ATHABASCA UNIVERSITY

OCCUPATIONAL DISAPPOINTMENT IN EMERGENCY DEPARTMENT NURSES AS A RESULT OF VERBAL ABUSE

BY

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF NURSING

FACULTY OF HEALTH DISCIPLINES

ATHABASCA, ALBERTA

MARCH, 2021

Approval of Thesis

The undersigned certify that they have read the thesis entitled

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In partial fulfillment of the requirements for the degree of

Master of Nursing

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April 9, 2021

Dedication

This work is dedicated first and foremost, to my husband Bobby, who without question, continues to allow me as much time as is necessary to complete my education. There is never any guilt placed on my absences from the dinner table nor is there question over domestic tasks left undone. I am forever grateful that I found a partner who would allow me such unfettered freedom to achieve my personal goals and it is simply because of him that I was able to finish the work laid in front of me. Thank you.

This work is also dedicated to my colleagues in the various emergency departments I have been fortunate to be employed beside. Nurses are all special people, but emergency nurses have a grit to them that makes them unique from any other specialty. There are no deeper laughs than those at five in the morning and no harder workers than those who together endeavour to keep others alive. Emergency nurses are expected to know it all but are not valued as know-it-alls. This thesis provides an understanding of how emergency nurses deal with the constant, everyday verbal abuse from members of the community they serve. It is meant to highlight the realities of emergency nursing and develop a greater understanding of the emergency nurses' experience. I hope that it also has afforded my colleagues a voice.

Acknowledgement

It is with great pleasure that I acknowledge the ongoing and unceasing encouragement of my thesis supervisor, Dr. Lynn Corcoran. You are the backbone to this work, providing the foundation upon which I completed this thesis. Throughout the last few years, your guidance has never wavered and your support in all aspects of my life has been appreciated. Thank you for pushing me along, for checking in always at the right time and for being my cheerleader. I could not have done this without you.

Abstract

Occupational disappointment is a novel concept in emergency nursing, defined as a feeling of disheartenment with career choice in this group of nurses who enter the profession to help others. It results from prevalent, unaddressed verbal abuse in the emergency department directed towards nurses from patients and/or their visitors. In the limited literature published, it is shown to be conceptually different from nursing burnout syndrome and compassion fatigue, yet it can lead to negative effects for nurses and their patients. A qualitative descriptive methodology was used in this research study to yield a straight description of occupational disappointment. Six emergency department nurses were interviewed to explore the questions: What are the concerns of nurses about occupational disappointment? What are nurses' responses towards occupational disappointment? From an emic perspective, nurses in this study discussed the prevalence of occupational disappointment in emergency nursing culture and offer their concerns regarding this pervasive issue.

Keywords: Emergency department, Emergency nurses, Emergency nursing, Occupational disappointment, Verbal abuse, Verbal violence

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Chapter 1. Introduction

Verbal abuse or verbal violence is frequently experienced by nurses. Nurses in the emergency department (ED) are a specialized group who are particularly susceptible to experience this workplace abuse (Al-Shamlan, Jayaseeli, Al-Shawi & Al-Joudi, 2017) which often originates from patients and/or their visitors. Though ED nurses must meet multiple demands including resuscitation of people while simultaneously supporting families or providing health teaching for prevention of illness, research indicates ED nurses are at highest risk to be subjected to verbal abuse (Al-Shamlan et al., 2017; Banda, Mayers & Duma, 2016; Copeland & Henry, 2017; Partridge & Affleck, 2017; Pich, Kable & Hazelton, 2017; Zhang et al., 2017).

The effects of verbal abuse are varied in nature; some nurses have identified a negative impact on their nursing practice which directly affects patient care (Al Bashtawy & Aljezawi, 2016; Banda et al., 2016; Hassankhani, Parizad, Gacki-Smith, Rahmani & Mohammadi, 2017; Yoon & Sok, 2016). Others have identified an organizational impact due to sick leave and recruitment difficulties (Al Bashtawy & Aljezawi, 2016; Hassankhani et al., 2017; Howerton Child & Sussman, 2017; Li, Chao & Shih, 2017; Yoon & Sok, 2016). Notably, a novel theme has been identified in recent verbal abuse research. Occupational disappointment (OD) is the feeling of disheartenment by nurses who enter the profession to help people but who are then faced with continued verbal abuse from patients and/or their visitors (Howerton Child & Sussman, 2017). The feeling of satisfaction in career choice can be lost as a result of endemic verbal abuse left unaddressed. Moreover, the misalignment of expectations of what emergency nursing ought to be and the reality experienced by nurses remains problematic. As a newly defined outcome of verbal abuse, the resultant impacts on patient care as a result of OD are yet to be determined.

