situation. He was a young adult and had a family that cared about him and wanted him to have the medication. I tried multiple different ways to approach and provide his oral medication. He was very strong and coordinated in his upper body but was unable to walk without assistance. I knew that he could hurt me if I came close to his arms and hands. He was a young man and likely much stronger than me in the upper body. I took this into account and approached an arm’s distance away. I also knew that he could not chase after me because he could not ambulate well. I would not have gone into that room alone if he could ambulate well and could potentially overpower me. I knew I could keep myself safe by taking into account his abilities and disabilities. I knew the history of the patient, but I also knew my limitations. I knew to keep a safe distance from his arms and exit the room quickly. In this case I provided the medication and arm’s distance away. He threw it at me, and I quickly exited the room.

When I returned to the room it was difficult to feel safe. It was a challenge to be in close proximity to the patient. When I came back, I kind of approached him sideways, in a way that he could not hit at me and hoped for the best. I opened the door and kept it open, so I had an exit. I never blocked my exit. I kept that exit clear and just went slowly in a nonthreatening way. I didn't come straight on; I went sideways to him and kept my back against the wall. I kept my hands kind of loose.

It is a little bit of acting, I try to act friendly and relaxed not like I'm scared or threatening or bossy. I try to act like I'm going to be their friend and help them. I try to be as nonthreatening as possible. I have found that most people respond to the non-verbal language and that can be more important. Sometimes, the verbal language does not make any sense to a patient. I've had patients with dementia (also brain injury and language barrier etc.) that cannot understand my words but understand my actions. They can sense my behaviour, my face and body language. When I have a patient that was known to be aggressive, I tell a coworker if I was going into the room and to keep an ear out. If it's something that they really need, then you can only put it off for so long.

A situation that is very challenging to manage safely is when a patient refuses basic hygiene care. Another challenge is managing an individual's bladder or bowel incontinence when they are unable to self manage. It requires hands on care to clean and manage an incontinent patient. I have had patients that are incontinent of urine or stool and are sitting in a wet bed or worse in the hallway with the other patients. It is a mess. A patient like that cannot be left alone until they are agreeable to care. They may never be agreeable to care. They present a risk to other patients on the unit when bodily fluids are not contained. It is an unsafe situation. In those cases, we would need a team effort to find a way to safely clean them up. I would have to get

> some help to go in, maybe with someone else that they might like a little bit better. A lot of the philosophy now is just to leave if they refuse care. “Non forced care” is a great philosophy for the individual patient and to respect their rights. The problem is the individual has to live with fifteen or twenty other patients. The whole unit of patients has to collectively be kept safe. It does not feel good to always comply with a patient’s wishes to refuse care. It many instances it seems to create more problems for the patient and co-patients. (P3, story)

Where Do We Go From Here?

Salient Vulnerability Theory proposes that patients who are dependent on nurses for health care are vulnerable, which confers a special obligation on the nurse. The theory also recognizes that nurses are vulnerable to the actions and choices of those in their environment, especially the patients with whom they spend much time in close contact. While there is no expectation that a nurse will remain in a caregiving situation where they are in physical or psychological peril, the nature of the nurse-patient relationship and attendant obligations means there is a high threshold for a decision to leave when a patient is vulnerable. I have proposed that the threshold lies at the point at which the danger renders the nurse’s vulnerability more salient than the patient’s.

I have laid out this theory using the stories of participants’ experiences with workplace violence to describe the decision-making process and explain how nurses justify their decisions to stay, pause or leave a patient care situation, and how vulnerability impacts the emotional fallout from those experiences. The implications of this theory and the recommendations that follow from it are twofold: first, nursing is a high-risk profession and must be recognized as such. Second, we must address vulnerability in order to ameliorate the problem of workplace violence against nurses, and this must happen at a systemic, even societal level. While these stories provided examples of individual nurses’ situations and decisions, they illustrate issues that are clearly structural in nature. Nurses do everything

within their power to provide care that is safe for everyone, and yet violence still happens with catastrophic regularity. This suggests that durable solutions to the problem do not lie (solely) with individual practitioners and explains why workplace violence remains widespread. Nurses' vulnerabilities, while manifesting in individually embodied ways, are a result of systems and structures that permit them to develop to the point that they cause harm. P3's story offers some insights that capture these implications and set the stage for four critical recommendations.

Ethical Decisions

Nursing practice is intrinsically conflict-laden, even as its purpose is to provide aid and comfort. Its very nature means there will always be competing and even mutually exclusive priorities among which a nurse needs to choose. In P3's story, we see situations where a person needs care for their own safety or that of others in the environment but demonstrates their refusal by striking out. The nurse's priorities are providing patient care and preserving dignity, all while ensuring the safety and health of the nurse, the patient, and others. In this story, we hear of strategies for maintaining the balance that allows for care without too many compromises, and for an approach that permits the nurse to get the job done, until the dynamic shifts and they become vulnerable to the patient's aggression. P3 does not suggest there is a time when the nurse would abandon the patient altogether, indeed, they suggest that the nurse is never fully absolved of their duty of care. In this world, reapproaching is always an option, and when the refusal is persistent and a safety risk, there is the option of talking with the multidisciplinary team about other solutions. This is most important when the risk of leaving is high due to the nature of the treatment the person is refusing. The degree to which it affects their own health or the health and safety of others, increases the stakes, and makes it more important to keep trying in different ways. A nurse only leaves the person without a particular intervention when the person either understand the implications of their refusal of care, or those implications are less impactful. When the patient is not

capable of understanding these risks, essential care tends to be provided even contrary to someone's wishes, in situations where it will do more good than harm. Ideally, finding a way to provide care that does not result in trauma or refusal is ideal, but not always possible, and these situations are both practically and morally hazardous. The decisions nurses make, and the risks they take in the course of their work impact them personally, but the roots of the issue run much deeper. Vulnerability is as much a structural issue as an individual one and requires a systems approach to address it.

The implication of Salient Vulnerability Theory is that the nurse needs to understand the nature of the patient's vulnerability, as well as their own. These considerations are nuanced and highly contextual, and there needs to be room in the nurse's practice to gather enough information about a patient to understand the constellation of risks and threats that impact them. This requires the ability to conduct a thorough assessment of the patient's health condition, supports, and needs, excellent inter- and intradisciplinary communication, and effective therapeutic communication with the patient and their family, to ensure an accurate picture of the historical and contextual elements that influence how a patient experiences the world. This requires time and resources.

The nurse also needs to be aware of their own baseline vulnerability and to acknowledge that it may vary day-to-day, or even minute-to-minute. An honest recognition of the nurse's sensitivity and capacity for managing a difficult encounter offers the nurse the opportunity to plan for situations where they will need additional supports or strategies. Mindful assessment of one's internal and external environment provides important information on the nurse's relative vulnerability, and awareness of when it might acquire salience. Furthermore, nurses' vulnerabilities impose an obligation on the part of the employer to ensure that the context in which the nurse practices is as safe as possible. It is unreasonable for a nurse to assume sole responsibility for mitigating the risks that are inherent features of the work environment. Along with things like personal protective equipment to prevent

communicable diseases, a safe workplace includes features that protect the nurse from the hazards intrinsic to their work, like violence, ensuring they have the skills and resources required to provide optimal care and maintain their vulnerabilities at a manageable level.

In summary, it is the salient vulnerability that drives decision making about the provision of care when a patient is aggressive, but measures that address the safety of both nurse and patient must target vulnerability at a deeper level. Nurses must be provided the time and resources necessary to assess and respond to the demands of each situation in order to make care decisions that maximize the health, dignity, and safety of all.

Determining a Course of Action

To determine a course of action, P3 describes abrupt turning points where their vulnerability suddenly increases relative to the patient's. They consider factors that alter their risk, such as unpredictability, physical strength, and limitations to the person's mobility. The patient's vulnerability also includes the nature of the treatment being refused, and a consideration of whether it is essential to health or safety as compared to being needed for comfort, and the extent to which the person has the capacity to understand the implications of their refusal. P3 notes that people with cognitive impairment have diminished capacity for appreciating the purpose and goals of care, as well as the material implications of refusal, so the burden on the nurse to get the job done is higher. Rebalancing vulnerabilities through mitigation of risks includes strategies for safe care such as knowing the patient, approaching carefully, assessing the situation and leaving when necessary. When other people are at risk, it also affects the balance of vulnerabilities. In this case, the nurse may need to be more forceful or insistent, to protect others. The nurse benefits from the knowledge of the implications of respecting the person's refusal as opposed to forcing care in someone's best interests.

The implication of a theory that places vulnerability at the centre of a process for making decisions about providing care when the patient is violent is that addressing the vulnerability can prevent the violence. There will always be a possibility that the nurse is exposed to violence because it features as a symptom or consequence of many health conditions. However, the factors that increase and mitigate vulnerability can be addressed, and threats to the nurse can be ameliorated. Some of the elements antecedent to violence are within the control of the nurse. However, many must be addressed at a system level. Changing the physical environment to make it more conducive to recovery is a start, for example by creating hospital units where it is possible to meet patient needs for privacy, uninterrupted sleep, and rehabilitative activity. Staffing models that ensure nurses have the time they need to develop a therapeutic rapport and respond to patient needs promptly will improve patient safety and decrease the risk of a critical event. This reduces patient vulnerability and will correspondingly improve nurses' susceptibility to moral distress and to violence perpetrated by angry, frustrated, or scared people. If avoidable violence was prevented, and residual incidents of aggression could be traced back to being merely symptoms of certain health conditions, like pain or altered levels of consciousness are, they could be prevented or addressed proactively, rather than reactively, and both the incidence and magnitude of negative outcomes would improve. The considerations that factor into decisions about a course of action are highly contextual, but the care environment itself must be structured to support measures to reduce the impacts of vulnerability overall.

Moral Distress

P3 notes that it does not feel good to leave someone without care, even if they express that desire, but neither does it feel good to force care. This tension demonstrates the conflict between what is considered best practice (i.e., non-forced care and respect for refusal) and the nurse's personal and professional values to ensure people are safe, comfortable, and their needs are being met. The nurse is

constantly assessing which need is greater: the need to preserve the patient's autonomy, or the need for physiological requirements to be met, when both cannot happen at the same time. Worse, the nurse experiences distress at the insult to the person's dignity when they are unable to do both.

The irreconcilability of these mutual vulnerabilities is what generates moral distress. The safety and comfort of other people in the environment factors into moral distress, because it forces the nurse to provide an unwanted intervention to protect a greater good. Imposing constraints on someone else's autonomy is contrary to the values that nurses are socialized to uphold and that tend to be internalized by people attracted to caring professions. Even when they are imposed for justifiable, virtuous, pragmatic, or practical reasons, the interventions required to address workplace violence are done to restore the salience of the patient's vulnerability, rebalancing the intersecting risks and threats, and reinstating the nurse's duty of care. Because the violence-related interventions that are within the nurse's power to implement are invasive and tend to compromise the patient's dignity, the nurse is left with a sense of having failed. However, addressing intersecting vulnerabilities can prevent violence and the moral distress that its interventions create. Prevention of violence precludes the moral distress associated with being unable to do what is felt to be morally right, by eliminating the need to make decisions between mutually exclusive options. System-level interventions can alleviate the need for these kinds of impossible choices.

Recommendations

The identification of vulnerability as key to decisions regarding workplace violence strongly implies that addressing vulnerability will reduce the incidence of violence and improve the risks of injury from aggression when it does occur in the nursing workplace. We can infer from this understanding of decisions that nurses face and the considerations that factor into those decisions that are captured by a calculation of salient vulnerabilities, that if we mediate the vulnerability of both nurses and patients, the

incidence and impact of violence, including injury and moral distress, will improve. The recommendations from this study follow from this inference.

As noted previously, vulnerability is a function of exposure, sensitivity, and capacity to adapt or accommodate to threats. It is important to note that there are limits to the ability of a nurse to control many of the factors that increase their sensitivity to harm. Sensitivities tend to be characteristics of the individual nurse; this is why two nurses in the same situation may experience different levels of vulnerability. The nurse's stature, physical strength and agility, or conditions such as pregnancy can make them more sensitive to the potential impact of violence. Nurses can take personal measures to maintain their physical and psychological fitness to practice, and to continually develop the personal knowledge (Carper, 1978) required to reduce their sensitivity to violence, but it is much more difficult to manage the exposure to threats inherent in the work environment and improve the capacity for responding to them effectively in the absence of structures that support the mitigation of risks and harms.

To reduce exposure to the threat of workplace violence, and improve the ability to respond when violence occurs, nursing must firstly be recognized by its members, employers, and society broadly, as a high-risk profession. This recognition would strengthen the justification for implementation of measures to equip nurses with the means to mitigate risks, and for the design of health and social systems that empower nurses to use their knowledge, skills, and abilities to the benefit of all. While the people who require nursing intervention are inherently vulnerable by virtue of their dependency, nurses are equally, but differently susceptible to harms from the relationships and procedures required to provide those interventions. A universal understanding of the risks inherent in nursing practice is a critical component in the process of addressing these vulnerabilities.

Indeed, this recognition of the dangers intrinsic to nursing practice offer solutions that, if implemented, will reduce the mutual vulnerabilities for nurse and patient, leading to a reduction in

violence and its impacts. This goal is achievable through staffing levels that recognize and reflect the high-risk nature of health care, training and equipment to respond to known and anticipated threats, working environments that are conducive to the safety of patients, visitors and nurses, and deliberate attention to practices that facilitate healing from the experiences and impacts of workplace violence. Interventions that support the inherent risks of nursing practice will improve all vulnerabilities, that is, the exposure, sensitivity, and adaptive capacity of both nurses and patients.

Table 5 is a summary of the recommendations issuing from this study. A short exploration of each follow.

Table 5

Recommendations

Nurse and patient vulnerabilities can be addressed by:
1. Ensuring adequate staffing
2. Providing training and equipment
3. Designing safe workspaces
4. Healing spaces and practices of support

Adequate Staffing

The first recommendation concerns the availability of human resources sufficient to meet patient needs without unreasonable compromises to the safety of nurses, patients, or others in the environment. Staffing ratios appropriate to this task would provide nurses with the contact time needed to engage in the kind of approach, assessment and intervention that permits them to recognize and act upon risks and meet patient needs with compassion and respect. Patient care improves when the nurse can meet needs at a pace that the patient dictates (Bayram et al., 2023). Things as simple as the ability to

conduct more frequent assessments, or providing information or pain medication quickly will prevent the suffering, uncertainty and fear that can prompt a violent outburst. Likewise, proceeding slowly when a patient has a history of trauma or requires time to process experiences may be necessary to maintain a peaceful encounter. However, the nurse needs to have the capacity to provide care in this optimal way, which is generally not possible in the context of short staffing and overcrowding. Adequate staffing means care can be tailored more effectively to meet the needs of the patient, rather than arranged to accommodate the nurse's severely limited capacity to meet the infinite demands for their attention. In this environment, the nurse is faced with fewer ethical dilemmas about the prioritization of care and the need to navigate multiple conflicting and mutually exclusive demands, resulting in better outcomes and less moral distress.

Training and Equipment

Recognition of the high risk nature of nursing practice also requires interventions to ensure nurses have the skills and tools necessary to manage intersecting vulnerabilities. Just as personal protective equipment and universal infection control precautions reduce the spread of communicable diseases, interventions such as education and training in gentle persuasive techniques, the recognition of salient vulnerabilities, and the implementation of safety equipment and resources that decrease the likelihood and potential impact of violence are needed. Like staffing, this is a responsibility of the employer, and by extension, the policy decisions that finance the health system. Knowledge and use of best practices while interacting with people who have health conditions associated with aggression is an individual responsibility that will enable patient-centered care and reduce violent outbursts, but this requires ongoing research and education. Attention to the particular vulnerabilities of each patient and each nurse will permit tailored interventions and protections that improve the effectiveness of care interventions, reduce violence, and eliminate moral uncertainty around how to manage when tensions

and conflict escalate. This would also give nurses a framework for discussing the moral conflicts they are experiencing and support greater understanding of what is behind different responses to threats of violence.

Training for supervisors is important as well, to ensure there is appropriate support available to nurses who have faced a traumatic or ethically challenging patient encounter. Cohesive teams and supportive leadership mitigate risks and permit recovery from difficult situations through debriefing, collegial support when it is necessary to hand over patient care to someone else, and the ability for nurses to take time away from the environment when needed. Equipment such as alarms, security cameras, and metal detectors will improve the ability to recognize and respond to escalating situations. Combined with appropriate staffing levels, this would improve the baseline risk level. Many events could be prevented if there was deliberate attention to ensuring nurses have the skills to do their work safely, and the tools they need to mitigate any remaining risk.

Well-Designed Workspaces

When violence, and the increased risk of injury from it can both be traced to the physical environment, it follows naturally that changes in the environment should improve outcomes. While it is unlikely that nurses will ever be completely free of the risk of violence and aggression, their exposure can be reduced by ensuring that workspaces are well-designed, with the safety and dignity of patients and staff in mind. Visibility, privacy, and the ability to meet people's needs for toileting, sleep and meaningful activity, quiet solitude, and social interaction are central to a patient-centered care environment that reduces risks to the people working and receiving health care services within it. The nurse's sensitivity to violence, that is, the magnitude of potential harm, and their capacity to overcome a threat can be moderated by ensuring the nurse has space to do work efficiently and safely, and the ability to move themselves, or their patient, into an environment that best meets needs at the time,

whether that is leaving an escalating situation, or providing a quiet place for a patient to recover from an event. The physical environment of care is crucial to its level of safety, and to reducing the incidence and magnitude of the violence that can arise within it.

Healing Spaces and Practices of Support

The fourth and final recommendation emerging from this research concerns the aftermath of decisions required to navigate workplace violence: establishing healing spaces that normalize and encourage practices of support for health care providers throughout the entire health care system. This recommendation recognizes the impact of trauma from the experience of violence, and, importantly, from the impossible choices it produces for people who are responsible for managing it. Prioritizing violent incident debriefing by individuals and teams is central to this recommendation.

People affected by any traumatic incident, whether it is the experience of violence, or the experience of facing a decision that ultimately results in moral compromise, require time and support for the physiological and emotional effects of the event to subside. Unfortunately, the nature of nursing work is such that there is always more that needs to be done, so as soon as a crisis is resolved, the nurse moves on to the next task. It is uncommon to take time to attend to the very real outcomes that eventually culminate in the physical, emotional, and spiritual sequelae of moral distress described by Rushton (2018). The result of this unprocessed trauma is moral residue, which impairs resilience and the ability to cope with even regular demands of nursing work, ultimately increasing the salience of the nurse's vulnerability.

Holding space for healing and practices of interpersonal support promotes the processing of challenging experiences through story-telling and story-listening. In fact, participants in this study repeatedly described a lack of support from supervisors and colleagues as compounding the injuries and insults of workplace violence. Debriefing is a shared experience that can help those who were impacted

– even peripherally – make sense of an event. Harking back to the very reasons I chose a story-telling method for this research, this transformation of subjective experiences into mutual understanding makes it possible to move forward from a difficult situation. The ability to talk through a decision, to see that others recognize and identify with the struggle, is invaluable. Vulnerability thus diffused results in individuals who are less sensitive to the impacts of moral challenges, and better able to adapt when moral conflict is present. In other words, sharing experiences ameliorates vulnerability.

To that end, my final recommendation is to normalize a robust and effective debriefing process after violence. Establishing healing spaces and prioritizing practices of support can rebalance vulnerabilities and promote resilience. Such acts of caring and respect will bolster the ability to bounce back from a difficult experience. It permits the identification of lessons learned with respect to how a decision unfolded, and how future incidents – of both violence itself, and the impossible choices that it generates – might be approached, or even prevented. Workplaces must prioritize the health and safety of their nurses in this way. Recognizing moral conflict as a universal experience with significant impacts makes space to head off negative consequences and reinforces those aspects of the experience that generate growth and healing. This is how we can move forward, and ensure that positive results can, indeed, come from these difficult experiences.