Problem Statement and Purpose

Occupational disappointment has emerged as a newly defined outcome of verbal abuse and it is necessary to explore it further. Little is known about the way nurses exhibit OD or the alterations in nurses' behaviour or nursing practice that can occur. The purpose of this study is to explore the concept of OD in ED nurses as a result of verbal abuse from patients and/or their visitors. The goals of this research are to identify how nurses experience feelings of OD and identify common themes to further understand this phenomenon. This study is significant because OD has been connected to burnout and job satisfaction for ED nurses (Howerton Child & Sussman, 2017); conducting this exploratory research may yield opportunities for future research to distinguish it from these similar concepts. To date, it has been challenging to locate scholarly nursing literature specifically referring to OD, however, the opportunity to highlight this phenomenon will allow for greater understanding and may also determine avenues to prevent it or recover from it.

Inspiration for this Research

Inspiration for this research stems from personal and current experience as an ED nurse in Canada. I maintain a firm belief that ED nurses choose emergency nursing to help the sickest and most vulnerable people however, the experiences of abuse, verbal abuse in particular, are often unexpected despite this work and the services provided. I feel a connection to this emerging topic; this may be similarly felt amongst my nursing colleagues due to verbal abuse and as such, their experiences may be found to also include OD.

This research was motivated in part by a critical incident that occurred in my place of employment. In February 2016, there was a public incident after two unrelated children were misdiagnosed in the ED where I work. The misdiagnoses contributed to lengthy admissions in a

larger children's hospital for both children (Lakeridge Health Patient Experience Panel, 2016). These occurrences led to the creation of a Facebook group forum that overtly criticized ED staff, predominantly ED nurses and physicians. The isolated anecdotes of dissatisfied ED patients on the forum challenged the competence of staff; patients publicly opined what they perceived as negligence. During the height of this public relations crisis, nurses spoke critically about inaction from those in traditional leadership roles in the ED, in defense of the front-line staff. Personally, I felt verbally abused by the community I was serving and believed the work environment lacked safety. There were many times I considered resigning and applying to other organizations. It is fair to say that a feeling of OD continues to exist amongst my nursing colleagues in this ED. This critical incident is the antecedent to my master's study and is what motivated me to explore the topic of OD as a result of verbal abuse directed at nurses in the ED.

Chapter 2. Literature Review

A review of literature was necessary to explore verbal abuse towards ED nurses as a means of gaining insight into the issue of OD in ED nurses. In this review I clarify types of verbal abuse and examine data specific to the ED including environmental impacts, policy issues and reporting practices of verbal abuse among nurses. In this body of literature, I will examine the outcomes of verbal abuse towards ED nurses, notably an evaluation of current literature regarding OD and the impact on nursing work performance. Phenomenological views from nurses who have been victims of verbal abuse from patients and visitors are incorporated and a summary of strategies for the prevention of endemic verbal abuse towards emergency nurses in the recent literature is also discussed.

The issue of verbal abuse from patients and visitors against nurses has been widely researched (Al-Ali, Al Faouri & Al-Niarat, 2016; Al Bashtawy & Aljezawi, 2016; Al-Shamlan et al., 2017; Ashton, Morris & Smith, 2017; Avander, Heikki, Bjerså & Engström, 2016; Baig et al., 2018; Banda et al., 2016; Boulger, Werman & Pinto, 2017; Chang & Cho, 2016; Copeland & Henry, 2017; Fisekovic Kremic, Terzic-Supic, Santric-Milicevic & Trajkovic, 2017; Gillespie, Papa & Gomez, 2016; Han et al., 2017; Hassankhani et al., 2017; Hogarth, Beattie & Morphet, 2017; Hsieh, Hung, Wang, Ma & Chang, 2016; Hyland, Watts & Fry, 2016; Kilic, Aytac, Korkmaz & Ozer, 2016; Li et al., 2017; Partridge & Affleck, 2017; Pich et al., 2017; Ramacciati, Ceccagnoli, Addey, Rasero, 2018; Yoon & Sok, 2016; Zhang et al., 2017). However, the emerging topic of OD as a newly identified outcome of verbal abuse which necessitates further exploration. Researchers report that OD may not be influential enough to force nurses to leave their profession, however it does affect the level of satisfaction they experience regarding career choice (Howerton Child & Sussman, 2017). Due to its novelty, I had difficulty locating studies

that explored the concept of OD. However, there is a significant body of recent literature available that examines the effects of verbal abuse directed towards emergency nurses. This review utilizes this literature to explore the concepts peripherally, in order to gain better understanding of verbal abuse and how it leads to OD.

Literature Search

A search across Athabasca University Library databases was conducted including search tools Discover Ebsco and ProQuest Nursing. Four concepts were entered incorporating Boolean operators to narrow the search. These concepts were 'verbal abuse' AND 'emergency department' OR 'emergency room' AND 'nurs*'. The search strings using 'nurs*' allowed for literature including the terms 'nurse' or 'nursing' to be in the results. The following limiters were applied: (a) scholarly, peer-reviewed articles; (b) publication date set between January 1, 2016 to December 31, 2018; and (c) source type limited to academic journals. The time limiter was applied in order to review the most current literature pertaining to verbal abuse in the ED. Source type limiter eliminated other sources such as magazines or e-books. The following inclusion criteria were applied to results:

- Papers written or available in English.
- Studies that reported on patient or visitor verbal abuse.
- Studies that explored experiences of nurses working in the ED.

The nursing literature discusses the issue of workplace violence which includes physical, verbal and/or psychological harm. Much of the literature accessed focuses specifically on verbal violence, which will be the primary interest of this review. The term verbal violence, verbal aggression and verbal abuse were found among all literature and considered to be interchangeable for this review and as such, literature with these terms was included. Initially,

252 papers were identified. Titles and abstracts were reviewed in full and those studies that specifically identified as originating from hospital based EDs, and which discussed nurses' experience of verbal abuse originating from patients and visitors were isolated. A total 31 studies met these criteria and were included in this literature review.

Analysis of Verbal Abuse in the Literature

Variations of verbal abuse. Verbal abuse in the ED is an important issue and literature suggests that nurses experience different types (Al-Shamlan et al., 2017; Ashton et al., 2017; Baig et al., 2018; Han et al., 2017; Hogarth et al., 2017; Howerton Child & Sussman, 2017; Hyland et al., 2016). Verbal abuse has been considered psychological violence, which includes bullying, humiliation, harassment and threats (Al-Shamlan et al., 2017; Fisekovic Kremic et al., 2017). It is also coercive or degrading behaviour in the workplace that leads to emotional harm (Avander et al., 2016; Hassankhani et al., 2017). For example, a threatening tone of voice can escalate to a verbal threat of assault (Partridge & Affleck, 2017). Hassankhani et al.'s (2017) exploratory study of 16 Iranian ED nurses' experiences of workplace violence captured a threat towards one nurse: "I'll put the ER on fire and kill you all" (p. 3) demonstrating the severity of the threats that can occur in this environment. Threats of legal action are commonly reported by nurses that stem from perceived lapses in care from patients and families (Avander et al., 2016; Howerton Child & Sussman, 2017). This is concerning because legal threats impose upon the livelihood of individuals, at times without clear evidence.

Verbal abuse can be directed from patients and visitors however it has also been identified to originate from physicians and nursing colleagues (Chang & Cho, 2016; Li et al., 2017; Yoon & Sok, 2016). In a survey of 312 newly licensed nurses in Korea, respondents indicated that nurse colleagues were found to be the main perpetrators of verbal abuse (50%),

followed closely by patients themselves (47.8%) (Chang & Cho, 2016). Despite this, studies in this review support the notion that patients are the main source of verbal abuse towards ED nurses (Al-Ali et al., 2016; Avander et al., 2016; Fisekovic Kremic et al., 2017; Partridge & Affleck, 2017). This suggests that ED nurses are subject to multiple forms of verbal abuse from multiple sources.