This section has outlined four recommendations that stem from Salient Vulnerability Theory and the recognition of nursing as inherently dangerous work. The recommendations, including safe staffing, training and equipment, well-designed workspaces, and space and supports for healing, are system-level interventions with the potential to significantly reduce the vulnerabilities of nurses and patients. They place the onus for addressing workplace violence beyond the remit of the nurse at the point of care. The problem of violence in the nursing workplace affects individuals most directly, but the responsibility for durable, upstream solutions falls on society. While the vulnerabilities that influence a decision about

whether to intervene in a dangerous or escalating situation are highly individualized, this theory places the contextuality of their impacts at the centre of solutions that can only be implemented through public policy decisions that recognize the costs of the problem and the moral responsibility that drives the need for systemic responses. Just as a patient is vulnerable to a nurse's choices and actions, nurses are vulnerable to societal priorities that fail to recognize and respond to the inherent dangers of the work they do. To meet these responsibilities, we need a health system that is built and funded to be capable of meeting patient needs without placing nurses at risk in the process.

The recommendations presented here, adequate staffing, training and equipment, well-designed workspaces, and space for healing and practices of support capture the essence of how the theory of salient vulnerability explains these fraught decisions. They recognize the inherently high-risk nature of health professions and place the onus for addressing the factors that multiply and mitigate risks on society, and on public policy decisions that support the reduction of the vulnerabilities of both nurse and patient. They offer practical ways to reduce violence, lessen its impact when it is unavoidable, and diminish the experience of moral distress when difficult patient care situations arise. Most importantly, these findings and recommendations have the potential to reduce the vulnerability of both patients and nurses through a positive impact on the exposure, sensitivity, and capacity to overcome threats, offering benefits to individuals and the health system as a whole.

Summary

This chapter has used participant narratives to demonstrate the application and implications of the proposed theory of salient vulnerability. In this study, I examined how the members of this fundamentally high-risk profession navigate the moral dilemmas that arise when they encounter workplace violence. I identified that decisions about whether and how to intervene with a patient who is aggressive or violent are based on an assessment of the intersecting vulnerabilities of patient and nurse

in that moment. When we understand how decisions are made, we can moderate the factors that contribute to the decision process. To that end, I offered four recommendations to address the problem of violence in the nursing workplace.

In the final chapter of this dissertation, I provide a few concluding words on positionality, limitations, applicability, and opportunities for further study.

Chapter Ten: Summary and Conclusion

The findings of this study support a theory of salient vulnerability for understanding how nurses navigate the moral dilemmas that arise when they encounter workplace violence. In the preceding chapters, I provided an overview of the problem of violence in the nursing workplace, reviewed the literature, and outlined the methodological foundations of this research. I described the methods used to conduct the study, summarized the findings, and proposed Salient Vulnerability Theory as the outcome of the work. The implications of the findings and proposed theory were described and discussed.

To conclude, I address the applications of this study for the profession and practice of nursing. I note the study's strengths, limitations, and opportunities for further research, and provide a final reflection on my positionality and its impact on the theoretical approach.

Applicability

Salient Vulnerability Theory fills in some of the knowledge gaps that exist regarding nurses' decision-making processes, which persist despite the vast literature on prevalence, incidence, antecedents and consequences of workplace violence. This theoretical approach may be applicable to various moral problems and challenges in the delivery of health care, including resource allocation, triage and wait list protocols, and the management of moral distress and moral residue. This knowledge may indeed support the development and maintenance of nurses' resilience to managing the dilemmas that arise in the context of the very intimate and emotional work they do.

The ubiquity of violence in health care contexts means this work has wide applicability. The theoretical approach can inform education for nurses and other health care professionals. Recommendations from the study include ensuring adequate staffing, training and equipment, well-designed workspaces, and spaces for healing and practices of support; the implementation of these recommendations has the potential to address the problem of workplace violence from a number of

angles. It can reduce the experience of ethical dilemmas related to the provision of care to someone who is aggressive by mitigating both the risk and impact of violence, and providing resources and supports for managing it when it happens. Furthermore, this work draws attention to the need to recognize nursing as an essential but dangerous occupation, and the resulting societal responsibility for mitigating its risks, providing a basis for policy decisions that address workplace violence in healthcare and other spheres.

Opportunities for Further Study

Opportunities for further study are significant, including the application of Salient Vulnerability Theory to other kinds of problems in the realm of bioethics. Further study on the ways to address vulnerabilities, including empirical investigation of the role of vulnerability in violence and its responses would be useful in informing and refining the theory. As well, development and validation of practical applications such as a screening tool to identify nurses and patients at risk could be very powerful in the prevention and management of workplace violence. This work may also have interest for other professions and disciplines. It would be useful to explore how, for example, physicians, social services workers, teachers, or law enforcement officers conceptualize vulnerability and apply it to their work, and whether policies relating to mitigating or managing violence in those kinds of workplaces make a difference to its incidence or the magnitude of its impacts, which could in turn inform nursing-related policy. Finally, it has implications for our understanding of how nurses make ethical decisions and could be applied across the spectrum of nursing practice, to all areas of the profession. Empirical testing of the study's recommendations, including development of a framework for incident debriefing will be important.

Reflections on Positionality

I have been a registered nurse for more than 20 years. I have been incredibly fortunate to have benefited from this profession and have tried to give back as much as I have received from it. I am grateful that my first-hand experience with workplace violence is minimal, but, as noted previously, my second-hand experience with the issue, having supported many nurses and health care teams through decisions related to patients whose care is challenged by aggression and violence, sparked a passion for the topic. As a nurse ethicist, I came to see this problem as an exemplar of the moral dilemmas that nurses manage every day. In nearly every patient encounter, nurses make decisions. Some are big, and some are almost inconsequential, but all require careful consideration and the application of personal and professional values to navigate. Unfortunately, those values are not always aligned, or even internally compatible. This is complicated by a health system whose funding and structures make the achievement of values-based goals all but impossible, resulting in moral challenges that are incredibly complex.

The opportunity to study the dilemma of workplace violence – the unbearable choice between fulfilling a duty to provide care and leaving the situation to preserve one's safety – was irresistible. The theoretical approach to the navigation of the moral challenges of violence that I have called Salient Vulnerability Theory accounts for the decisions that nurses make in these kinds of situations, and the considerations that factor when determining a course of action. It is my hope that the understanding this new framework offers will inform measures to prevent and mitigate workplace violence. My previous studies in public administration have also informed the recommendations that stem from this work: the recognition that the problem of violence against nurses is in its essence a structural one that requires societal intervention.

This project necessarily required the involvement of nurses with lived experience of workplace violence. The only way to gain a perspective on decision making is to hear from people who have made those kinds of decisions. It was such a privilege to receive these stories, some of which were highly emotional for both researcher and participant. It is my hope that the sharing of these stories can be part of participants' healing from the traumas they have experienced. I am profoundly grateful for their willingness to share their stories, and as I have learned from every single one, I have been moved by them as well. Although the research is mine, the results belong equally to those who shaped its development through their participation, and to those who will be impacted by its application in the future.

Of interest, my assumptions about the decision-making process and existence of moral distress as a result of the experience of workplace violence were not entirely borne out through the experience of conducting this study. While some participants described a specific thought process in deciding whether to stay or leave a contentious or volatile situation, many described simply going on instinct, and providing care despite considerable, clear and present risks. Unpacking these responses demonstrated to me that nurses instinctively recognize the asymmetry of vulnerabilities and consider it a professional and ethical obligation, a privilege even, to respond in ways that prioritize the health and safety of their patients. I know it is not the most popular notion, but I do truly view these people as heroes, and I am incredibly proud to count myself among them.

Strengths and Limitations

This study has a number of strengths worth mentioning here. The direct connection with people who have lived experience of the phenomenon in question provided an opportunity for authentic representation and mutual exploration of the topic, and co-creation of the conceptual approach. Likewise, the story-telling method employed in Phase 2 helped frame the emergent theory and provided

an engaging platform to explore this tragically prevalent and persistent issue. The overwhelming interest from prospective participants speaks to the urgent need for continued study of the issue of workplace violence. There remains much to be done in this area.

As an exploratory, grounded theory study, this work does have some limitations. Recruitment of participants was done via convenience sample, and therefore they were not representative of the entire target population. As such the experiences examined here are also not intended to be representative. I did not collect demographics on participants. In retrospect, I wish I had altered the design to collect information on age, gender, years in practice and practice area. Although these factors often emerged organically during the interview, it would have been interesting to look at connections between demographic categories and participants' responses to the challenging situations they described. A more formal way to document nursing designation may also have illuminated differences between the various professional classifications.

This study is but one small part of a massive topic, on which there are many opportunities for further research. While the methods used for recruitment and data collection clearly yielded a rich dataset, further studies may benefit from consideration of certain limitations. Firstly, I recognize the choice not to collect demographic information was a lost opportunity to examine possible connections and alignments more deeply between, for example, years of nursing experience or area of practice, and the tools and strategies available to the nurse in managing violent incidents. I focused on recruitment via channels that generated interest among Manitoba and Ontario nurses primarily; it is difficult to know if or how findings may have been affected had I received participants with a wider geographic representation. Having said that, there was so much interest in the study that I had to turn prospective participants away, so perhaps focusing on a more limited geographic area would have been a better way to refine the method for wider application in subsequent studies.

With respect to the ways in which I conducted interviews, the fact that most participants chose not to use a camera barred the use of nonverbal language to assess motivation for participating, and the credibility of their contribution. However, prioritization of participants' privacy and psychological safety is a priority in this type of research, which felt more important in the moment than any benefit I might derive from visualizing a participant. It was important that each participant provided their story in their own voice and requiring certain procedures such as the use of a camera, or requiring proof of licensure could have jeopardized the genuineness of the person's contribution. This was a choice to assume the person was who they said they were and had genuine reasons for participating in the study.

Finally, the sensitivity of the topic made iterative review of the theoretical development impractical. Given that some participants did not choose to complete the initial review and editing of their transcript, I chose not to survey participants on the thematic findings and analysis in any ongoing way. To that end, I took the corrected/approved transcript as the unit of analysis, without checking participants' impressions of my evolving interpretation of the dataset. While this may, for some, render this work less rigorous, I felt it consistent with the pragmatist underpinnings of constructivist grounded theory, and a reasonable exploratory study. Undertaking a similar study with a smaller group might permit to a greater degree the hallmark co-construction and iterative refinement of theory that comprises the constructivist grounded theory methodology.

Conclusions

This qualitative study has examined the problem of how nurses navigate the moral dilemmas that arise when they encounter workplace violence. Specifically, I looked at the ethical decisions nurse make, the considerations that factor into decisions about the course of action, and the experience of moral distress when workplace violence occurs. Using a constructivist grounded theory methodology, I identified three categories of ethical decisions that nurses consider: *Getting the Job Done (Stay), Shifting*

the Dynamic (Pause), and *Withdrawing from the Situation (Leave).* To determine a course of action, participants identified factors that multiply risks, such as factors related to the nurse, patient or environment, and factors that mitigate risks, including risk assessment, the availability of supports, and skills and tools. The experience of moral distress fell into four categories: *Choosing to Disengage, Living with Moral Residue, Witnessing Patient Impacts,* and *Working Under Structural Constraints*. This analysis resulted in the development of Salient Vulnerability Theory, a substantive theoretical framework for understanding how nurses navigate decisions about intervening in the context of violence. The theory proposes that patient vulnerability provides a moral obligation to provide care, however that obligation is limited by violence that places the nurse at risk. When this happens, the nurse's vulnerability becomes salient, and a decision to leave the situation can be justified until such a time as a balance is restored and the nurse can safely resume care. The theory has important implications for how we understand nurses' ethical decision-making processes, in this area, and more broadly, across the entire scope of the nursing profession. The recommendations that emerged from this new theory have the capacity to reduce the incidence and impact of violence and the resulting moral distress by addressing the problem at a societal level, and include ensuring adequate staffing, the implementation of effective training and equipment, well-designed workspaces, and spaces for healing and practices of support. Empirical confirmation of Salient Vulnerability Theory and the effectiveness of suggested interventions is recommended.

The problem of workplace violence has always affected nurses and is unlikely to ever be eliminated completely. However, this study is a step towards reducing the incidence and impact of violence for nurses. A world where stories like those offered by participants of this study do not occur is possible, and within reach. This study offers a path in that direction and hope for a more peaceful future.

References

Abdellah, R. F., & Salama, K. M. (2017). Prevalence and risk factors of workplace violence against health care workers in emergency department in Ismailia, Egypt. *The Pan African Medical Journal*, *26*(21), Article 21. https://doi.org/10.11604/pamj.2017.26.21.10837

Abozaid, D. A., Momen, M., Ezz, N. F. A. E., Ahmed, H. A., Al-Tehewy, M. M., El-Setouhy, M., El-Shinawi, M., Hirshon, J. M., & Houssinie, M. E. (2022). Patient and visitor aggression de-escalation training for nurses in a teaching hospital in Cairo, Egypt: BMC Nursing. *BMC Nursing*, *21*(1), 1–8. https://doi.org/10.1186/s12912-022-00828-y

Aivazi, A. A., Menati, W., Tavan, H., Navkhasi, S., & Mehrdadi, A. (2017). Patients' bill of rights and effective factors of workplace violence against female nurses on duty at Ilam teaching hospitals. *Journal of Injury & Violence Research*, *9*(1), 1–6. https://doi.org/10.5249/jivr.v9i1.779

Al-Ali, N. M., Al Faouri, I., & Al-Niarat, T. F. (2016). The impact of training program on nurses' attitudes toward workplace violence in Jordan. *Applied Nursing Research*, *30*, 83–89. https://doi.org/10.1016/j.apnr.2015.11.001

Al-Qadi, M. M. (2020). Nurses' perspectives of violence in emergency departments: A metasynthesis. *International Emergency Nursing*, *52*, 100905. https://doi.org/10.1016/j.ienj.2020.100905

Al-Qadi, M. M. (2021). Workplace violence in nursing: A concept analysis. *Journal of Occupational Health*, *63*(1). https://doi.org/10.1002/1348-9585.12226

Alsharari, A. F., Abu-Snieneh, H. M., Abuadas, F. H., Elsabagh, N. E., Althobaity, A., Alshammari, F. F., Alshmemri, M. S., Aroury, A. M., Alkhadam, A. Q., & Alatawi, S. S. (2021). Workplace violence towards emergency nurses: A cross-sectional multicenter study. *Australasian Emergency Care*. https://doi.org/10.1016/j.auec.2021.01.004

AlShehri, A. (2020). A systematic review of patient and family violent behaviour in Saudi Arabian emergency units. *International Journal of Nursing Education*, *12*(3), 66–71. https://doi.org/10.37506/ijone.v12i3.9724

Alzheimer's Society of Canada (2019, May). *Conversations about dementia and responsive behaviours.* https://alzheimer.ca/sites/default/files/documents/conversations_dementia-and-responsive-behaviours.pdf

Andersen, L. P., Elklit, A., & Pihl-Thingvad, J. (2021). Work-related violence and organizational commitment among health care workers: Does supervisor's support make a difference? *International Archives of Occupational and Environmental Health*, *94*(7), 1645–1657. https://doi.org/10.1007/s00420-021-01749-0

Armstrong, A. E. (2006). Towards a strong virtue ethics for nursing practice. *Nursing Philosophy*, *7*(3), 110–124. https://doi.org/10.1111/j.1466-769X.2006.00268.x

Arnold, T. C. (2020). Moral distress in emergency and critical care nurses: A metaethnography. *Nursing Ethics*, *27*(8), 1681–1693. https://doi.org/10.1177/0969733020935952

Asikainen, J., Vehviläinen-Julkunen, K., Repo-Tiihonen, E., & Louheranta, O. (2020). Violence factors and debriefing in psychiatric inpatient care: A review. *Journal of Psychosocial Nursing & Mental Health Services*, *58*(5), 39–49. https://doi.org/10.3928/02793695-20200306-01

Austin, C., Saylor, R., & Finley, P. (2017). Moral distress in physicians and nurses: Impact on professional quality of life and turnover. *Psychological Trauma: Theory, Research, Practice, and Policy*, *9*(4), 399–406. http://dx.doi.org/10.1037/tra0000201

Babiarczyk, B., Turbiarz, A., Tomagová, M., Zeleníková, R., Önler, E., & Sancho Cantus, D. (2020). Reporting of workplace violence towards nurses in 5 European countries—A cross-sectional study.

International Journal of Occupational Medicine and Environmental Health, *33*(3), 325–338. https://doi.org/10.13075/ijomeh.1896.01475

Başoğul, C., Arabacı, L. B., Büyükbayram, A., Aktaş, Y., & Uzunoğlu, G. (2019). Emotional intelligence and personality characteristics of psychiatric nurses and their situations of exposure to violence. *Perspectives in Psychiatric Care*, *55*(2), 255–261. https://doi.org/10.1111/ppc.12358

Bayram, A., Özsaban, A., & Torun Kiliç, Ç. (2023). Verbal violence and missed nursing care: A phenomenological study. *International Nursing Review*, *70*(4), 544–551. https://doi.org/10.1111/inr.12882

Beattie, J., Innes, K., Griffiths, D., & Morphet, J. (2018). Healthcare providers' neurobiological response to workplace violence perpetrated by consumers: Informing directions for staff well-being. *Applied Nursing Research*, *43*, 42–48. https://doi.org/10.1016/j.apnr.2018.06.019

Beattie, J., Innes, K., Griffiths, D., & Morphet, J. (2020). Workplace violence: Examination of the tensions between duty of care, worker safety, and zero tolerance. *Health Care Management Review*, *45*(3), E13–E22. https://doi.org/10.1097/HMR.0000000000000286

Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (Eighth edition.). Oxford University Press.

Bekelepi, N., & Martin, P. (2023). Self-reported incidents of violence towards nurses working in acute psychiatric units: Curationis. *Curationis*, *46*(1), 1–8. https://doi.org/10.4102/curationis.v46i1.2350

Benedetti, D. J., Lewis-Newby, M., Roberts, J. S., & Diekema, D. S. (2021). Pandemics and beyond: Considerations when personal risk and professional obligations converge. *Journal of Clinical Ethics*, *32*(1), 20–34.

Blanchard, M., Somme, D., Charras, K., & Corvol, A. (2022). Caregivers facing violence in long-term care setting: A cross analysis of incident reports and caregivers speech. *Journal of Nursing Management*, *30*(6), 1768–1776. https://doi.org/10.1111/jonm.13651

Blau, F. D., Koebe, J., & Meyerhofer, P. A. (2021). Who are the essential and frontline workers? *Business Economics*, *56*(3), 168–178. https://doi.org/10.1057/s11369-021-00230-7

Boateng, G. O., & Brown, K. K. (2022). "Go back to your country": Exploring nurses' experiences of workplace conflict involving patients and patients' family members in two Canadian cities. *Nursing Inquiry*, *29*(1), 1–12. https://doi.org/10.1111/nin.12444

Brophy, J., Keith, M., & Hurley, M. (2019). Breaking point: Violence against long-term care staff. *New Solutions: A Journal of Environmental and Occupational Health Policy*, *29*(1), 10–35. https://doi.org/10.1177/1048291118824872

Brophy, J. T., Keith, M. M., & Hurley, M. (2018). Assaulted and unheard: Violence against healthcare staff. *New Solutions: A Journal of Environmental and Occupational Health Policy*, *27*(4), 581–606. https://doi.org/10.1177/1048291117732301

Brune, S., Killam, L., & Camargo-Plazas, P. (2023). Caring knowledge as a strategy to mitigate violence against nurses: A discussion paper. *Issues in Mental Health Nursing*, *44*(5), 437–452. https://doi.org/10.1080/01612840.2023.2205502

Buitrago, J. (2023). Strategies to mitigate moral distress in oncology nursing. *Clinical Journal of Oncology Nursing*, *27*(1), 87–91. https://doi.org/10.1188/23.CJON.87-91

Burke Draucker, C. (2019). Responses of nurses and other healthcare workers to sexual harassment in the workplace. *Online Journal of Issues in Nursing*, *24*(1), 9–9. https://doi.org/10.3912/OJIN.Vol24No01Man03

Butler, J. (2004). *Precarious life: The powers of mourning and violence*. Verso.