Emergency department data. Research from Hassankhani et al. (2017) explained that healthcare workers are 16 times more susceptible to violence than employees in other fields, however, ED nurses in particular are at especially high risk of being subjected to verbal abuse as a result of factors including contact with stressed or aggressive patients, or those under the influence of drugs and alcohol (Al-Shamlan et al., 2017; Banda et al., 2016; Copeland & Henry, 2017; Partridge & Affleck, 2017; Pich et al., 2017; Zhang et al., 2017). A recent cross-sectional study of 391 Saudi Arabian nurses found that ED nurses are exposed to significantly ($p<0.001$) more verbal abuse (71.4%) than nurses from inpatient departments (23.4%) or outpatient departments (34.2%) (Al-Shamlan et al., 2017). Comparatively, a study of four EDs across Australia surveying 179 nurses found that 89.9% of respondents had experienced some form of verbal abuse in the preceding six months (Partridge & Affleck, 2017). These studies illustrate that incidence and prevalence of verbal abuse towards ED nurses is greater than nurses in other fields.

This literature review also found that some studies report that ED nurses accept verbal abuse as part of the job (Ashton et al., 2017; Baig et al., 2018; Hogarth et al., 2016; Hyland et al., 2016) and they also accept it as unintentional violence from sick patients experiencing medical, social or psychological crises (Hogarth et al., 2016; Hyland et al., 2016). Verbal abuse seems to be part of ED nurses' everyday work as it occurs with such frequency that nurses do not consider

it to be violence at all (Baig et al., 2018). This acceptance may infer that it is an expectation of nurses' work rather than an anomaly that should be eliminated and may be a key reason why verbal abuse is found to be so prevalent among ED nurses.

Emergency department environmental impacts. The busy ED environment is a central factor contributing to the prevalence of verbal abuse experienced by ED nurses. For example, heavy workloads in the context of relative resource deficits challenge nurses with the perpetual prioritization of patient needs (Atakro, Ninnoni, Adatara, Gross & Agbavor, 2016). The unpredictable nature of the department leads to fluctuations in patient numbers and acuity, without additional nursing support. This creates greater demand for care on the individual nurse, leading to reduced contact time between nurses and patients (Atakro et al., 2016). This can threaten the quality of nursing care and families and patients may respond with fear and defensiveness for perceived lapses in medical care.

Triage wait times. Long wait times were cited as a source of patient frustration leading to outbursts of violence (Al Bashtawy & Aljezawi, 2016; Gillespie et al., 2016; Han et al., 2017; Howerton Child & Sussman, 2017; Lenaghan, Cirrincione & Henrich, 2018; Pich et al., 2017; Zhang et al., 2017). The wait times in the triage area, in particular, is where verbal abuse was often experienced (Al Bashtawy & Aljezawi, 2016; Howerton Child & Sussman, 2017; Pich et al., 2017; Ramacciati et al., 2018). An Australian study of 531 nurses who had worked in the ED within the preceding six months found three times greater incidence of patient-related violence in the triage area (Pich et al., 2017). Research has singled it out as the starting point for aggression (Al Bashtawy & Aljezawi, 2016; Howerton Child & Sussman, 2017), in part due to patient and visitor unfamiliarity with the triage process (Howerton Child & Sussman, 2017) and further escalated by prolonged wait times. One nurse reported, "Triage is fine, if there is zero wait.

Anything other than that, the verbal insults are flying. It is exhausting" (Howerton Child & Sussman, 2017, p. 549). This data suggests that strategies to educate patients about the triage process may be of use to counteract episodes of aggression.

Ineffective communication. Workload demands can also lead to ineffective communication between nurses and their patients (Han et al., 2017; Zhang et al., 2017). For example, nurses were found to lack the time or energy to deal with verbal abuse accordingly (Han et al., 2017) because of the demands of the ED environment. Further, verbal abuse is exacerbated by the working environment of the ED such as resource deficits requiring nurses to reprioritize patients' basic needs, chronic understaffing and the over-crowded and high-acuity nature of the ED contributing to the stress of patients and nurses alike (Atakro et al., 2016; Kennedy, 2017; Zhang et al., 2017). These factors inherently create barriers to adequate communication between nurses and their patients because of the nature of the work itself.

Negative progression. Negative progression is described as an effect experienced by patients who perceive themselves as moving backwards rather than forwards in their process to receiving care (Lenaghan et al., 2018). Literature has found that the design of the ED can influence the occurrences of verbal abuse and negative progression can be felt when patients are sent back to the waiting room after already waiting for triage or registration. This has potential to increase feelings of discrimination or neglect which creates more opportunities for verbal aggression (Lenaghan et al., 2018). It can exacerbate stress levels in patients who are already experiencing heightened levels of anxiety (Lenaghan et al., 2018) thus, the tendency of patients to lash out can be rooted in department design itself, which like other instigating factors, remain beyond nurses' control.