Byon, H. D., Sagherian, K., Kim, Y., Lipscomb, J., Crandall, M., & Steege, L. (2021). Nurses' experience with Type II workplace violence and underreporting during the COVID-19 pandemic. *Workplace Health & Safety*, 21650799211031233. https://doi.org/10.1177/21650799211031233

Campbell, S. M., Ulrich, C. M., & Grady, C. (2016). A broader understanding of moral distress. *American Journal of Bioethics*, *16*(12), 2–9.

Canadian Institute for Health Information (2024, February) *The state of the health workforce in Canada, 2022.* Canadian Institute for Health Information. https://www.cihi.ca/en/the-state-of-the-health-workforce-in-canada-2022/supply-and-distribution

Canadian Nurses Association. (2017). *Code of ethics for registered nurses*.

Carper, B. A. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, *1*(1), 13–24.

Casey, B. (Ed.). (2019). *Violence facing health care workers in Canada: Report of the Standing Committee on Health*. House of Commons 42nd Parliament, 1st Session. www.ourcommons.com

Cetinkaya, F., Dur, N., Akbulut, Z., Eryalcin, O., & Korkmaz, M. (2018). Evaluation of the violence experienced by nurses of different generations and their strategies for coping with the stress resulting from violence. *International Journal of Caring Sciences*, *11*(3), 1756–1762.

Chaiwuth, Chawapornpan Chanprasit, Thanee Kaewthummanukul, Jantararat Chareosanti, Wichit Srisuphan, & Stone, T. E. (2020). Prevalence and risk factors of workplace violence among registered nurses in tertiary hospitals. *Pacific Rim International Journal of Nursing Research*, *24*(4), 538–552.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. SAGE.

Charmaz, K. (2017). The power of constructivist grounded theory for critical inquiry. *Qualitative Inquiry*, *23*(1), 34–45. https://doi.org/10.1177/1077800416657105

Charmaz, K. (2021). The genesis, grounds, and growth of constructivist grounded theory. In Morse et al., (Eds.), *Developing grounded theory: The second generation revisited* (2nd ed., pp. 153–187). Routledge. https://doi.org/10.4324/9781315169170-13

Charmaz, K., & Bryant, A. (2016). Constructing grounded theory analyses. In D. Silverman (Ed.), *Qualitative Research* (4th ed., pp. 347–362). Sage.

Choi, S.-Y., Kim, H., & Park, K.-H. (2022). Experience of violence and factors influencing response to violence among emergency nurses in South Korea: Perspectives on stress-coping theory. *Journal of Emergency Nursing*, *48*(1), 74–87. https://doi.org/10.1016/j.jen.2021.07.008

Clarke, K., & Leh, S. K. (2023). A nurse leader directed violence risk assessment on patient-to-nurse violence: A quality improvement project. *Nurse Leader*, *21*(6), 681–686. https://doi.org/10.1016/j.mnl.2023.05.004

Clifford, C., & Doody, O. (2018). Exploring nursing staff views of responsive behaviours of people with dementia in long-stay facilities. *Journal of Psychiatric and Mental Health Nursing*, *25*(1), 26–36. https://doi.org/10.1111/jpm.12436

College of Registered Nurses of Manitoba (2018, September). *Requisite skills and abilities.* Retrieved April 30, 2024 from https://www.crnm.mb.ca/wp-content/uploads/2022/01/Requisite-Skills-and-Abilities.pdf

College of Registered Nurses of Manitoba (2022, December). *Practice direction: Practice expectations for RNs.* Retrieved April 30, 2024 from https://www.crnm.mb.ca/wp-content/uploads/2022/01/RN-practice-expectations-FINAL.pdf

Cooke, S., Booth, R., & Jackson, K. (2022). Moral distress in critical care nursing practice: A concept analysis. *Nursing Forum*, *57*(6), 1478–1483. https://doi.org/10.1111/nuf.12786

Copeland, D., & Arnold, S. (2021). The moral dilemma of interpreting workplace violence. *Nursing Inquiry*, *28*(4), e12406. https://doi.org/10.1111/nin.12406

Corley, M. C., Minick, P., Elswick, R. K., & Jacobs, M. (2005). Nurse moral distress and ethical work environment. *Nursing Ethics*, *12*(4), 381–390. https://doi.org/10.1191/0969733005ne809oa

Crandall, J., Coatsworth-Puspoky, R., Schlegel, K., Beker, L., McLelland, V. C., & Martin, L. S. (2022). Implementing Gentle Persuasive Approaches dementia education for staff on in-patient medicine units: A program evaluation. *Dementia (London, England)*, *21*(4), 1173–1199. https://doi.org/10.1177/14713012211070148

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sage Publications.

Dal Pai, D., Saboia Sturbelle, I. C., dos Santos, C., Petri Tavares, J., & Lautert, L. (2018). Physical and psychological violence in the workplace of healthcare professionals. *Texto & Contexto Enfermagem*, *27*(1), 1–10. https://doi.org/10.1590/0104-07072018002420016

de Lima Trindade, L., Ribeiro, S. T., Argenta Zanatta, E., Vendurscolo, C., & Dal Pai, D. (2019). Verbal aggression in nursing work at the hospital. *Revista Eletronica de Enfermagem*, *21*, 1–8. https://doi.org/10.5216/ree.v21.54333

DiGangi Condon, K. A., Berger, J. T., & Shurpin, K. M. (2021). I've got the power: Nurses' moral distress and perceptions of empowerment. *American Journal of Critical Care*, *30*(6), 461–465. https://doi.org/10.4037/ajcc2021112

Dillon, S., & Craig, C. (2022). *Storylistening: Narrative evidence and public reasoning*. Routledge.

Dodek, P. M., Wong, H., Norena, M., Ayas, N., Reynolds, S. C., Keenan, S. P., Hamric, A., Rodney, P., Stewart, M., & Alden, L. (2016). Moral distress in intensive care unit professionals is associated

with profession, age, and years of experience. *Journal of Critical Care*, *31*(1), 178–182. https://doi.org/10.1016/j.jcrc.2015.10.011

Driver, J. (2022, June 27). Moral Theory. *The Stanford Encyclopedia of Philosophy (Fall 2022 Edition)*, Edward N. Zalta & Uri Nodelman (Eds.). https://plato.stanford.edu/archives/fall2022/entries/moral-theory/

Dunseth-Rosenbaum, T., Krueger, K., Spradlin, E., Hoffbauer, C., & Loper, P. (2023). Workplace violence in the hospital: strategies for meaningful change. *Journal of Emergency Nursing*, *49*(3), 345–351. https://doi.org/10.1016/j.jen.2023.01.005

Dunsford, J. (2021). Nursing violent patients: Vulnerability and the limits of the duty to provide care. *Nursing Inquiry*, e12453. https://doi.org/10.1111/nin.12453

East, L., Heaslip, V., & Jackson, D. (2020). The symbiotic relationship of vulnerability and resilience in nursing. *Contemporary Nurse*, *56*(1), 14–22. https://doi.org/10.1080/10376178.2019.1670709

Eche, I. J., Phillips, C. S., Alcindor, N., & Mazzola, E. (2023). A Systematic review and meta-analytic evaluation of moral distress in oncology nursing. *Cancer Nursing*, *46*(2), 128–142. https://doi.org/10.1097/NCC.0000000000001075

Edward, K., Stephenson, J., Ousey, K., Lui, S., Warelow, P., & Giandinoto, J.-A. (2016). A systematic review and meta-analysis of factors that relate to aggression perpetrated against nurses by patients/relatives or staff. *Journal of Clinical Nursing*, *25*(3–4), 289–299. https://doi.org/10.1111/jocn.13019

Epstein, E. G., Haizlip, J., Liaschenko, J., Zhao, D., Bennett, R., & Marshall, M. F. (2020). Moral distress, mattering, and secondary traumatic stress in provider burnout: A call for moral community. *AACN Advanced Critical Care*, *31*(2), 146–157. https://doi.org/10.4037/aacnacc2020285

Epstein, E. G., & Hamric, A. B. (2009). Moral distress, moral residue, and the crescendo effect. *The Journal of Clinical Ethics*, *20*(4), 330–342. https://doi.org/10.1086/JCE200920406

Escribano, R. B., Beneit, J., & Luis Garcia, J. (2019). Violence in the workplace: Some critical issues looking at the health sector. *Heliyon*, *5*(3), e01283–e01283. https://doi.org/10.1016/j.heliyon.2019.e01283

Esposito, C. L., & Contreras Sollazzo, L. (2021). A time-limited look at whether the New York State Felony D law or workplace violence programs mitigate violence against nurses in the healthcare setting. *Journal of the New York State Nurses Association*, *48*(1), 11–29.

Fareld, V. (2023). Vulnerability, violence and nonviolence. In S. Falke, V. Fareld & H. Meretoja (Eds.), *Interpreting Violence*. Routledge. (pp. 179-191).

Fineman, M. (2021). The vulnerable subject: Anchoring equality in the human condition. In F. Gordon & D. Newman (Eds.), *Leading Works in Law and Social Justice*. Taylor & Francis Group. (pp. 226-239). http://ebookcentral.proquest.com/lib/umanitoba/detail.action?docID=6461785

Foli, K. J. (2022). A middle-range theory of nurses' psychological trauma. *Advances in Nursing Science*, *45*(1), 86–98. https://doi.org/10.1097/ANS.0000000000000388

Ford, D. P., Myrden, S. E., & Kelloway, E. K. (2016). Workplace aggression targets' vulnerability factor: Job engagement. *International Journal of Workplace Health Management*, *9*(2), 202–220. https://doi.org/10.1108/IJWHM-11-2015-0065

Frank, A. W. (2010). Letting stories breathe: A socio-narratology. University of Chicago Press.

Freire, P. (2000). *Pedagogy of the oppressed 30th anniversary ed*. Continuum.

Fry, S. T. (1989). Toward a theory of nursing ethics. *Advances in Nursing Science*, *11*(4), 9–22. https://doi.org/10.1097/00012272-198907000-00005

Fujimoto, H., Greiner, C., Mukaihata, T., & Hashimoto, T. (2022). Associations between psychiatric home-visit nursing staff's exposure to violence and conditions of visit to community-living individuals with mental illness. *Japan Journal of Nursing Science*, *19*(4), e12485. https://doi.org/10.1111/jjns.12485

Fumis, R. R. L., Junqueira Amarante, G. A., de Fátima Nascimento, A., & Vieira Junior, J. M. (2017). Moral distress and its contribution to the development of burnout syndrome among critical care providers. *Annals of Intensive Care*, *7*(1), 71–71. https://doi.org/10.1186/s13613-017-0293-2

Funk, L., Spencer, D., & Herron, R. (2021). Making sense of violence and victimization in health care work: The emotional labour of 'not taking it personally.' International Review of Victimology, 27(1), 94–110. https://doi.org/10.1177/0269758020953760

Gabe, J., & Ann Elston, M. (2008). 'We don't have to take this': Zero tolerance of violence against health care workers in a time of insecurity. *Social Policy & Administration*, *42*(6), 691–709. https://doi.org/10.1111/j.1467-9515.2008.00632.x

Galtung, J. (1968). A structural theory of aggression. *Journal of Peace Research*, 95–119.

Galtung, Johan. (1996). *Peace by peaceful means: Peace and conflict, development and civilization*. SAGE Publications Ltd. http://uml.idm.oclc.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=e000xna&AN=309786&site=ehost-live

Galtung, J., & Fischer, D. (2013). *Johan Galtung* (Vol. 5). Springer Berlin Heidelberg. https://doi.org/10.1007/978-3-642-32481-9

Garren-Grubbs, T., & Hendrickx, L. (2023). Rural emergency department nurses' experiences with workplace violence. *Online Journal of Rural Nursing & Health Care*, *23*(2), 91–107. https://doi.org/10.14574/ojrnhc.v23i2.746

Gilson, E. (2014). *The Ethics of vulnerability: A feminist analysis of social life and practice*. Routledge. https://doi.org/10.4324/9780203078136

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Sociology Press.

Goodin, R. E. (1985). *Protecting the vulnerable: A reanalysis of our social responsibilities*. University of Chicago Press.

Hamric, A. B. (2014). A case study of moral distress. *Journal of Hospice & Palliative Nursing*, *16*(8), 457–463. https://doi.org/10.1097/NJH.0000000000000104

Hamric, A. B., Borchers, C. T., & Epstein, E. G. (2012). development and testing of an instrument to measure moral distress in healthcare professionals. *AJOB Primary Research*, *3*(2), 1–9. https://doi.org/10.1080/21507716.2011.652337

Han, C.-Y., Chen, L.-C., Lin, C.-C., Goopy, S., & Lee, H.-L. (2021). How emergency nurses develop resilience in the context of workplace violence: A grounded theory study. *Journal of Nursing Scholarship*, *53*(5), 533–541. https://doi.org/10.1111/jnu.12668

Hattingh, C., Nabasenja, C., Daniels, E. R., Kalondo, L., Karera, A., & Amkongo, M. (2019). Workplace violence involving radiographers at a state radiology department in Windhoek Namibia. *South African Radiographer*, *57*(1), 19–23. https://doi.org/10.10520/ejc-saradio-v57-n1-a4

Havaei, F., Adhami, N., Tang, X., Boamah, S. A., Kaulius, M., Gubskaya, E., & O'Donnell, K. (2023). Workplace predictors of violence against nurses using machine learning techniques: A cross-sectional study utilizing the national standard of psychological workplace health and safety. *Healthcare (Basel)*, *11*(7), 1008-. https://doi.org/10.3390/healthcare11071008

Havaei, F., Astivia, O. L. O., & MacPhee, M. (2020). The impact of workplace violence on medical-surgical nurses' health outcome: A moderated mediation model of work environment conditions and

burnout using secondary data. *International Journal of Nursing Studies*, *109*, 103666. https://doi.org/10.1016/j.ijnurstu.2020.103666

Havaei, F., & MacPhee, M. (2020). The impact of heavy nurse workload and patient/family complaints on workplace violence: An application of human factors framework. *Nursing Open*, *7*(3), 731–741. https://doi.org/10.1002/nop2.444

Havaei, F., & MacPhee, M. (2021). Effect of workplace violence and psychological stress responses on medical-surgical nurses' medication intake. *Canadian Journal of Nursing Research*, *53*(2), 134–144. https://doi.org/10.1177/0844562120903914

Heaslip, V., & Board, M. (2012). Does nurses' vulnerability affect their ability to care? *British Journal of Nursing (Mark Allen Publishing)*, *21*(15), 912–916. https://doi.org/10.12968/bjon.2012.21.15.912

Hiebert, B. J., Care, W. D., Udod, S. A., & Waddell, C. M. (2022). Psychiatric nurses' lived experiences of workplace violence in acute care psychiatric units in western Canada. *Issues in Mental Health Nursing*, *43*(2), 146–153. https://doi.org/10.1080/01612840.2021.1956656

Hollywood, L., & Phillips, K. E. (2020). Nurses' resilience levels and the effects of workplace violence on patient care. *Applied Nursing Research*, *54*, 151321. https://doi.org/10.1016/j.apnr.2020.151321

Hong, S., Kim, H., & Cha, M. (2022). Comparing workplace violence among nurses and other professionals using online articles: A social network analysis. *Journal of Nursing Management*, *30*(6), 1750–1758. https://doi.org/10.1111/jonm.13668

Howerton Child, R. J., & Sussman, E. J. (2017). Occupational disappointment: Why did I even become a nurse? *Journal of Emergency Nursing*, *43*(6), 545–552. https://doi.org/10.1016/j.jen.2017.06.004

Hsu, M.-C., Chou, M.-H., & Ouyang, W.-C. (2022). Dilemmas and repercussions of workplace violence against emergency nurses: A qualitative study. *International Journal of Environmental Research and Public Health*, *19*(5), Article 5. https://doi.org/10.3390/ijerph19052661

Iennaco, J. D., Molle, E., Allegra, M., Depukat, D., & Parkosewich, J. (2024). The aggressive incidents in medical settings (AIMS) study: Advancing measurement to promote prevention of workplace violence. *Joint Commission Journal on Quality & Patient Safety*, *50*(3), 166–176. https://doi.org/10.1016/j.jcjq.2023.11.005

Ishihara, I., Inagaki, S., Osawa, A., Umeda, S., Hanafusa, Y., Morita, S., & Maruyama, H. (2022). Effects of an ethics education program on nurses' moral efficacy in an acute health care facility. *Journal of Nursing Management*, *30*(7), 2207–2215. https://doi.org/10.1111/jonm.13579

Jameton, Andrew. (1984). *Nursing practice: The ethical issues*. Prentice-Hall.

Jones-Bonofiglio, Kristen. (2020). *Health Care Ethics through the Lens of Moral Distress* (1st ed. 2020.). Springer International Publishing.

Jussab, F., & Murphy, H. (2015). "I just can't, I am frightened for my safety, I don't know how to work with her": Practitioners' experiences of client violence and recommendations for future practice. *Professional Psychology, Research and Practice*, *46*(4), 287–297. https://doi.org/10.1037/pro0000035

Kellett, P. (2011). Narrative and the teaching practice of conflict analysis, transformation and peacebuilding. In *Critical issues in peace and conflict studies: Theory, practice, and pedagogy* (pp. 311–328). Lexington Books.

Kim, S., Buttrick, E., Bohannon, I., Fehr, R., Frans, E., & Shannon, S. E. (2016). Conflict narratives from the health care frontline: A conceptual model. *Conflict Resolution Quarterly*, *33*(3), 255–277. https://doi.org/10.1002/crq.21155

Kim, S. C., Quiban, C., Sloan, C., & Montejano, A. (2021). Predictors of poor mental health among nurses during COVID-19 pandemic. *Nursing Open*, *8*(2), 900–907. https://doi.org/10.1002/nop2.697

Kim, S., Mayer, C., & Jones, C. B. (2021). Relationships between nurses' experiences of workplace violence, emotional exhaustion and patient safety. *Journal of Research in Nursing*, *26*(1–2), 35–46. https://doi.org/10.1177/1744987120960200

Kiymaz, D., & Koç, Z. (2022). Workplace violence, occupational commitment and intention among emergency room nurses: A mixed-methods study. *Journal of Clinical Nursing*, *n/a*(n/a), 1–16. https://doi.org/10.1111/jocn.16331

Kleissl-Muir, S., Raymond, A., & Rahman, M. A. (2018). Incidence and factors associated with substance abuse and patient-related violence in the emergency department: A literature review. *Australasian Emergency Care*, *21*(4), 159–170. https://doi.org/10.1016/j.auec.2018.10.004

Kobayashi, Y., Oe, M., Ishida, T., Matsuoka, M., Chiba, H., & Uchimura, N. (2020). Workplace violence and its effects on burnout and secondary traumatic stress among mental healthcare nurses in Japan. *International Journal of Environmental Research and Public Health*, *17*(8), 2747. http://dx.doi.org.uml.idm.oclc.org/10.3390/ijerph17082747

Kołodziej, K., Lickiewicz, J., Jelonek, E., Mlocek, M., Murzyn, M., & Dudek, M. (2021). Psychiatric nurses' experiences of patient aggression. *Nursing in the 21st Century*, *20*(3), 160–167. https://doi.org/10.2478/pielxxiw-2021-0021

Konttila, J., Kähkönen, O., & Tuomikoski, A.-M. (2020). Nurses' experiences of workplace violence in psychiatric nursing: A qualitative review protocol. *JBI Evidence Synthesis*, *18*(9), 2025–2030. https://doi.org/10.11124/JBISRIR-D-19-00254

Küçükkelepçe, G. E., Özkan, T. K., & Beşirik, S. A. (2022). The relationship between moral distress levels and ethical climate perceptions of PICU nurses. *Journal of Nursing Management*, *30*(7), 2416–2423. https://doi.org/10.1111/jonm.13871

Kumari, A., Sarkar, S., Ranjan, P., Chopra, S., Kaur, T., Baitha, U., Chakrawarty, A., & Klanidhi, K. B. (2022). Interventions for workplace violence against health-care professionals: A systematic review: Work. *Work*, *73*(2), 415–427. https://doi.org/10.3233/WOR-210046

Kvas, A., & Seljak, J. (2014). Unreported workplace violence in nursing. *International Nursing Review*, *61*(3), 344–351. https://doi.org/10.1111/inr.12106

Kwak, Y., Han, Y., Song, J., & Kim, J. (2020). Impact of emotional labour and workplace violence on professional quality of life among clinical nurses. *International Journal of Nursing Practice (John Wiley & Sons, Inc.)*, *26*(1), N.PAG-N.PAG. https://doi.org/10.1111/ijn.12792

Lackey, S. A. (2020). The role of relationship-based care in developing empathy through vulnerability: Visual cues for conversation and change. *Creative Nursing*, *26*(4), e97–e101. https://doi.org/10.1891/CRNR-D-20-00008

Laeeque, S. H., Bilal, A., Hafeez, A., & Khan, Z. (2019). Violence breeds violence: Burnout as a mediator between patient violence and nurse violence. *International Journal of Occupational Safety and Ergonomics: JOSE*, *25*(4), 604–613. https://doi.org/10.1080/10803548.2018.1429079

Lantta, T., Anttila, M., Kontio, R., Adams, C. E., & Välimäki, M. (2016). Violent events, ward climate and ideas for violence prevention among nurses in psychiatric wards: A focus group study. *International Journal of Mental Health Systems*, *10*(1), 27. https://doi.org/10.1186/s13033-016-0059-5

Lauridsen, E. I., & Higginbottom, G. (2014). The roots and development of constructivist grounded theory. *Nurse Researcher*, *21*(5). https://doi.org/10.7748/nr.21.5.8.e1208

Li, L., Zhang, Q., Yang, H., & Undergraduate, S. L. (2022). Incidence and related influencing factors of workplace violence among psychiatric nurses in China: A systematic review and Meta-analysis. *Archives of Psychiatric Nursing*, *40*, 68–76. https://doi.org/10.1016/j.apnu.2022.04.005

Li, M., Liu, J., Zheng, J., Liu, K., Wang, J., Miner Ross, A., Liu, X., Fu, X., Tang, J., Chen, C., & You, L. (2020). The relationship of workplace violence and nurse outcomes: Gender difference study on a propensity score matched sample. *Journal of Advanced Nursing*, *76*(2), 600–610. https://doi.org/10.1111/jan.14268

Liaschenko, J., & Peter, E. (2016). Fostering nurses' moral agency and moral identity: The importance of moral community. *Hastings Center Report*, *46*(S1), S18–S21. https://doi.org/10.1002/hast.626

Lim, Z. Y., Idris, D. R., Abdullah, H. M. A. L., & Omar, H. R. (2023). Violence toward staff in the inpatient psychiatric setting: Nurses' perspectives: A qualitative study: Archives of Psychiatric Nursing. *Archives of Psychiatric Nursing*, *46*, 83–90. https://doi.org/10.1016/j.apnu.2023.08.008

Lindsay, G. M., & Schwind, J. K. (2016). Narrative inquiry: Experience matters. *Canadian Journal of Nursing Research*, *48*(1), 14–20. https://doi.org/10.1177/0844562116652230

Liu, J., Gan, Y., Jiang, H., Li, L., Dwyer, R., Lu, K., Yan, S., Sampson, O., Xu, H., Wang, C., Zhu, Y., Chang, Y., Yang, Y., Yang, T., Chen, Y., Song, F., & Lu, Z. (2019). Prevalence of workplace violence against healthcare workers: A systematic review and meta-analysis. *Occupational and Environmental Medicine*, *76*(12), 927–937. https://doi.org/10.1136/oemed-2019-105849

Liu, Y., Wang, X., Wang, Z., Zhang, Y., & Jin, J. (2023). Ethical conflict in nursing: A concept analysis. *Journal of Clinical Nursing*, *32*(15–16), 4408–4418. https://doi.org/10.1111/jocn.16563

Luna, F. (2009). Elucidating the concept of vulnerability: Layers not labels. *International Journal of Feminist Approaches to Bioethics*, *2*(1), 121–139. https://doi.org/10.3138/ijfab.2.1.121

Luna, F. (2019). Identifying and evaluating layers of vulnerability - a way forward. *Developing World Bioethics*, *19*(2), 86–95. https://doi.org/10.1111/dewb.12206

Magnavita, N., Heponiemi, T., & Chirico, F. (2020). Workplace violence is associated with impaired work functioning in nurses: An Italian cross-sectional study. *Journal of Nursing Scholarship*, *52*(3), 281–291. https://doi.org/10.1111/jnu.12549

McDougall, R. J., Gillam, L., Ko, D., Holmes, I., & Delany, C. (2020). Balancing health worker well-being and duty to care: An ethical approach to staff safety in COVID-19 and beyond. *Journal of Medical Ethics*, medethics-2020-106557. https://doi.org/10.1136/medethics-2020-106557

Mento, C., Silvestri, M. C., Bruno, A., Muscatello, M. R. A., Cedro, C., Pandolfo, G., & Zoccali, R. A. (2020). Workplace violence against healthcare professionals: A systematic review. *Aggression and Violent Behaviour*, *51*, 101381. https://doi.org/10.1016/j.avb.2020.101381

Mergen, M., & Akpınar, A. (2021). Vulnerability: An integrative bioethics review and a proposed taxonomy. *Nursing Ethics*, *28*(5), 750–765. https://doi.org/10.1177/0969733020976180

Merriam-Webster (n.d.a). Violence. In *Merriam-Webster.com dictionary.* Retrieved April 30, 2024 from https://www.merriam-webster.com/dictionary/violence

Merriam-Webster (n.d.a). Vulnerability. In *Merriam-Webster.com dictionary.* Retrieved April 30, 2024 from https://www.merriam-webster.com/dictionary/vulnerability

Mewborn, E. K., Fingerhood, M. L., Johanson, L., & Hughes, V. (2023). Examining moral injury in clinical practice: A narrative literature review. *Nursing Ethics*, *30*(7–8), 960–974. https://doi.org/10.1177/09697330231164762

Midtbust, M. H., Gjengedal, E., & Alnes, R. E. (2022). Moral distress - a threat to dementia care? A qualitative study of nursing staff members' experiences in long-term care facilities. *BMC Health Services Research*, *22*(1), 290. https://doi.org/10.1186/s12913-022-07695-y

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods*, *5*(1), 25–35.

Mills, S. (2004). *Discourse*. Taylor and Francis.

Mitchell, G. (2022, July 21). Global increase in violence against nurses since pandemic. *Nursing Times*. https://www.nursingtimes.net/news/coronavirus/global-increase-in-violence-against-nurses-since-pandemic-21-07-2022/

Morley, G., Bradbury-Jones, C., & Ives, J. (2020). What is 'moral distress' in nursing? A feminist empirical bioethics study. *Nursing Ethics*, *27*(5), 1297–1314. https://doi.org/10.1177/0969733019874492

Morley, G., Bradbury-Jones, C., & Ives, J. (2022). The moral distress model: An empirically informed guide for moral distress interventions. *Journal of Clinical Nursing*, *31*(9–10), 1309–1326. https://doi.org/10.1111/jocn.15988

Morley, G., & Sankary, L. R. (2024). Re-examining the relationship between moral distress and moral agency in nursing. *Nursing Philosophy*, *25*(1), e12419. https://doi.org/10.1111/nup.12419

Morphet, J., Griffiths, D., Beattie, J., Velasquez Reyes, D., & Innes, K. (2018). Prevention and management of occupational violence and aggression in healthcare: A scoping review. *Collegian*, *25*(6), 621–632. https://doi.org/10.1016/j.colegn.2018.04.003

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, *1*(2), 13–22. https://doi.org/10.1177/160940690200100202

Moverley, D., Park, T., & Montgomery, C. (2023). Debriefing and reflective interventions to address moral distress: A narrative review. *Canadian Journal of Critical Care Nursing*, *34*(1), 7–14. https://doi.org/10.5737/23688653-3417

Najafi, F., Fallahi-Khoshknab, M., Ahmadi, F., Dalvandi, A., & Rahgozar, M. (2018). Antecedents and consequences of workplace violence against nurses: A qualitative study. *Journal of Clinical Nursing*, *27*(1–2), e116–e128. https://doi.org/10.1111/jocn.13884

Naseem, M., Feroz, A. S., Arshad, H., Ashraf, S., Asim, M., Jamali, S., & Mian, A. (2022). Perceptions, challenges and experiences of frontline healthcare providers in Emergency Departments regarding Workplace Violence during the COVID-19 pandemic: A protocol for an exploratory qualitative study from an LMIC. *BMJ Open*, *12*(2), e055788. https://doi.org/10.1136/bmjopen-2021-055788

Nelson, S., & Baumann, A. (2021). Not part of the job: An analysis of characterizations of workplace violence against nurses in Canada by unions and professional associations. *Nursing Leadership (1910-622X)*, *34*(1), 45–59. https://doi.org/10.12927/cjnl.2021.26455

Nelson, S., Leslie, K., McCormick, A., Gonsalves, J., Baumann, A., Thiessen, N. J., & Schiller, C. (2023). Workplace violence against nurses in Canada: A legal analysis. *Policy, Politics, & Nursing Practice*, *24*(4), 239–254. https://doi.org/10.1177/15271544231182583

Nowrouzi-Kia, B., Isidro, R., Chai, E., Usuba, K., & Chen, A. (2019). Antecedent factors in different types of workplace violence against nurses: A systematic review. *Aggression & Violent Behaviour*, *44*, 1–7. https://doi.org/10.1016/j.avb.2018.11.002

Pariona-Cabrera, P., Cavanagh, J., & Bartram, T. (2020). Workplace violence against nurses in health care and the role of human resource management: A systematic review of the literature. *Journal of Advanced Nursing*, *76*(7), 1581–1593. https://doi.org/10.1111/jan.14352

Park, J. E., & Song, M. R. (2023). Effects of emergency nurses' experiences of violence, resilience, and nursing work environment on turnover intention: A cross-sectional survey. *Journal of Emergency Nursing*, *49*(3), 461–469. https://doi.org/10.1016/j.jen.2022.10.001

Petersen, J., & Melzer, M. (2023). Predictors and consequences of moral distress in home-care nursing: A cross-sectional survey. *Nursing Ethics*, *30*(7–8), 1199–1216. https://doi.org/10.1177/09697330231164761

Pilkington, B., & Giuliante, M. (2023). Nursing ethics as a distinct entity within bioethics: Implications for clinical ethics practice. *Nursing Ethics*, *30*(5), 671–679. https://doi.org/10.1177/09697330231174535

Powell, J. L. (2013). *Symbolic Interactionism*. Nova Science Publishers, Inc. http://uml.idm.oclc.org/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=e000xna&AN=635065&site=ehost-live

Powell, N., Ford, L., Rochinski, D., & McEvoy, V. (2023). The lived experience of workplace violence among emergency nurses. *Journal of Emergency Nursing*, *49*(3), 425–430. https://doi.org/10.1016/j.jen.2022.11.004

Quinn, J. M., & Koopman, J. M. (2023). Violence risk assessment in the emergency department. *Journal of Emergency Nursing*, *49*(3), 352-359.e1. https://doi.org/10.1016/j.jen.2023.02.006

Rajabi, F., Jahangiri, M., Bagherifard, F., Banaee, S., & Farhadi, P. (2020). Strategies for controlling violence against health care workers: Application of fuzzy analytical hierarchy process and fuzzy additive ratio assessment. *Journal of Nursing Management*, *28*(4), 777–786. https://doi.org/10.1111/jonm.12989

Recsky, C., Moynihan, M., Maranghi, G., Smith, O. M., PausJenssen, E., Sanon, P.-N., Provost, S. M., & Hamilton, C. B. (2023). Evidence-based approaches to mitigate workplace violence from patients and visitors in emergency departments: A rapid review. *Journal of Emergency Nursing*, *49*(4), 586–610. https://doi.org/10.1016/j.jen.2023.03.002

Rees, C., Wirihana, L., Eley, R., Ossieran-Moisson, R., & Hegney, D. (2018). The effects of occupational violence on the well-being and resilience of nurses. *The Journal of Nursing Administration*, *48*(9), 452–458. https://doi.org/10.1097/NNA.0000000000000648

Reichert, C. (2017). *Enough is enough: Putting a stop to violence in the health care sector*. http://www.deslibris.ca/ID/10092376

Reimer, L. E., Schmitz, C. L., Janke, E., Askerov, A., Strahl, barbara T., & Matyók, T. G. (2015). *Transformative change: An introduction to peace and conflict studies*. Lexington Books. http://uml.idm.oclc.org/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=1059954&site=ehost-live

Rushton, C. H. (2018). *Moral resilience: Transforming moral suffering in healthcare*. Oxford University Press.

Saleem, Z., Shenbei, Z., & Hanif, A. M. (2020). Workplace violence and employee engagement: The mediating role of work environment and organizational culture. *SAGE Open*, *10*(2), 215824402093588-. https://doi.org/10.1177/2158244020935885

Samuels, S. K., Hunt, S., & Tezra, J. (2018). Patient violence against healthcare workers. *Journal of Business and Behavioural Sciences*, *30*(2), 127–138.

Sanderson, C., Sheahan, L., Kochovska, S., Luckett, T., Parker, D., Butow, P., & Agar, M. (2019). Re-defining moral distress: A systematic review and critical re-appraisal of the argument-based bioethics literature. *Clinical Ethics*, *14*(4), 195–210. https://doi.org/10.1177/1477750919886088

Sarro, E. L., Haviland, K., Chow, K., Sequeira, S., McEachen, M. E., King, K., Aho, L., Coyle, N., Zhang, H., Lynch, K. A., Voigt, L., & McCabe, M. S. (2022). PASTRY: A nursing-developed quality improvement initiative to combat moral distress. *Nursing Ethics*, *29*(4), 1066–1077. https://doi.org/10.1177/09697330211062984

Sato, K., Yumoto, Y., & Fukahori, H. (2016). How nurse managers in Japanese hospital wards manage patient violence toward their staff. *Journal of Nursing Management*, *24*(2), 164–173. https://doi.org/10.1111/jonm.12281

Schlup, N., Gehri, B., & Simon, M. (2021). Prevalence and severity of verbal, physical, and sexual inpatient violence against nurses in Swiss psychiatric hospitals and associated nurse-related characteristics: Cross-sectional multicentre study. *International Journal of Mental Health Nursing*. https://doi.org/10.1111/inm.12905

Searby, A., Snipe, J., & Maude, P. (2019). Aggression management training in undergraduate nursing students: A scoping review. *Issues in Mental Health Nursing*, *40*(6), 503–510. https://doi.org/10.1080/01612840.2019.1565874

Sellman, D. (2005). Towards an understanding of nursing as a response to human vulnerability. *Nursing Philosophy*, *6*(1), 2–10. https://doi.org/10.1111/j.1466-769X.2004.00202.x

Senehi, J. (2002). Constructive storytelling: A peace process. *Peace and Conflict Studies*, *9*(2), 41–63. https://doi.org/10.46743/1082-7307/2002.1026

Senehi, J. (2020). Theory-building in peace and conflict studies: The storytelling methodology. In *Routledge Companion to Peace and Conflict Studies* (pp. 45–56). Routledge. https://search.lib.umanitoba.ca/permalink/01UMB_INST/1p55dqn/alma99149526541801651

Senz, A., Ilarda, E., Klim, S., & Kelly, A. (2021). Development, implementation and evaluation of a process to recognise and reduce aggression and violence in an Australian emergency department. *Emergency Medicine Australasia*, *33*(4), 665–671. https://doi.org/10.1111/1742-6723.13702

Serpe, R. T., Stryker, R., & Powell, B. (2020). *Identity and symbolic interaction: Deepening foundations, building bridges*. Springer.

Shea, T., Cooper, B., De Cieri, H., Sheehan, C., Donohue, R., & Lindsay, S. (2018). Postincident support for healthcare workers experiencing occupational violence and aggression. *Journal of Nursing Scholarship: An Official Publication of Sigma Theta Tau International Honor Society of Nursing*, *50*(4), 344–352. https://doi.org/10.1111/jnu.12391

Shea, T., Sheehan, C., Donohue, R., Cooper, B., & Cieri, H. D. (2017). Occupational violence and aggression experienced by nursing and caring professionals. *Journal of Nursing Scholarship*, *49*(2), 236–243. https://doi.org/10.1111/jnu.12272

Shi-Hong Zhao, Yu Shi, Zhi-Nan Sun, Feng-Zhe Xie, Jing-Hui Wang, Shu-E Zhang, Tian-Yu Gou, Xuan-Ye Han, Tao Sun, & Li-Hua Fan. (2018). Impact of workplace violence against nurses' thriving at work, job satisfaction and turnover intention: A cross-sectional study. *Journal of the Association of Occupational Health Professionals in Healthcare*, *38*(3), 15–24.