Reasons for nurse underreporting of verbal abuse.

Lack of organizational support. Lack of organizational encouragement to report verbal abuse highlighted the lack of organizational support for nurses reporting verbal abuse (Al-Shamlan et al., 2017; Fisekovic Kremic et al., 2017; Hogarth et al., 2017; Lenaghan et al., 2018). Additionally, verbal abuse is underreported due to perceived inaction after reporting (Al-Ali et al., 2016; Al Bashtawy & Aljezawi, 2016; Al-Shamlan et al., 2017; Ashton et al., 2017; Atakro et al., 2016; Copeland & Henry, 2017; Crilly, Greenslade, Lincoln, Timms & Fisher, 2017; Fisekovic Kremic et al., 2017; Gillespie, Leming-Lee, Crutcher & Mattei, 2016; Hogarth et al., 2017; Howerton Child & Sussman, 2017; Hyland et al., 2017; Lenaghan et al., 2018; Partridge & Affleck, 2017). Specifically, Hogarth et al.'s (2016) phenomenological study of 15 ED nurses captured the feeling of one nurse: "The problem is solved at the time but I don't think anything is done after that. I think once the shift is over that's it. Nothing happens after that" (p. 78). This example suggests that organizational inaction is a primary cause of nurses' unwillingness to report incidents of verbal abuse.

Lack of clarity for nurses about the outcomes of reporting of abusive events is another area where organizational support is lacking. Studies showed that nurses found no value in reporting because it did not influence future outcomes (Al-Ali et al., 2016; Al-Shamlan et al., 2017; Baig et al., 2018; Fisekovic Kremic et al., 2017; Hogarth et al., 2016). 'Useless' was the term used by nurses to describe reporting of verbal abuse in more than one study (Al-Ali et al., 2016; Al-Shamlan et al., 2017; Fisekovic Kremic et al., 2017) which suggests that nurses in these studies found little worth in reporting or not worth their time to report. However, the benefits to reporting are clear, as this data can ultimately facilitate the formulation of preventative strategies.

Lack of physical injury. Lack of reporting verbal abuse is attributed to the belief that it did not constitute violence if no physical injury can be reported (Al-Shamlan et al., 2017; Baig et al., 2018; Hogarth et al., 2016). In Copeland and Henry's (2017) research study of 147 ED staff members, the most frequently cited reason (37%) for not reporting incidents of verbal abuse was because "nobody was hurt" (p. 72). The lack of physical injury was found to suggest to nurses that the incident lacked importance and was not important enough to report (Baig et al., 2018). Authors in this mixed method study capture an ED director stating "Now people do not consider verbal violence as violence at all. They are so acclimatized to verbal abuse that they do not even consider that it is any sort of violence" (Baig et al., 2018, p. 4).

Underlying medical condition. In some studies, nurses felt that verbal abuse was rooted in patients' underlying conditions (Al-Shamlan et al., 2017; Avander et al., 2016; Hogarth et al., 2016). This behaviour has been described as being beyond a person's control due to the influence of drugs, pain or altered mental status (Ashton et al., 2017; Baig et al., 2018; Lenaghan et al., 2018). Nurses in these studies were found to absolve these patients of blame. Yet, the absence of reporting infers that the true nature of verbal abuse in EDs is unknown and suggests that it remains difficult to develop evidence-based strategies to deal with the issue (Hogarth et al., 2017; Howerton Child & Sussman, 2017). The sense that verbal abuse can be attributed to underlying medical condition (Ashton et al., 2017; Baig et al., 2018; Lenaghan et al., 2018) or because of lack of policy countering this behaviour (Al-Shamlan et al., 2017; Fisekovic Kremic et al., 2017; Hogarth et al., 2017; Lenaghan et al., 2018) exacerbates the issue as it leads nurses to fail to report every incident.

Workplace policy.