Shu-Fen Niu, Tso-Ying Lee, Jui-Chen Tsai, Shih-Chun Hsing, Shu-Ching Wu, & Ching-Chiu Kao. (2018). Workplace Violence Against Nurses in Northern Taiwan: A Cross-Sectional Study. *Journal of Nursing*, *65*(6), 44–54. https://doi.org/10.6224/JN.201812_65(6).07

Sim, I. O., Ahn, K. M., & Hwang, E. J. (2020). Experiences of psychiatric nurses who care for patients with physical and psychological violence: A phenomenological study. *International Journal of Environmental Research and Public Health*, *17*(14), 5159. http://dx.doi.org.uml.idm.oclc.org/10.3390/ijerph17145159

Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondejewski, J., & Smith-MacDonald, L. (2017). Compassion fatigue: A meta-narrative review of the healthcare literature. *International Journal of Nursing Studies*, *69*, 9–24. https://doi.org/10.1016/j.ijnurstu.2017.01.003

Sinh Minh Do, Anh Thi Lan Mai, & Mai Thi Thuy Vu. (2023). Workplace violence among nurses in public hospitals in Vietnam: A cross-sectional study. *Pacific Rim International Journal of Nursing Research*, *27*(3), 617–632. https://doi.org/10.60099/prijnr.2023.262238

Somes, J. (2023). Agitated geriatric patients and violence in the workplace. *Journal of Emergency Nursing*, *49*(3), 320–325. https://doi.org/10.1016/j.jen.2022.12.009

Song, C., Wang, G., & Wu, H. (2021). Frequency and barriers of reporting workplace violence in nurses: An online survey in China. *International Journal of Nursing Sciences*, *8*(1), 65–70. https://doi.org/10.1016/j.ijnss.2020.11.006

Spector-Mersel, G. (2010). Narrative research: Time for a paradigm. *Narrative Inquiry*, *20*(1), 204–224. https://doi.org/10.1075/ni.20.1.10spe

Spelten, E., Brodie, T., O'Meara, P., Vuuren, J. van, & McGillion, A. (2020). Violence against emergency department nurses: Can we identify the perpetrators? *PLoS One*, *15*(4), e0230793. http://dx.doi.org.uml.idm.oclc.org/10.1371/journal.pone.0230793

Spelten, E., Thomas, B., O'Meara, P. F., Maguire, B. J., FitzGerald, D., & Begg, S. J. (2017). Organisational interventions for preventing and minimising aggression directed toward healthcare workers by patients and patient advocates. *Cochrane Database of Systematic Reviews*, *5*. https://doi.org/10.1002/14651858.CD012662

Spelten, E., van Vuuren, J., O'Meara, P., Thomas, B., Grenier, M., Ferron, R., Helmer, J., & Agarwal, G. (2022). Workplace violence against emergency health care workers: What Strategies do Workers use? *BMC Emergency Medicine*, *22*(1), 78. https://doi.org/10.1186/s12873-022-00621-9

Spencer, C., Sitarz, J., Fouse, J., & DeSanto, K. (2023). Nurses' rationale for underreporting of patient and visitor perpetrated workplace violence: A systematic review. *BMC Nursing*, *22*(1), 1–11. https://doi.org/10.1186/s12912-023-01226-8

Spiers, J. (2000). New perspectives on vulnerability using emic and etic approaches. *Journal of Advanced Nursing*, *31*(3), 715–721. https://doi.org/10.1046/j.1365-2648.2000.01328.x

Stevenson, K. N., Jack, S. M., O'Mara, L., & LeGris, J. (2015). Registered nurses' experiences of patient violence on acute care psychiatric inpatient units: An interpretive descriptive study. *BMC Nursing*, *14*(1), 1–13. https://doi.org/10.1186/s12912-015-0079-5

Suurmond, J. M. (2005). *Our walk and talk: Discourse analysis and conflict studies*. Clingendael Institute. http://www.jstor.org/stable/resrep05425.3

Tarzian, A. J., & Marco, C. A. (2008). Responding to abusive patients: A primer for ethics committee members. *HEC Forum*, *20*(2), 127–136. http://dx.doi.org.uml.idm.oclc.org/10.1007/s10730-008-9066-5

ten Have, H. (2016). *Vulnerability: Challenging bioethics*. Routledge. https://doi.org/10.4324/9781315624068

Thomas, B., McGillion, A., Edvardsson, K., O'Meara, P., Van Vuuren, J., & Spelten, E. (2021). Barriers, enablers, and opportunities for organisational follow-up of workplace violence from the perspective of emergency department nurses: A qualitative study. *BMC Emergency Medicine*, *21*(1), 19–19. https://doi.org/10.1186/s12873-021-00413-7

Thomas, T. A., & McCullough, L. B. (2015). A philosophical taxonomy of ethically significant moral distress. *Journal of Medicine & Philosophy*, *40*(1), 102–120. https://doi.org/10.1093/jmp/jhu048

Thorup, C. B., Rundqvist, E., Roberts, C., & Delmar, C. (2012). Care as a matter of courage: Vulnerability, suffering and ethical formation in nursing care. *Scandinavian Journal of Caring Sciences*, *26*(3), 427–435. https://doi.org/10.1111/j.1471-6712.2011.00944.x

Tiihonen K, Vehvilainen-Julkunen K, Nikkonen M, & Vuorio O. (2009). Prevalence and influence of violence in forensic psychiatric care. *Nursing Evidence / Tutkiva Hoitotyo*, *7*(1), 4–10.

Tilley, L., Mistretta, J., Barrett, C., & Billingsley, L. (2023). Workplace violence in health care: Utilization of protection, prevention, and planning strategies. *Journal of Radiology Nursing*, *42*(2), 186–190. https://doi.org/10.1016/j.jradnu.2023.02.010

Timmins, F., Catania, G., Zanini, M., Ottonello, G., Napolitano, F., Musio, M. E., Aleo, G., Sasso, L., & Bagnasco, A. (2021). Nursing management of emergency department violence—Can we do more? *Journal of Clinical Nursing*. https://doi.org/10.1111/jocn.16211

Tronto, J. C. (1993). *Moral boundaries: A political argument for an ethic of care*. Routledge.

Varcoe, C., Doane, G., Pauly, B., Rodney, P., Storch, J. L., Mahoney, K., McPherson, G., Brown, H., & Starzomski, R. (2004). Ethical practice in nursing: Working the in-betweens. *Journal of Advanced Nursing*, *45*(3), 316–325. https://doi.org/10.1046/j.1365-2648.2003.02892.x

Varcoe, C., Pauly, B., Webster, G., & Storch, J. (2012). Moral distress: Tensions as springboards for action. *HEC Forum*, *24*(1), 51–62. https://doi.org/10.1007/s10730-012-9180-2

Victor, E., Luna, F., Guidry-Grimes, L., & Reiheld, A. (2022). Vulnerability in practice: Peeling back the layers, avoiding triggers, and preventing cascading effects. *Bioethics*, *36*(5), 587–596. https://doi.org/10.1111/bioe.13023

Vidal-Martí, C. (2021). Incidence of type II workplace violence in Catalan nursing homes: Work. *Work*, *68*(4), 1203–1210. https://doi.org/10.3233/WOR-213449

Walker, M. U. (1989). Moral understandings: Alternative "epistemology" for a feminist ethics. *Hypatia*, *4*(2), 15–28.

Walsh, J. P. (2018). Care, commitment and moral distress. *Ethical Theory and Moral Practice*, *21*(3), 615–628. https://doi.org/10.1007/s10677-018-9911-9

Webster, G., & Baylis, F. (2000). Moral Residue. In S. B. Rubin & L. Zoloth (Eds.), *Margin of Error: The Ethics of Mistakes in the Practice of Medicine* (pp. 217–229). University Pub. Group.

Wei, C.-Y., Chiu, S.-T., Chien, L.-Y., & Huang, N. (2016). Workplace violence against nurses – Prevalence and association with hospital organizational characteristics and health-promotion efforts: Cross-

sectional study. *International Journal of Nursing Studies*, *56*(April 2016), 63–70. https://doi.org/10.1016/j.ijnurstu.2015.12.012

Wilkinson, J. M. (1987). Moral distress in nursing practice: Experience and effect. *Nursing Forum*, *23*(1), 16–29. https://doi.org/10.1111/j.1744-6198.1987.tb00794.x

Wirth, T., Peters, C., Nienhaus, A., & Schablon, A. (2021). Interventions for workplace violence prevention in emergency departments: A systematic review. *International Journal of Environmental Research and Public Health*, *18*(16), Article 16. https://doi.org/10.3390/ijerph18168459

Woo, S., Choi, H., & Shin, S. (2024). Effects of workplace violence on emotional distress. *Journal of Psychosocial Nursing & Mental Health Services*, *62*(4), 24–32. https://doi.org/10.3928/02793695-20230919-04

World Health Organization. (2020). *State of the world's nursing report 2020: Investing in education, jobs and leadership*. https://www.who.int/publications-detail-redirect/9789240003279

Zaczyk, I., Młocek, M., Wilczek-Rużyczka, E., & Kwak, M. (2018). Patient aggression on inpatient psychiatric wards and professional burnout among nurses. *Polish Nursing / Pielegniarstwo Polskie*, *70*(4), 339–345. https://doi.org/10.20883/pielpol.2018.41

Zeng, L., Zhang, X., Wang, F., Yun, J., Lai, L., Jin, M., Liu, G., Qiu, Y., & Wang, J. (2022). Prevalence and influencing factors of posttraumatic growth among nurses suffering from workplace violence: A cross-sectional study. *International Journal of Mental Health Nursing*. https://doi.org/10.1111/inm.12984

Zeydi, A., Ghazanfari, M. J., Suhonen, R., Adib-Hajbaghery, M., & Karkhah, S. (2022). Effective interventions for reducing moral distress in critical care nurses. *Nursing Ethics*, *29*(4), 1047–1065. https://doi.org/10.1177/09697330211062982

Appendixes

Appendix 1: Study Information Document

Peace and Conflict Studies
Graduate Programs

252 St. Paul's College
70 Dysart Road, University of Manitoba
Winnipeg, MB R3T 2N2 Canada
Phone: 204.474-8894 Fax: 204.474.8828

Nurses' Experience of Violence in the Workplace

An Invitation to Participate in a Research Study

Are you a nurse who has experienced violence in your workplace?

Would you be willing to share your experiences in a research project?

Principal Investigator: Jennifer Dunsford, RN, MN, MPA email dunsforj@myumanitoba.ca

Research Supervisor: Dr. Jessica Senehi Jessica.senehi@umanitoba.ca

You are being invited to participate in a research study being conducted as part of the principal investigator's PhD dissertation. Phase 1 involves participating in an individual interview and, if you choose, Phase 2 will involve the development of a narrative or story based on your experience. Please take your time to review this information and discuss any questions you may have with the investigator, your friends, or family before you make your decision.

Purpose of this Study

This project is examining the factors and processes nurses use to decide whether and how to provide care when they encounter violence at work.

Participants Selection

To be eligible to participate in this study, you must be a nurse working in Canada who has experienced workplace violence, and who is willing to be interviewed about their experience. 20-30 participants will be asked to participate.

Study Methods

This multi-phase study. The first phase will be conducted through individual interviews. Once you have completed this phase of the study, you will also be invited to an optional, second phase to develop an experience with workplace violence into a written narrative. This will permit deeper exploration of the themes identified in the interview data.

Study procedures

- The method of data collection for the first phase will be an individual interview.

- The interview will take approximately 60 minutes. In-person sessions will be audio recorded using the built-in recording app on the investigator's password-protected University-supplied laptop and then transcribed using a software application nVivo to ensure accurate reporting of the information that you provide. You will be invited to review and correct the transcript. If you do not wish to be recorded, the investigator will take notes.

- The interview will be conducted by the researcher either in person at a time and location that is convenient for you, or via a secure virtual platform such as MS Teams or Zoom. Participants outside of Winnipeg will be interviewed virtually. You will be welcome to take any measures to ensure you feel comfortable during the interview, including using a pseudonym and leaving your camera off (if virtual).

- You will be asked some questions relating to your nursing career and a time when you experienced abuse, aggression, or violence at work. Your story will help us understand how nurses make decisions about whether to stay in or withdraw from situations where violence is possible or happening.

- After the interview, the researcher will make notes in a reflective journal, stored in a secure electronic file in the investigator's University OneDrive account, to be reviewed during the analysis and writing phases. No identifying information will be included in this journal.

- Virtual interviews will be conducted over Zoom or MS Teams using a secure University of Manitoba account.

Data Collection

Interviews conducted in person will be audio recorded on a voice recorder application on the researcher's University-supplied laptop. Interviews conducted via a virtual platform will be recorded using the built-in software. Recordings will be used for the purposes of transcription and then destroyed once the transcriptions have been approved by the participant – at latest by approximately May 2024. Once your interview is transcribed, you will be sent the transcript for review, within approximately one week of the interview. You will be invited to review the transcript and return any changes, additions, deletions or clarifications to the investigator within approximately 2 weeks or at a time that is reasonable for you. If you do not reply, the investigator will contact you by email one further time to ask if : a) you are satisfied with the transcript and continue to consent to its inclusion in the study; b) would like to withdraw your consent to participate, in which case your interview recording and transcript will be deleted; or c) would like to submit revisions to your data, in which case a mutually agreeable date will be determined. If the

investigator is unable to reach you at this stage, it will be assumed that you are withdrawing your consent to participate in the study, and your interview recording and transcript will be deleted.

Benefits and Risks

Benefits to participating in this study: for some individuals, sharing and talking about your experiences might help you work through traumatic events.

Your participation in this interview will help us investigate the decision-making processes nurses use to decide whether to stay in a situation where violence is possible or happening, or to withdraw. This information will be used to develop a theoretical model of nurses' decision-making processes, and to identify the factors that can help prevent or address violence in the nursing workplace.

There are some risks to participating in this interview. Workplace violence is traumatic and recounting it can be stressful. In the event that you feel distressed at any time during the interview, please inform the interviewer. Together, you will then determine if you would like to stop the audio-recording, take a break, continue the interview, or end the interview completely. Prior to beginning the interview, the investigator will provide by email a PDF list of resources to address any distress that may occur.

Costs

There is no cost to you to attend the individual interview.

Payment for participation

Participants will receive an honorarium of $20 for participating in this study. There is also no cost to you to participate. You will receive your honorarium by cash or e-transfer prior to beginning the interview.

Confidentiality

We will do everything possible to keep your personal information confidential. Please avoid mentioning specific names or places during the interview. All data will be anonymized through destruction of the master list containing the participants names and their corresponding pseudonyms by August 2025. All data collected will only ever be labelled with your assigned code – P1, P2, etc. Your real name or identifying features such as your institution, or the names of other people you mention will NOT be included in any study material. The reflective journal will be assigned the same fictitious name as your transcript. As an example, the investigator will be the only person who knows which participant is P1, P2 etc. The investigator will revise the text within the document to remove any features that might identify you. Your name will not be used at all in the study data records or reporting, or in the investigator's reflective journal. If the results of this study are presented in a meeting, or published, nobody will be able to tell that you participated. Please note that although you will not be identified as the speaker, your words may be used to highlight a specific point. If you have previously reported any incident you describe in the study, others may recognize the story. You will have the opportunity to revise any element of the transcript that you wish, including removing parts if you feel they might be identifiable. Non-identifiable data will be kept for 10 years and deleted in August 2033.

Transcripts and the researcher's research journal will be reviewed carefully to determine individual and contextual factors that you considered in the context of any incident you describe in the interview. Direct quotes may be used to demonstrate key points with no reference to your real name or position.

Some data and information from this study may be sent outside of the University of Manitoba to other researchers, organizations, or made publicly available, or may be used by the researcher for further analysis, testing, as part of the research study, or a requirement by a granting agency or journal. Any information sent out of the University of Manitoba will not show your name or address, or any other identifiable personal information about you. However, despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

Furthermore, any incidents of abuse discovered during the interview may be reported to legal authorities as required by law.

The University of Manitoba Research Ethics Board may review records related to the study for quality assurance purposes.

Voluntary Participation/Withdrawal from the Study

You are free to withdraw from the study for up to three months after your interview with no repercussions, by telling the investigator, or emailing the investigator at dunsforj@myumanitoba.ca. You are not required to provide a reason for withdrawing from the study. If you choose to withdraw from the study after data analysis and reporting has begun, it may be difficult to fully extract your interview or narrative data. However, it will be removed from analysis to the extent possible, and no quotations from your interview will be used, until the point it has been published or disseminated, approximately January 2025. If you choose to withdraw, the honorarium is yours to keep.

Questions

If any questions come up during or after the study, contact the principal investigator Jennifer Dunsford at 204-797-4591. Yu may also contact my supervisor, Dr. Jessica Senehi, at Jessica.senehi@umanitoba.ca. For questions about your rights as a research participant, you may contact The University of Manitoba, Fort Garry Campus Research Ethics Board Office at humanethics@umanitoba.ca, 204-474-7122.

Are you interested?

To complete the Expression of Interest Questionnaire, click here or copy and paste https://forms.office.com/r/30EZSsiyd5 into your browser, or email the investigator at dunsforj@myumanitoba.ca.

Appendix 2: Social Media Posting

Appendix 3: Postcard

University of Manitoba

Invitation to Participate in a Research Study

Nurses' Experience of Violence in the Workplace

Are you a nurse who has experienced violence in your workplace?
Would you be willing to share your experiences in a research project?

Principal Investigator: Jennifer Dunsford, RN, MN, MPA

email dunsforj@myumanitoba.ca

I am looking for nurses to participate in a research study, conducted within the Individual Interdisciplinary Studies PhD program and supervised by Dr. J. Senehi of Peace and Conflict Studies to examine the factors and processes nurses use to decide whether and how to provide care when they encounter violence at work.

If you are a nurse working in Canada who has had experience with abuse, aggression, or violence from patients/clients at work, and you would be willing to participate in an interview, I would like to speak with you.

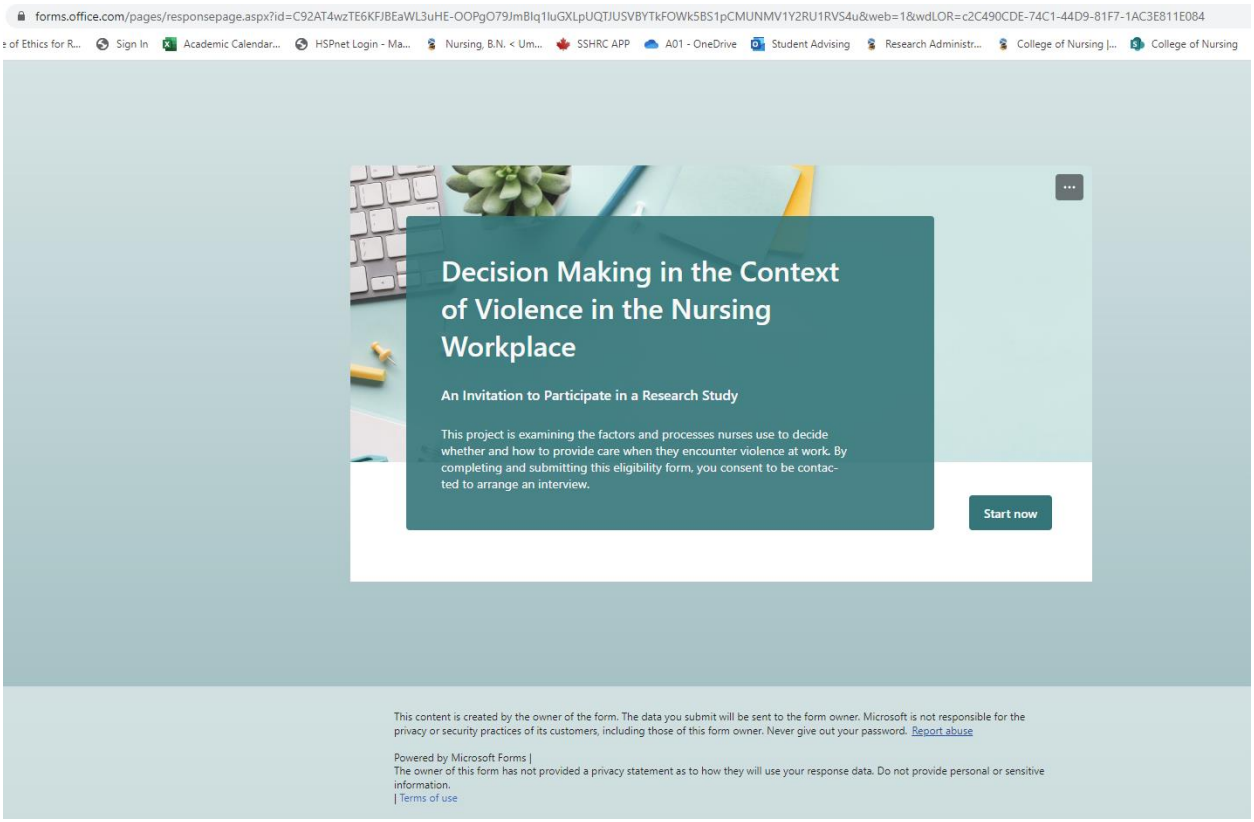
Email me with any questions. You can also access information about the study and a short screening questionnaire by scanning the QR code with your phone, or going to https://home.cc.umanitoba.ca/~dunsforj/study.pdf

for more information!

Appendix 4: Expression of Interest Questionnaire

Questionnaire created in MS Forms and stored in PI's Microsoft 360 account. Data collected on submission was stored in the same account. All were password protected.

Screen Shot of Eligibility Questionnaire:



Decision Making in the Context of Violence in the Nursing Workplace

Screening Questionnaire

All questions are optional. No identifying information will appear on transcripts, research reports, or publications. This information is collected solely for the purposes of gathering background information and contacting you. This questionnaire will take less than 5 minutes to complete.

1. Name

Enter your answer

2. Preferred method of contact (enter phone number or email address)

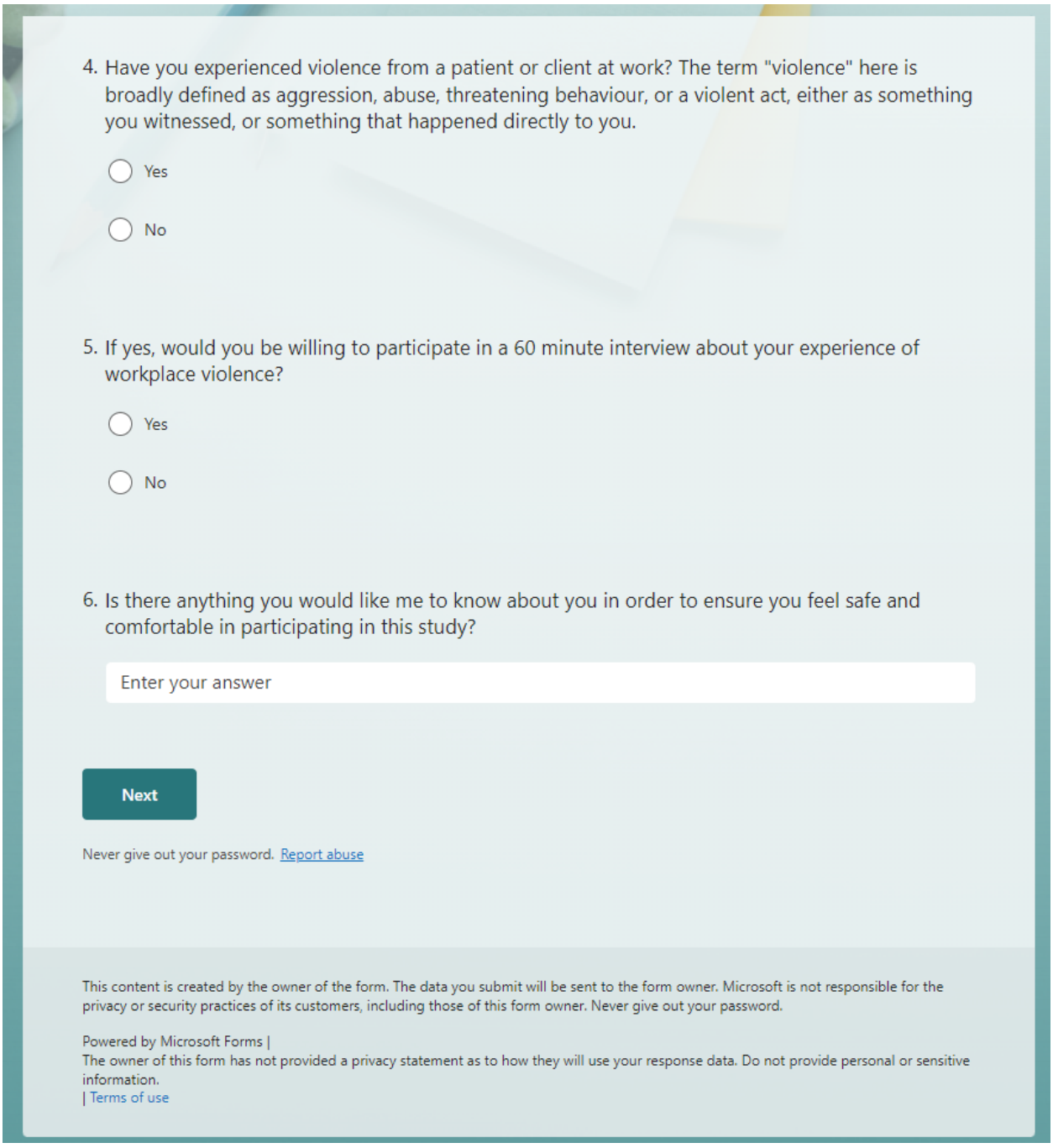
Enter your answer

3. Preferred pronouns

Enter your answer

4. Have you experienced violence from a patient or client at work? The term "violence" here is broadly defined as aggression, abuse, threatening behaviour, or a violent act, either as something you witnessed, or something that happened directly to you.

- ◯ Yes
- ◯ No



4. Have you experienced violence from a patient or client at work? The term "violence" here is broadly defined as aggression, abuse, threatening behaviour, or a violent act, either as something you witnessed, or something that happened directly to you.

- ◯ Yes
- ◯ No

5. If yes, would you be willing to participate in a 60 minute interview about your experience of workplace violence?

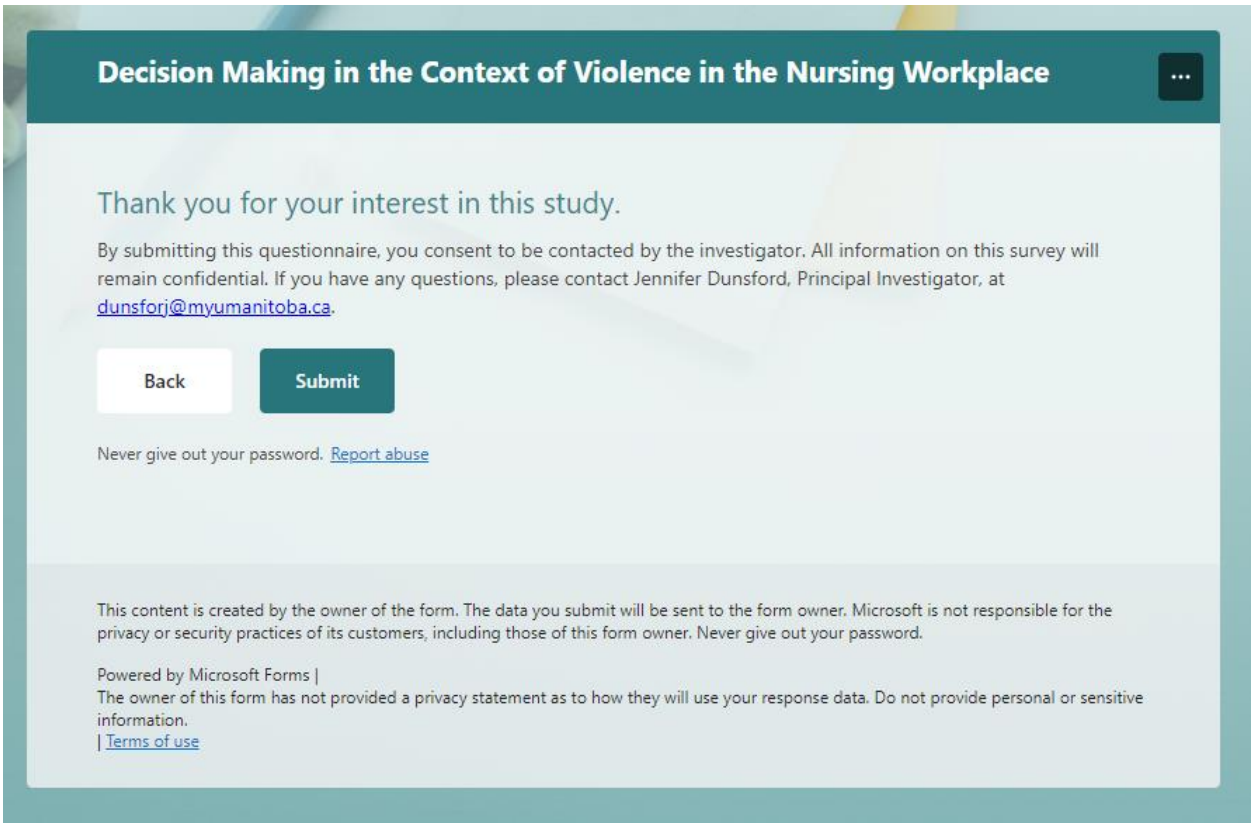
- ◯ Yes
- ◯ No

6. Is there anything you would like me to know about you in order to ensure you feel safe and comfortable in participating in this study?

Enter your answer

Next

Never give out your password. Report abuse


Decision Making in the Context of Violence in the Nursing Workplace
...
Thank you for your interest in this study.
By submitting this questionnaire, you consent to be contacted by the investigator. All information on this survey will remain confidential. If you have any questions, please contact Jennifer Dunsford, Principal Investigator, at dunsforj@myumanitoba.ca.
Back
Submit
Never give out your password. Report abuse
This content is created by the owner of the form. The data you submit will be sent to the form owner. Microsoft is not responsible for the privacy or security practices of its customers, including those of this form owner. Never give out your password.
Powered by Microsoft Forms |
The owner of this form has not provided a privacy statement as to how they will use your response data. Do not provide personal or sensitive information.
| Terms of use

Appendix 5: Response to Expression of Interest

Email sent to anyone who contacted the principal investigator directly to indicate interest in participating.

Subject: Thank you for your interest in the study *Nurses' Experience of Violence in the Workplace*

Dear Potential Study Participant:

Thank you for contacting me regarding the project, Nurses' Experience of Violence in the Workplace. This study is being facilitated as part of a PhD dissertation at the University of Manitoba under the supervision of Dr. J Senehi of the Mauro Centre for Peace and Conflict Studies (Jessica.senehi@umanitoba.ca). This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus.

Please find attached information about the study. Please read the document and click on the link at the bottom to complete an eligibility questionnaire. You may contact me (dunsforj@myumanitoba.ca) if you have questions about the study.

Sincerely,
Jennifer Dunsford, RN, MN, MPA, PhD(c)
dunsforj@myumanitoba.ca

Appendix 6: Phase 1 Consent Form

Peace and Conflict Studies
Graduate Programs

252 St. Paul's College
70 Dysart Road, University of Manitoba
Winnipeg, MB R3T 2N2 Canada
Phone: 204.474-8894 Fax: 204.474.8828

Consent Form

Research Project Title: Nurses' Experience of Violence in the Workplace

Phase 1 – Individual Interview

Principal Investigator and contact information: Jennifer Dunsford, RN, MN, MPA
dunsforj@myumanitoba.ca

Research Supervisor (if applicable) and contact information: Dr. Jessica Senehi
Jessica.senehi@umanitoba.ca

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

You are being invited to participate in a research study being conducted as part of the principal investigator's PhD dissertation. Phase 1 involves participating in an individual interview and, if you choose, Phase 2 will involve the development of a narrative or story based on your experience. Please take your time to review this consent form and discuss any questions you may have with the investigator, your friends, or family before you make your decision. This consent form may contain words that you do not understand. Please ask the investigator to explain any words or information that you do not clearly understand.

1. **Purpose of this Study**

This project is examining the experience of nurses who encounter violence from patients or clients in the workplace.

2. **Study Methods**

This is a multi-phase study. The first phase will be conducted through individual interviews. Once you have completed this phase of the study, you will also be invited to an optional, second phase to develop an experience with workplace violence into a written narrative. This consent concerns Phase 1.

3. **Study procedures**

Phase 1

- The method of data collection for the first phase will be an individual interview.
- The interview will take approximately 60 minutes. In-person sessions will be audio recorded using the built-in recording app on the investigator's password-protected University-supplied laptop and then transcribed using a software application nVivo to ensure accurate reporting of the information that you provide. You will be invited to review and correct the transcript. If you do not wish to be recorded, the investigator will take notes.
- The interview will be conducted by the researcher either in person at a time and location that is convenient for you, or via a secure virtual platform such as MS Teams or Zoom. Participants outside of Winnipeg will be interviewed virtually. You will be welcome to take any measures to ensure you feel comfortable during the interview, including using a pseudonym and leaving your camera off (if virtual).
- You will be asked some questions relating to your nursing career and a time when you experienced abuse, aggression, or violence at work. Your story will help us understand how nurses make decisions about whether to stay in or withdraw from situations where violence is possible or happening.
- After the interview, the researcher will make notes in a reflective journal, stored in a secure electronic file in the investigator's University OneDrive account, to be reviewed during the analysis and writing phases. No identifying information will be included in this journal.
- Virtual interviews will be conducted over Zoom or MS Teams using a secure University of Manitoba account.

Phase 2

- In the second phase, the researcher will work with you to develop a first-person narrative account of your experience of workplace violence (a story).
- You can be as involved in this phase as you wish, from not participating at all, to having the researcher draft a story for you to review and edit, to writing your own account. The amount of time required is estimated to range from 0 to 90 minutes, depending on your desired level of involvement. You will be invited to review, edit, or correct the narrative so that it is told in your own words and voice. You will have the final say on how your story is told. More detailed information on this phase is available on request and will be discussed in detail once you have completed the review of your interview transcript.

4. **Data Collection**

Interviews conducted in person will be audio recorded on a voice recorder application on the researcher's University-supplied laptop. Interviews conducted via a virtual platform will be recorded using the built-in software. Recordings will be used for the purposes of transcription and then destroyed once the transcriptions have been approved by the participant – at latest by approximately May 2024. Once your interview is transcribed, you will be sent the transcript for review, within approximately one week of the interview. You will be invited to review the transcript and return any changes, additions, deletions or clarifications to the investigator within approximately 2 weeks or at a time that is reasonable for you. If you do not reply, the investigator will contact you by email one further time to ask if : a) you are satisfied with the transcript and continue to consent to its inclusion in the study; b) would like to withdraw your consent to participate, in which case your interview recording and transcript will be deleted; or c) would like to submit revisions to your data, in which case a mutually agreeable date will be determined. If the investigator is unable to reach you at this stage, it will be assumed that you are withdrawing your consent to participate in the study, and your interview recording and transcript will be deleted.

5. **Confidentiality of Data**

We will do everything possible to keep your personal information confidential. Please avoid mentioning specific names or places during the interview. All data will be anonymized through destruction of the master list containing the participants names and their corresponding pseudonyms by August 2025. All data collected will only ever be labelled with your assigned code – P1, P2, etc. Your real name or identifying features such as your institution, or the names of other people you mention will NOT be included in any study material. The reflective journal will be assigned the same fictitious name as your transcript. As an example, the investigator will be the only person who knows which participant is P1, P2 etc. The investigator will revise the text within the document to remove any features that might identify you. Your name will not be used at all in the study data records or reporting, or in the investigator's reflective journal. If the results of this study are presented in a meeting, or published, nobody will be able to tell that you participated. Please note that although you will not be identified as the speaker, your words may be used to highlight a specific point. If you have previously reported any incident you describe in the study, others may recognize the story. You will have the opportunity to revise any element of the transcript that you wish, including removing parts if you feel they might be identifiable. Non-identifiable data will be kept for 10 years and deleted in August 2033.

Transcripts and the researcher's research journal will be reviewed carefully to determine individual and contextual factors that you considered in the context of any incident you describe in the interview. Direct quotes may be used to demonstrate key points with no reference to your real name or position.

Some data and information from this study may be sent outside of the University of Manitoba to other researchers, organizations, or made publicly available, or may be used by the researcher for further analysis, testing, as part of the research study, or a requirement by a granting agency or journal. Any information sent out of the University of Manitoba will not show your name or address, or any other identifiable personal information about you. However, despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

Furthermore, any incidents of abuse discovered during the interview may be reported to legal authorities as required by law.

The University of Manitoba Research Ethics Board may review records related to the study for quality assurance purposes.

6. **Communication**

Communication regarding Phase 1 will be by email or phone, whichever you prefer.

7. **Benefits and Risks**

Benefits to participating in this study: for some individuals, sharing and talking about your experiences might help you work through traumatic events.

Your participation in this interview will help us investigate the decision-making processes nurses use to decide whether to stay in a situation where violence is possible or happening, or to withdraw. This information will be used to develop a theoretical model of nurses' decision-making processes, and to identify the factors that can help prevent or address violence in the nursing workplace.

There are some risks to participating in this interview. Workplace violence is traumatic and recounting it can be stressful. In the event that you feel distressed at any time during the interview, please inform the interviewer. Together, you will then determine if you would like to stop the audio-recording, take a break, continue the interview, or end the interview completely. Prior to beginning the interview, the investigator will provide by email a PDF list of resources to address any distress that may occur.

8. **Compensation**

Participants will receive an honorarium of $20 for participating in this study. There is also no cost to you to participate. You will receive your honorarium by cash or e-transfer at the start of the interview.

9. **Withdrawing from the Study**

You are free to withdraw from the study for up to three months after your interview with no repercussions, by telling the investigator, or emailing the investigator at dunsforj@myumanitoba.ca. You are not required to provide a reason for withdrawing from the study. If you choose to withdraw from the study after data analysis and reporting has begun, it may be difficult to fully extract your interview or narrative data. However, it will be removed from analysis to the extent possible, and no quotations from your interview will be used, until the point it has been published or disseminated, approximately January 2025. If you choose to withdraw, the honorarium is yours to keep.

10. **Dissemination of Results**

Results of this study may be disseminated via scholarly papers and presentations, and the researcher's dissertation will be available on mSpace. Findings may also be incorporated into educational programs, codes of ethics, and policies, procedures, or tools on managing and preventing workplace violence.

A 1–2-page summary of the results will be provided to participants by mail or email by May 2025 if they wish to receive it.

11. **Destruction of Data**

Interview recordings will be destroyed once the interview has been transcribed and the transcript approved by the participant, at latest by May 2024. Anonymized data such as transcripts will be kept for 10 years and deleted in August 2033.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or HumanEthics@umanitoba.ca. **A copy of this consent form has been given to you to keep for your records and reference.**

Participant printed/typed name_____

Date _____

☐ I am willing to be recorded to facilitate transcription.

☐ I am willing to be contacted to participate in Phase 2 of this study.

If you would like a summary of the results of this study, please print email or postal address below. The summary should be available by May 2025.

Participant's preferred method of contact (email or phone): _____

Email or postal address: _____

Participant's Signature: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Printed Name: _____ Date _____

Interviewer's signature: _____

Honorarium Provided: _____ Crisis Resources provided: _____

Appendix 7: Crisis Counselling Resources

Crisis Counselling Services

<table>
<tr><td colspan="2">Canada
Wellness Together Canada
To connect with a mental health professional one-on-one:
• call 1-866-585-0445 or text WELLNESS to 741741 for adults
You can also visit Wellness Together Canada to access different levels of support, including:
• one-on-one counselling
• credible articles and information
• self-guided courses and programs
• peer support and coaching</td></tr>
<tr><td>Manitoba
Klinic Crisis Line
204-786-8686 or 1-888-322-3019
Crisis Response Centre
817 Bannatyne, Winnipeg; attend in person
Adult Mobile Crisis Service
204-940-1781
Adult Community Mental Health Intake
204-788-8330</td><td>British Columbia
Mental Health and Information and Support Line: 310-6789
Alberta
Mental Health Helpline: 1-877-303-2642
Saskatchewan
Regina Mobile Crisis Services: 306-525-5333
Saskatoon Mobile Crisis: 306-933-6200</td></tr>
<tr><td>Ontario
ConnexOntario Helpline: Toll-free: 1-866-531-2600
Live web chat
Email
Quebec
Info-Social 811: free and confidential telephone consultation service</td><td>New Brunswick
Chimo Help Line: 1-800-667-5005
Newfoundland and Labrador
Mental Health Crisis: 811
Nova Scotia
Provincial Mental Health and Addictions Crisis Line: 1-888-429-8167
Prince Edward Island
Mental Health and Addictions Phone Line: 1-833-553-6983</td></tr>
<tr><td>Northwest Territories
NWT Help Line – 1-800-661-0844
Yukon
Mental Wellness and Substance Use Services: 867-456-3838 or toll-free 1-866-456-3838.</td><td>Nunavut
Nunavut Kamatsiaqtut Help Line: Toll Free 1-800-265-3333
In Iqaluit 979-3333
Healing by Talking Program is a free telephone counselling: 1-888-648-0070 or healing@gov.nu.ca</td></tr>
</table>

Appendix 8: Interview Guide

Interview Questions – Semi-Structured Interview Guide

The recording has started. I want to remind you that you can halt the interview at any time and can withdraw from the study at any time until the final publication is accepted. Please let me know if you wish to withdraw.

After this interview, I will transcribe the recording and send it to you to review. You are welcome to change, clarify, correct or expand anything you see in the transcript.

Some of the questions I ask may concern traumatic events or raise difficult memories. Please let me know if you would like to skip any question that causes you emotional discomfort or distress. I have sent you a list of resources to support your mental health and emotional well-being, which I would encourage you to access if you do feel upset or triggered by this interview.