Zero-tolerance. In the literature, nurses were described to be frustrated that little was done to prevent the explicit verbal abuse they suffered (Al-Shamlan et al., 2017; Ashton et al., 2017). A recent systematic review of 12 studies exploring staff experiences of aggression in the ED described the inevitability of aggression in the ED due to lack of organizational preventive policies (Ashton et al., 2017). One ED nurse providing care in the United States reported: "The sign also stated that if you acted in any of these ways, you were going to be escorted out by security and police. I have yet to see this happen" (Wolf, Delao & Perhats, 2014, p. 307).

The inconsistent enforcement of institutional policies, specifically, a zero-tolerance policy, remains a barrier to effective implementation of prevention programs in the ED (Al-Shamlan et al., 2017; Ashton et al., 2017). Some studies found that nurses incorrectly believed a zero-tolerance policy towards violence, including verbal violence, existed in their institution where one did not (Copeland & Henry, 2017; Hogarth et al., 2016; Howerton Child & Sussman, 2017). Explicit zero-tolerance policies may be a viable means of deterring verbal abuse and other violence perpetrated by family members or visitors (Copeland & Henry, 2017) however it is argued by some researchers that a zero-tolerance policy has not yet been well-established as a means to reduce workplace violence (Howerton Child & Sussman, 2017). National media campaigns to ensure consumers are aware of zero-tolerance policies for verbal abuse in the healthcare sector have also been suggested (Ashton et al., 2017; Howerton Child & Sussman, 2017; Hyland et al., 2017), nevertheless, the inconsistencies in policy enforcement leave the impression upon nurses that they are unprotected in their front-line role and that workplace violence policies are otherwise meaningless.

Workplace interventions/tools. Training programs focussed on improving nursing empathy level and effective communication skills have been suggested as a means for prevention of verbal abuse (Al-Ali et al., 2016; Howerton Child & Sussman, 2017; Ramacciati et al., 2018; Zhang et al., 2017). One grounded theory study of 28 ED nurses discussed the tools available to ED nurses to de-escalate violent situations (Howerton Child & Sussman, 2017). These tools were found to be designed for other settings, such as correctional facilities and modified for an ED (Howerton Child & Sussman, 2017). Mandatory de-escalation classes were found to lack clear evidence on the reliability of their strategies in the ED setting specifically (Howerton Child & Sussman, 2017). Conversely, 47% of nurses in another study which surveyed 147 ED nurses, believed that de-escalation training would make the environment safer (Copeland & Henry, 2017). This variation suggests that there is a need for a validated ED-specific de-escalation tool that is simple to use and apply in time-sensitive situations so that ED nurses are armed with appropriate tools for mitigating violence that arises in their workplace. This review found that ED nurses believed verbal abuse in their workplace was preventable and emphasized the need for education on de-escalation techniques (Al-Shamlan et al., 2017; Hassankhani et al., 2017; Hogarth et al., 2017; Howerton Child & Sussman, 2017; Zhang et al., 2017).

The Project Secretariat of the Ministry of Labour and Ministry of Health and Long-Term Care (2017) in the Province of Ontario, Canada, in response to an identified increase of workplace violence in hospitals mainly experienced by nurses, established an initiative in an effort to reduce risk of violence for nurses. This report concluded that the general public lacks awareness of the impact of violence on healthcare workers, supporting the need for a national media campaign. It also confirmed the importance of maintaining reporting systems to capture data, recognizing the gap in information should data not be reported or collected accurately.

Additionally, this report reaffirmed that hospitals should set goals to eliminate workplace violence through collaboration with unions, patient advocates and frontline staff.

Outcomes of Verbal Abuse Towards Emergency Nurses

Organizational costs. The aggression that ED nurses face has been found to increase costs to the organization due to increase in sick leave, workers' compensation claims as a result of psychological effects, or resignation (Al Bashtawy & Aljezawi, 2016; Hassankhani et al., 2017; Howerton Child & Sussman, 2017; Li et al., 2017; Yoon & Sok, 2016). A persistent culture of verbal abuse towards nurses can also lead to compromised quality of care as less experienced nurses are utilized due to possible recruitment problems (Ashton et al., 2017; Howerton Child & Sussman, 2017; Yoon & Sok, 2016). The effects of verbal abuse on both nursing staff and the organization as a whole demonstrate the importance of ensuring that this issue is addressed promptly when it occurs. ED nurses must have the capacity to recognize and be empowered in their reporting of verbal abuse. Additionally, organizational leaders must support ED nurses when reporting takes place, so that the ultimate goal of compassionate patient care is not compromised.

Impact