Throughout the interview, please respect the confidentiality of the people you have encountered and try to not mention specific people, organization names etc. if at all possible. If you have reported this incident to others in the past, others may be able to recognize the narrative regardless of how anonymized the narrative. For this reason, confidentiality cannot be guaranteed, however if you do share anything specific, I will ensure it is not included in the transcripts created from this interview, and I will change identifying information to ensure anonymity of you or anyone you might talk about. You will also have the chance to review the transcript later and are welcome to clarify, edit or delete any part of the interview.

There are no right or wrong answers, the focus is only on your perspective and your voice. To help this, I may ask “silly” questions – I am trying to ensure that I am not making any assumptions and ensure I

understand what you mean not what I know from my experiences. Do you have any questions for me at this point?

The following questions are examples of how I will establish rapport and trust and are intended to be cues for starting the conversation. I may or may not use them, depending on the participant and the situation.

1. Tell me about your nursing career. How long have you been a nurse?
2. What province do/did you practice in?
3. Where what area of nursing do/did you practice? How did you come to have the position?
4. Tell me about an experience that gets at what nursing means to you. Why are you a nurse? What do you love about it?
5. Can you tell me about a time when your work was challenging or difficult?
6. Let's talk about patients.
    a. What kind of patient do you love to care for?
    b. Can you describe a 'difficult' patient encounter?
    c. Can you tell me about a time when you had a conflict with a patient or their family member?

The following questions are intended to unpack the experience of workplace violence and may or may not be asked verbatim.

7. Can you think of a time when you felt threatened at work?
    a. Tell me about the situation.
8. Have you ever thought about leaving a patient care encounter because you felt unsafe?
    a. Set the stage for me. Where did this take place? When? Who was involved?
    b. What happened?

   c. What did you decide to do? Stay or leave?
   d. Do you recall your thought process as you decided what to do?
   e. How did you decide what to do?
9. Once the situation was resolved, how did you feel?
   a. What would have helped in that situation?
10. How has this situation affected how you manage or approach aggressive or potentially aggressive people since?
11. Is there anything else you would like to say or add?
12. Would you consider participating in Phase 2 of this study, which would involve working with me to create a story or narrative document of your experience?

Appendix 9: Phase 2 Study Information

Peace and Conflict Studies
Graduate Programs

252 St. Paul's College
70 Dysart Road, University of Manitoba
Winnipeg, MB R3T 2N2 Canada
Phone: 204.474.8894 Fax: 204.474.8828

Nurses' Experience of Violence in the Workplace

An Invitation to Participate in a Research Study

Are you a nurse who has experienced violence in your workplace?

Would you be willing to share your experiences in a research project?

Principal Investigator: Jennifer Dunsford, RN, MN, MPA email dunsforj@myumanitoba.ca

Research Supervisor: Dr. Jessica Senehi Jessica.senehi@umanitoba.ca

You are being invited to participate in a research study being conducted as part of the principal investigator's PhD dissertation. Phase 1 involves participating in an individual interview and, if you choose, Phase 2 will involve the development of a narrative or story based on your experience. Please take your time to review this information and discuss any questions you may have with the investigator, your friends, or family before you make your decision.

Purpose of this Study

This project is examining the factors and processes nurses use to decide whether and how to provide care when they encounter violence at work.

Participants Selection

To be eligible to participate in this study, you must be a nurse working in Canada who has experienced workplace violence, and who is willing to be interviewed about their experience. I am seeking 5-8 people to participate in this project.

Study Methods

This is part of a multi-phase study. In this second phase, participants are invited to develop an experience with workplace violence into a written narrative. This will permit deeper exploration of the themes identified in the interview data.

Study procedures

In the second phase, the researcher will work with you to develop a first-person narrative account of your experience of workplace violence (a story).

The amount of time required is estimated to range from 0 to 90 minutes, depending on your desired level of involvement.

If you wish, you can write your own story. If you prefer, the researcher will review your interview transcript from Phase 1 and extract the story of your experience. You will be invited to review, edit, or correct the narrative so that it is told in your own words and voice. You will have the final say on how your story is told.

As part of the consent process, we will determine your desired level of involvement (e.g. from having the researcher provide you with a text of the story you related during the interview, for you to edit as you desire, through to writing your own story in your own words).

The time frame for this phase will be mutually agreed and reasonable for you. A process of creating the narrative will occur until you are satisfied with it but is expected to take approximately one month. Throughout the process, the researcher will check in by email to determine when and if: a) you are satisfied with the narrative and continue to consent to its inclusion in the study; b) would like to withdraw your consent to participate, in which case your narrative will be deleted; or c) require additional time to complete your narrative, in which case a mutually agreeable date will be determined. If the investigator is unable to reach you at this stage, it will be assumed that you are withdrawing your consent to participate in Phase 2, and your narrative will be deleted.

Data Collection

Interviews conducted in person will be audio recorded on a voice recorder application on the researcher's University-supplied laptop. Interviews conducted via a virtual platform will be recorded using the built-in software. Recordings will be used for the purposes of transcription and then destroyed once the transcriptions have been approved by the participant – at latest by approximately May 2024. Once your interview is transcribed, you will be sent the transcript for review, within approximately one week of the interview. You will be invited to review the transcript and return any changes, additions, deletions or clarifications to the investigator within approximately 2 weeks or at a time that is reasonable for you. If you do not reply, the investigator will contact you by email one further time to ask if : a) you are satisfied with the transcript and continue to consent to its inclusion in the study; b) would like to withdraw your consent to participate, in which case your interview recording and transcript will be deleted; or c) would like to submit revisions to your data, in which case a mutually agreeable date will be determined. If the investigator is unable to reach you at this stage, it will be assumed that you are withdrawing your consent to participate in the study, and your interview recording and transcript will be deleted.

Benefits and Risks

Benefits to participating in this study: for some individuals, sharing and talking about your experiences might help you work through traumatic events.

Your participation in this study will help us investigate the decision-making processes nurses use to decide whether to stay in a situation where violence is possible or happening, or to withdraw. This

information will be used to develop a theoretical model of nurses' decision-making processes, and to identify the factors that can help prevent or address violence in the nursing workplace.

There are some risks to participating in this phase. Workplace violence is traumatic and recounting it can be stressful. In the event that you feel distressed at any time during the process of developing your story, please inform the investigator. Together, you will then determine if you would like to pause or end the process of narrative development or withdraw completely. Prior to beginning the interview, the investigator will provide by email a PDF list of resources to address any distress that may occur. If you choose to withdraw, your story will not be included in the data set.

Costs

There is no cost to you to attend the individual interview.

Payment for participation

Participants will receive an honorarium of $20 for participating in this study. There is also no cost to you to participate. You will receive your honorarium by cash or e-transfer prior to beginning the process of story writing.

Confidentiality

Participant stories (Phase 2) will be confidential and kept only in a password-protected folder in the researcher's secure University of Manitoba OneDrive account.

All stories will be anonymized through destruction of the master list containing the participants names and their corresponding codes – P1, P2, etc. by August 2025. All data collected will only ever be labelled with your assigned pseudonym. Your real name or identifying features will NOT be included in any study material. The researcher will keep a reflective journal, and any notes concerning your story will be assigned the same fictitious name as your interview transcript from Phase 1. As an example, the investigator will be the only person who knows which participant is P1, P2 etc. Your name will not be used at all in the study data records or reporting, or in the investigator's reflective journal. If the results of this study are presented in a meeting, or published, nobody will be able to tell that you participated.

Please note that although you will not be identified as the speaker, your words may be used to highlight a specific point. We will do everything possible to keep your personal information confidential, however if you have reported the situation elsewhere, it is possible that others may recognize the story, therefore your anonymity cannot be guaranteed, therefore you will be reminded not to use specific names or places at any point. You will have the opportunity to revise any element of the story that you wish, including removing parts. Non-identifiable data will be kept for 10 years and deleted in August 2033. Stories will be included as part of the researcher's dissertation, so will be kept indefinitely.

Some data and information from this study may be sent outside of the University of Manitoba to other researchers, organizations, or made publicly available, or may be used by the researcher for further analysis, testing, as part of the research study, or a requirement by a granting agency or journal. Any information sent out of the University of Manitoba will not show your name or address, or any other identifiable personal information about you. However, despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

Furthermore, any incidents of abuse discovered during the interview may be reported to legal authorities as required by law.

The University of Manitoba Research Ethics Board may review records related to the study for quality assurance purposes.

Voluntary Participation/Withdrawal from the Study

You are free to withdraw from the study up to the point of any presentation or publication of findings, including submission of the dissertation, with no repercussions, by telling the investigator, or emailing the investigator at dunsforj@myumanitoba.ca. You are not required to provide a reason for withdrawing from the study. If you choose to withdraw from the study after data analysis and reporting has begun, it may be difficult to fully extract your narrative data. However, it will be removed from analysis to the extent possible, and no quotations from your story will be used, until the point it has been published or disseminated, approximately January 2025. If you choose to withdraw, the honorarium is yours to keep.

Questions

If any questions come up during or after the study, contact the principal investigator Jennifer Dunsford at 204-797-4591. You may also contact my supervisor, Dr. Jessica Senehi, at Jessica.senehi@umanitoba.ca. For questions about your rights as a research participant, you may contact The University of Manitoba, Fort Garry Campus Research Ethics Board Office at humanethics@umanitoba.ca, 204-474-7122.

Are you interested?

Please email the investigator at dunsforj@myumanitoba.ca to discuss the next steps!

Appendix 10: Story Prompts

Workplace Violence Study

Creating Your Narrative

Thank you for agreeing to participate in this phase of my study on workplace violence. You have indicated that you would like to write the narrative account of your experience.

In this phase of the study, I am gathering the stories of nurses' experience with workplace violence, in their own words. Take as much space as you need – stories could be anywhere from 400 words and up.

Please use the following prompts to set the scene. I am particularly interested in what you decided to do, and how you came to your decision, so please include anything you can recall about your thought process as you lived through the experience.

Do not worry about spelling, grammar, or perfect formatting – we can work together to polish the story once you have started it. Nothing will be changed without your approval. It will look how you want it to look.

Ultimately, this document is your words and your story. You will have the final say on what is included. Once you have approved the final draft, nothing will be changed.

Please let me know if you have any questions.

Jennifer Dunsford

dunsforj@myumanitoba.ca

Writing Prompts:

Describe a time when you:

- felt threatened
- faced violence at work
- chose not to provide care because it was too dangerous OR

- left a patient care encounter because you felt unsafe

Use some or all of the following prompts to craft your story:

- Who was involved?
- Where did it take place?
- When did this happen?
- How did events unfold?
- What did you decide to do?
- Do you recall your thought process as you decided what to do?
- How did you decide what to do?
- How did you handle it?
- What did you do afterwards?
- Why do you think it happened?
- How did the experience impact you?

Appendix 11: Phase 2 Consent Form

Peace and Conflict Studies
Graduate Programs

252 St. Paul's College
70 Dysart Road, University of Manitoba
Winnipeg, MB R3T 2N2 Canada
Phone: 204.474-8894 Fax: 204.474.8828

Consent Form

Research Project Title: Nurses' Experience of Violence in the Workplace

Phase 2 – Development of the Narrative

Principal Investigator and contact information: Jennifer Dunsford, RN, MN, MPA
dunsforj@myumanitoba.ca

Research Supervisor (if applicable) and contact information: Dr. Jessica Senehi
Jessica.senehi@umanitoba.ca

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

You are being invited to participate in a research study being conducted as part of the principal investigator's PhD dissertation. It will involve participating in an individual interview. Please take your time to review this consent form and discuss any questions you may have with the investigator, your friends, or family before you make your decision. This consent form may contain words that you do not understand. Please ask the investigator to explain any words or information that you do not clearly understand.

12. **Purpose of this Study**

This project is examining the experience of nurses who encounter violence from patients or clients in the workplace.

13. **Study Methods**

This is part of a multi-phase study. In this second phase, participants are invited to develop an experience with workplace violence into a written narrative. This consent concerns participation in Phase 2.

14. **Study procedures**

Phase 2

- In the second phase, the researcher will work with you to develop a first-person narrative account of your experience of workplace violence (a story).
- The amount of time required is estimated to range from 0 to 90 minutes, depending on your desired level of involvement.
- If you wish, you can write your own story. If you prefer, the researcher will review your interview transcript from Phase 1 and extract the story of your experience. You will be invited to review, edit, or correct the narrative so that it is told in your own words and voice. You will have the final say on how your story is told.

15. **Data collection**

As part of the consent process, we will determine your desired level of involvement (e.g. from having the researcher provide you with a text of the story you related during the interview, for you to edit as you desire, through to writing your own story in your own words).

The time frame for this phase will be mutually agreed and reasonable for you. A process of creating the narrative will occur until you are satisfied with it but is expected to take approximately one month. Throughout the process, the researcher will check in by email to determine when and if: a) you are satisfied with the narrative and continue to consent to its inclusion in the study; b) would like to withdraw your consent to participate, in which case your narrative will be deleted; or c) require additional time to complete your narrative, in which case a mutually agreeable date will be determined. If the investigator is unable to reach you at this stage, it will be assumed that you are withdrawing your consent to participate in Phase 2, and your narrative will be deleted.

16. **Confidentiality of data**

Participant stories (Phase 2) will be confidential and kept only in a password-protected folder in the researcher's secure University of Manitoba OneDrive account.

All stories will be anonymized through destruction of the master list containing the participants names and their corresponding codes – P1, P2, etc. by August 2025. All data collected will only ever be labelled with your assigned pseudonym. Your real name or identifying features will NOT be included in any study material. The researcher will keep a reflective journal, and any notes concerning your story will be assigned the same fictitious name as your interview transcript from Phase 1. As an example, the investigator will be the only person who knows which participant is P1, P2 etc. Your name will not be used at all in the study data records or reporting, or in the investigator's reflective journal. If the results of this study are presented in a meeting, or published, nobody will be able to tell that you participated.

Please note that although you will not be identified as the speaker, your words may be used to highlight a specific point, so you are reminded not to mention specific names or places. We will do everything possible to keep your personal information confidential, however if you have reported the situation

elsewhere, it is possible that others may recognize the story, therefore your anonymity cannot be guaranteed. You will have the opportunity to revise any element of the story that you wish, including removing parts. Narratives will be kept indefinitely as they will be submitted as part of the investigator's dissertation and may be used in part in publications. All other data will be kept for 10 years and deleted in August 2033.

Some data and information from this study may be sent outside of the University of Manitoba to other researchers, organizations, or made publicly available, or may be used by the researcher for further analysis, testing, as part of the research study, or a requirement by a granting agency or journal. Any information sent out of the University of Manitoba will not show your name or address, or any other identifiable personal information about you. However, despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

Furthermore, any incidents of abuse discovered during the interview may be reported to legal authorities as required by law.

The University of Manitoba Research Ethics Board may review records related to the study for quality assurance purposes.

17. **Communication**

Communication regarding Phase 2 will be by email or phone, whichever you prefer.

18. **Benefits and Risks**

Benefits to participating in this study: for some individuals, sharing and talking about your experiences might help you work through traumatic events.

Your participation in this study will help us investigate the decision-making processes nurses use to decide whether to stay in a situation where violence is possible or happening, or to withdraw. This information will be used to develop a theoretical model of nurses' decision-making processes, and to identify the factors that can help prevent or address violence in the nursing workplace.

There are some risks to participating in this phase. Workplace violence is traumatic and recounting it can be stressful. In the event that you feel distressed at any time during the process of developing your story, please inform the investigator. Together, you will then determine if you would like to pause or end the process of narrative development or withdraw completely. Prior to beginning the interview, the investigator will provide by email a PDF list of resources to address any distress that may occur. If you choose to withdraw, your story will not be included in the data set.

19. **Compensation**

Participants will receive an honorarium of $20 for participating in this study. There is also no cost to you to participate. You will receive your honorarium by cash or e-transfer.

20. **Withdrawing from the Study**

You are free to withdraw from the study up to the point of any presentation or publication of findings, including submission of the dissertation, with no repercussions, by telling the investigator, or emailing the investigator at dunsforj@myumanitoba.ca. You are not required to provide a reason for withdrawing from the study. If you choose to withdraw from the study after data analysis and reporting has begun, it may be difficult to fully extract your narrative data. However, it will be removed from analysis to the extent possible, and no quotations from your story will be used, until the point it has been published or disseminated, approximately January 2025. If you choose to withdraw, the honorarium is yours to keep.

21. **Dissemination of Results**

Your story may be included in full or in part in the researcher's dissertation, and/or in presentations, articles, chapters or books developed from the findings of this research. You will retain the right to edit, revise, change or withdraw your story from the study up to the point of publication.

Stories and the researcher's research journal will be reviewed carefully to determine individual and contextual factors that you considered in the context of any incident you describe in the interview. Direct quotes may be used to demonstrate key points with no reference to your real name or position.

Results of this study may be disseminated via scholarly papers and presentations, and the researcher's dissertation will be available on mSpace. Findings may also be incorporated into educational programs, codes of ethics, and policies, procedures, or tools on managing and preventing workplace violence.

A 1–2-page summary of the results will be provided to participants by mail or email by May 2025 if they wish to receive it.

22. **Destruction of Data**

Correspondence, coded and identifiable data, and drafts of your story will be destroyed once the research study is complete and the investigator has submitted the dissertation, approximately May 2025.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or HumanEthics@umanitoba.ca. **A copy of this consent form has been given to you to keep for your records and reference.**

Participant printed/typed name_____

Date _____

☐ I consent to the inclusion of my narrative document in whole or in part as part of the researcher's dissertation and/or in publications. I understand this document will be kept indefinitely.

If you would like a summary of the results of this study, please print email or postal address below. The summary should be available by May 2025.

Participant's preferred method of contact (email or phone): _____

Email or postal address: _____

Participant's Signature: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Printed Name: _____ Date _____

Interviewer's signature: _____

Honorarium Provided: _____

Appendix 12: The Narrative Documents

P2's Story: Nurses Have Been People's Punching Bags for Years. It's Got to Stop.

When I was working up north, we had two long-term patients, a husband and wife. They were sent to us as a social admission. We had this couple for a long time. One day, I was doing rounds with a coworker on the combined med/surg/obstetrics unit. I went into the man's room, and he was attempting to sew a button on a pair of pajama bottoms that came from the hospital. I told him he didn't need to do that, and I went out and I got a new pair of pajama bottoms for him and brought them in. I was tidying the room, and I heard something behind me. I turned around and he was coming at me with a buck knife. It was pretty scary. I didn't know what was going on, so I backed up into a corner, not realizing that then I couldn't get out.

As nurses we're told, just be calm, don't yell, but I realized I was going to be hurt really badly. I remember backing up against the wall and thinking to myself, should I relax my abdomen, or should I tense it up? What's going to do the least amount of damage when he stabs me?

I yelled for my colleague. He came running down the hall right away. He saw what was going on and grabbed the patient by the shirt and threw him onto his bed. That's how I got out of there. After that, I said I would look after everybody else, but not that patient.

What hurt the most was that the hospital was very blasé about the whole thing. They questioned my colleague and I separately, like we were criminals. What also upset me was the security guard. My colleague yelled for him. He saw a lot of what happened, and then later denied it. I saw some of the ladies that were in the maternity part of the hospital watching what was going on, but they denied it too. That really hurt. I was also asked what I did to provoke the attack.

My husband at that time was a police officer. He wanted to have this fellow charged with assault, but the hospital told me that if we pursued that, that it could affect my job. I agreed to continue working there, and not to press charges, but I told management that I wanted him out of the hospital. We had

had a report from his home community that he had never done anything like this, but his granddaughter came down and apologized and told us that one of the reasons he was sent to us was because he was so violent.

The incident affected how I provided care after that, because if I felt threatened in the future, I would just back right off.

Nurses have been people's punching bags for years. It's got to stop.

P3's Story: Can This Patient Really Hurt Me?

There are always the patients that you know from their history have a tendency to be aggressive, and so, I'll just ask them if they need care, and if they don't, I leave. I've had incidences where I went in and right away, they're throwing an item at me. Well, then, of course, I'm going to try to leave the room and re-approach later. That works to a certain extent. People with dementia often forget that they have been aggressive so it's a brand new thing, when they are offered care again maybe five minutes later.

Where I really see the problem is when there's a risk to themselves, or a risk to other patients in the environment. I have had incidences where a patient is zipping around in an electric wheelchair. It puts themselves and other patients in danger of a collision. Then I'm not in a position to just leave them and re-approach in a few minutes. It's a safety thing. So that's when I'll end up having a call a code white, to try to contain it somehow. Calling the code brings the help to de-escalate the situation. From experience I have a sense if people are going to be volatile and even then, there are times that I have misread the situation. I have learned that you never know what's going through someone's mind.

There was a time when I went into the room to give a patient their medication. I talked to the patient. They kind of knew who I was. I said, "here's your medication". And then all of a sudden, out of the blue, they hit the medication out of my hand. The tablets and med cup went flying and ended up on the floor. I tried to be non-threatening and unfazed by it to not inflame the patient more. I thought, "Can this patient really hurt me?" and decided I had to leave the room and hopefully not get hurt. When I would interact with a patient that had unpredictable, violent behaviour I thought about if they can actually hurt me. It is difficult to make a safe decision when unfamiliar with the patient. I would just say, "OK, I'll just come back later", and leave the room when confronted with an angry patient that is refusing a medication.

Now, if it was a medication that was not really all that important for their health and they could miss a dose without ill effect, like PRN Colace [a laxative given as needed], I would leave it. I would write 'refused' on the MAR [medication administration record] and document that the patient refused. I respect that a patient has a right to refuse a medication or treatment. It gets trickier if it's an anti-seizure, analgesic or time sensitive medication as an example. I think about the outcome of a missed medication. If there is a potential for a serious side effect, I would go back later to the patient. I know that continued refusal and aggression from a patient would mean a conversation with the doctor and team.

In the instance I'm thinking of, the patient refused an anti-seizure medication. He had a brain injury as well as some other cognitive deficits and was not fully orientated to his situation. He was a young adult and had a family that cared about him and wanted him to have the medication. I tried multiple different ways to approach and provide his oral medication. He was very strong and coordinated in his upper body but was unable to walk without assistance. I knew that he could hurt me if I came close to his arms and hands. He was a young man and likely much stronger than me in the upper body. I took this into account and approached an arm's distance away. I also knew that he could not chase after me because he could not ambulate well. I would not have gone into that room alone if he could ambulate well and could potentially overpower me. I knew I could keep myself safe by taking into account his abilities and disabilities. I knew the history of the patient, but I also knew my limitations. I knew to keep a safe distance from his arms and exit the room quickly. In this case I provided the medication and arm's distance away. He threw it at me, and I quickly exited the room.

When I returned to the room it was difficult to feel safe. It was a challenge to be in close proximity to the patient. When I came back, I kind of approached him sideways, in a way that he could not hit at me and hoped for the best. I opened the door and kept it open, so I had an exit. I never

blocked my exit. I kept that exit clear and just went slowly in a non-threatening way. I didn't come straight on, I went sideways to him and kept my back against the wall. I kept my hands kind of loose.

It is a little bit of acting, I try to act friendly and relaxed not like I'm scared or threatening or bossy. I try to act like I'm going to be their friend and help them. I try to be as non-threatening as possible. I have found that most people respond to the non-verbal language and that can be more important. Sometimes, the verbal language does not make any sense to a patient. I've had patients with dementia (also brain injury and language barrier etc.) that cannot understand my words but understand my actions. They can sense my behaviour, my face and body language. When I have a patient that was known to be aggressive, I tell a coworker if I was going into the room and to keep an ear out.

If it's something that they really need, then you can only put it off for so long.

A situation that is very challenging to manage safely is when a patient refuses basic hygiene care. Another challenge is managing an individual's bladder or bowel incontinence when they are unable to self manage. It requires hands on care to clean and manage an incontinent patient. I have had patients that are incontinent of urine or stool and are sitting in a wet bed or worse in the hallway with the other patients. It is a mess. A patient like that cannot be left alone until they are agreeable to care. They may never be agreeable to care. They present a risk to other patients on the unit when bodily fluids are not contained. It is an unsafe situation. In those cases, we would need a team effort to find a way to safely clean them up. I would have to get some help to go in, maybe with someone else that they might like a little bit better. A lot of the philosophy now is just to leave if they refuse care. "Non forced care" is a great philosophy for the individual patient and to respect their rights. The problem is the individual has to live with fifteen or twenty other patients. The whole unit of patients has to collectively be kept safe. It does not feel good to always comply with a patient's wishes to refuse care. It many instances it seems to create more problems for the patient and co-patients.

P8's Story: My Livelihood Shouldn't Impact the Rest of my Life

I was working at one of the community hospitals, and I had a patient that had some mental capacity issues. She was like a 5-year-old in a 40-year old's body. Nobody had told me that she had a tendency to be violent. On this day, I had come in to give her some medication. She was quite agitated and out of control, and she bit my finger, latching on to it and growling at me. Her elderly father was standing in the background, trying to tell her to back off. She growled longer and harder, shaking her head like a dog. It took a while before she finally let go. It sparked a trip down to emergency to make sure that there was no damage, and I had to have blood work drawn and get a tetanus shot.

I wonder if the incident could have been prevented. Maybe her family could have brought in some things that gave her greater comfort, because she was in an unfamiliar environment. It was hard to get medications into her. It was hard to keep her under control. With a child, you can calm them down by hugging them or using soft words or teddy bears. But that's not appropriate for a 40-year-old lady. She had her familiar person with her, but I think he probably needed some coaching on how to talk to her because he just got angry with her. Maybe some distraction techniques for her might have worked a little better.

I refused to take care of her after that. There was an altercation with another nurse, who was badly hurt by this patient, so I flat out refused to take care of her the next day when I was at work. The cognitive ability of the patient doesn't make a difference in my risk assessment. It's still a threat to me. I'll think, what can I do differently to get them to calm down? In the end, though, it's still a threat, whether the patient has full cognitive ability or not. So, I'm not going to go in any further than I have to, if I feel like they're going to hurt me.

This incident changed how I practice nursing. Now, whenever I get the hint of feeling threatened, I back off. I know I might not be giving the greatest attention to the patient that I can when I'm afraid

that they are going to hurt me. I pay more attention to how they talk to me. Are they giving me verbal threats? Are they giving me physical indicators that they might be violent? When there are more threatening situations, I try to keep calm, and leave the situation. At that point, I just flat out tell the patients, ‘if you continue with your behaviour, then you're not going to have a nurse’. I decided that my livelihood shouldn't impact the rest of my life, and one violent incident can do that. So, whenever I felt like I was getting backed into a corner by a patient, I just backed off with some of my nursing care. I'll come back later. I try and move my care around to see if they'll be calmer in a while, and if they're not, then I go ask for a patient assignment change. I've got a life to live.

P23's Story: Reckoning with Myself

The following is my account of an incident in my workplace that affected me differently than other, more typical, instances of verbal aggression and potential violence. I have chosen this story for its particular nuances and for the difference in how it made me feel compared to other situations.

For 20 years, I have worked with this patient in inpatient and outpatient settings. Despite many instances of verbal aggression and unpredictability, we had forged a type of understanding and rapport that allowed us to work together through the many exceptional circumstances he has faced throughout the years. Most verbal aggression was directed at others, and until the day this incident occurred, I had been able to help de-escalate and redirect him so that he could still obtain the care he needed. He had, unfortunately, alienated family and had limited tolerance for situations that required patience or predictable attendance. By the time this incident occurred, he had no other care providers or supports. He had also recently been stabbed, not for the first time, and with sutures, staples and the beginning of an infection, and had come in for wound care, although my role in is mental health care.

That day, we went to our department's treatment room, which is small, away from the main area and behind a closed door. I began removing the old dressing from the ER and cleansing the wound. I was assessing the extent of his significant injuries when I suddenly realized he had begun to masturbate. It took me a minute to process this; I was so shocked and it was so out of character – and bizarre for a moment when his other mangled hand was on the table and quite grotesque. I asked him to stop; instead he stood up, exposing himself, and continued. I backed away and assertively told him to stop. He barely reacted apart from sitting back down. I didn't feel I had a choice but to quickly re-bandage his hand and send him on his way, asking him to return in a few days to have the wound reassessed.

What surprised me more than the incident itself was how angry I was. It felt, at that moment, like more of a violation than if he had begun screaming at me. After all these years, with no one else

providing health care to him, and at a time when he was in serious need of care and support, this. I suppose there were also thoughts of what would have happened if he had become physically sexually aggressive at that time. Without wanting to seem dramatic, in general, I think, women live with fear of moments like this, and it reminded me of my vulnerability in that setting. It disturbed me, on some level, that I would need to keep my cool, be professional, not act in a way that would let him know I was upset. This is always the job but this time I was rattled.

Things have changed since the incident. A report was completed and a plan for having another person in the room going forward was implemented. Security was called to stand by every time he came to the clinic for the next 1 to 2 months, until he was able to demonstrate consistent 'appropriate' behaviour. He still gets irritable but hates having security present so things don't seem to escalate anymore. I felt conflicted, even though I wanted to prioritize the safety of the team and myself, because the presence of security often re-traumatizes those who have had incidents with them, especially 'back in the old days.'

I did try at the first subsequent appointment to explain the reason for these changes and referenced "what happened the other day". He glared at me intensely then abruptly left, swearing and yelling about how this was "bullshit." We haven't talked about it since.

His wounds have healed. He still lives in a dangerous setting where a similar incident could easily occur. He is getting older; he is developing other physical health issues. His mental illness is treated but his capacity to care for himself is deteriorating. I am not able to help him as I would many others, in part because of long-term challenges, and in part because there is now an unspoken barrier.

I am a champion of preventing violence rather than just being reactive. I preach about it, and I formally teach about it. My approach to my role is wholly focused on respecting where people are at, rolling with the changes in people's presentations, collaborating toward solutions or recovery in general.

As much as possible, I try to keep things light, use humour, offer hope and a place to unpack difficult emotions. I don't like that I felt a sense of betrayal in this moment. I couldn't land on an excuse or reason for it. His symptoms weren't poorly managed, he wasn't intoxicated. This wasn't a known possibility. I felt like he forced me to treat him differently, be colder, more detached. There wasn't a way to properly debrief.

I don't want this to colour how I interact with people going forward. I don't want to become jaded or cynical. I want to continue to have unconditional positive regard for people, to be empathic and to keep my sense of humour. I think a lot of job satisfaction comes from how we view ourselves in our roles – what we give to nursing can really determine what we get out of it. This situation didn't shake all of this to its core, but it did lead to initial anger, some careful planning and a bit of a reckoning with myself.

P40's Story: Constant Vigilance Takes a Toll

I love working with patients who come in really sick. They come in often in a terrible mental state. Seeing them get better and get back to their normal is really rewarding. Sometimes they are coming from the lowest point in their life, and we help them get back to a meaningful life that they're happy with. I find it very rewarding to be there for people in the worst time of their life, and then see them get so much better.

I feel threatened at work all the time, but I've never had to choose not to provide care at all. Even when it's dangerous, I always end up providing some kind of care. I might limit my interactions to the bare minimum that is safe for me and that patient and everyone else on the team, but I'm always doing something for them. Part of the problem is that the way the unit is set up is very dangerous. The patients all share rooms. We have no comfort room. We do have five seclusion rooms that are used if patients are on red flag status where they have correctional supervision and they need to be locked up the majority of the time. But most patients are just free on the unit, and there is usually no extra security. It's just the nurses, the unit assistants, and sometimes multiple murderers walking around.

There is nowhere a patient can go to be alone. When someone is in that state of mind where they could escalate and we could still prevent it, having the ability to give them a quiet room that isn't locked, that has a couch or a bean bag chair, some sensory things just to calm down, would be really valuable. Right now, all we have to offer them is going to their shared room.

I've never been physically seriously injured, to the point I needed to take time off work. I have been punched in the face. I've been spit on and I've been grabbed and pushed. There are patients who just have a threatening aura. Mentally, the constant need to be vigilant takes a toll.

I took some time off work last year because things just accumulated. The thing that triggered me was a situation where a patient was in a seclusion room. He was well known to be very verbally

aggressive and intimidating to people and the environment. He was a big guy with a very loud, deep voice. He was always very angry. He had a diagnosis of schizophrenia and did not want to take any medications. I took a phone call from a family member who wanted to talk to him, and so I went to his room to let him know. He shot out of bed, straight up, and started screaming that he was going to kill me. Then he started coming at me really fast. I remember in that moment thinking, oh, this is where my career ends. I jumped back and started speed walking down the hallway away from him. He followed me, still screaming and swearing at me. And at this point, I knew that he wasn't going to hurt me. He was just really angry, but the way that he just exploded was so scary. He was the kind of person where he would come to you if he wanted something, so I knew I was taking a risk telling him he had a phone call. I knew not to go to him because if you disturb him, he blows his top.

Afterwards, I remember sitting at the nursing desk, and I kind of dissociated. Even though he didn't touch me, it was still very, very stressful. That’s when I knew I needed to take some time off.

P56's Story: Am I Doing More Harm Than Good?

I can't think of a situation in which we said we were not going in to provide care at all. The situations were always temporary. We would decide we're not going in until we have more people, or until police came. At the same time, we sometimes have to make decisions in a split second.

The ones that stick out were ethical dilemmas. For example, one patient who had a horrible trauma history. He came from a war-torn country and had watched his family be slaughtered in front of him. He had been forced to perform sexual acts on his siblings, otherwise, they would die, or he would die. We tried to approach his care from a trauma informed perspective. This is the last person that you want to lay hands on. But then as things happen, he had an order that required us to give him medication against his will. We had to weigh the pros and cons of approaching this man with a bunch of security guards, essentially, something that would resemble a lot of what he had lived through, to do this intervention that ultimately, we thought would help him more. That was pretty hard. It was traumatizing for everybody. I still think about that guy.

Another situation that comes to mind is about a person who was unwell, but there was also a personality and behavioural component. It was a young man of colour, and it was around the time of the George Floyd protests. On this day, he had locked himself in a room. It was the interview room, so there were windows all around and we could see what was happening. He had taken apart a table. He was making threatening gestures with the legs of the table, and he had taken off his shirt. He had wrapped his arms to fight, and he was yelling profanities at us. He screamed at us how he's going to hurt us in all kinds of different ways. "I want to see your brain splatter all over the walls! I'm going to find you when I get out of here and I'm going to hurt you and your family! I remember your face!". This was one time we decided we were not going in. He was not going anywhere; he was not hurting himself. We decided just

to hold off until we had more staff, and security came. Then collaboratively, we made the decision to call the police in.

We called 911, and it was incredibly invalidating, because the people at 911 said, if this person's locked in, why can't you just go and grab them? If you have security, why can't you just use that resource? Why do you need police there? We needed to advocate for ourselves and for the patient. We had to tell them we don't have the expertise to go in and de-escalate the situation. We don't have the means to get the weapons away from this person, to move them away or give them their medication in a safe way. We also had to consider that we didn't want our security guards in harm's way either. Just because they are security or we are front line staff, it doesn't mean that we are punching bags. Then, we needed to wait 20 minutes, 30 minutes, 40 minutes until police showed up.

Then when the police came, they went in and tased the patient. We put him in restraints because we didn't want it to happen again. We can put them in a seclusion room, but if we need to take them to the bathroom or give them supper, it could happen again. Even restraining him was quite difficult. Because of the patient's ethnicity and the current context, things like physical asphyxiation were in the forefront of our minds. And there were 10 people piled up on top of this guy. It was difficult.

It was hard to go back to work the next shift. It was hard to go back to work thinking, am I doing more harm than good? Is this caring? Is this the thing I went to school for? Is this why I wanted to do this job? It really kind of got me questioning my identity as a caregiver. I was also concerned about my safety and my co-workers.

I don't think we had a formal debriefing on this situation, but we did have an informal debrief after, in the back room once things were settled. We all acknowledged how that was really messed up. We checked in with each other, asked each other, how are you doing? We all talked, validating each other, which was an important piece. It was good to know that I wasn't the only one going through this

identity crisis or thinking that I'm weird for feeling this way. We were all thinking that was messed up. That was not a great outcome. That was unpleasant for everybody involved.

Afterwards, it was unfortunate because he developed side effects from the medication. We couldn't even say OK, now you're feeling better. So, it wasn't great. He was more settled, but he had these terrible side effects. The family was not happy that police were called. The family was not happy that he got tased, and I don't blame them. You leave your family member in the hospital. You don't think that they're going to be getting involved with police.

Eventually I think the patient got the message that violence is not the way to get things, and if he behaved like this, then we would have to respond with injections and him being tied down to a bed. We were able to get him to see that if his goal was to get out of the hospital, then we needed to see certain behaviours. Eventually, patients need to get to a point of accepting their situation, which is not easy.

For us, then, it just became way more apparent that for this patient in these situations, there were things that we would try to do to de-escalate situations. If we couldn’t de-escalate the situation, at least we had a plan for how we would escalate interventions.

I think early on I developed ways of coping, of leaving work at work, and making a very clear distinction between work and home. I would bring things home from work often, and I would still feel really angry or sad about something that happened. It would impact my life outside of work and make those emotions even more intense. There were times I chose to do some counselling over things that had happened to me at work.

Eventually, things were affecting me to the point that I could see other problems developing. I would go to Walmart, and I would hear a beep that sounded just like the beep from code whites. And I would get an autonomic kind of response, my heart would race, I would get all sweaty, almost bordering on a PTSD response. I realized that was not normal. This was not something that I should be

experiencing at Walmart. At that point, I made the decision to move from that environment and seek something else.

Appendix 13: Certificate of Research Ethics Board Approval

University of Manitoba | Research Ethics and Compliance

Human Ethics - Fort Garry
208-194 Dafoe Road
Winnipeg, MB R3T 2N2
T: 204 474 8872
humanethics@umanitoba.ca

PROTOCOL APPROVAL

Effective: June 13, 2023 Expiry: June 12, 2024

Principal Investigator:	Jennifer Dunsford
Advisor:	Jessica Senehi
Protocol Number:	HE2023-0102
Protocol Title:	*Nurses' Experience of Violence in the Workplace - April 2023*

Andrea L Szwajcer, Chair, REB2

Research Ethics Board 2 has reviewed and approved the above research. The Human Ethics Office (HEO) is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*- TCPS 2 (2022).

This approval is subject to the following conditions:

i. Approval is granted for the research and purposes described in the protocol only.

ii. Any changes to the protocol or research materials must be approved by the HEO before implementation.

iii. Any deviations to the research or adverse events must be reported to the HEO immediately through an REB Event.

iv. This approval is valid for one year only. A Renewal Request must be submitted and approved prior to the above expiry date.

v. A Protocol Closure must be submitted to the HEO when the research is complete or if the research is terminated.

vi. The University of Manitoba may request to audit your research documentation to confirm compliance with this approved protocol, and with the UM *Ethics of Research Involving Humans*Ethics of Research Involving Humans policies and procedures.

Appendix 14: Participant Checklist Template

Participant – Initials

☐ Phase 1 Consent received

☐ Interview booked

☐ Interview completed

Date/Time of interview

Saved as

☐ Honorarium sent DATE TIME

☐ Honorarium recorded

☐ Honorarium accepted and link recorded

☐ Transcription complete and sent to participant for checking. Date sent:

☐ Transcript approved. Date received:

☐ Transcript uploaded to nVivo

☐ Interested in Phase 2

☐ Phase 2 Consent received

☐ Story draft – ☐Participant or ☐PI

☐ Story approved. Date:

Notes: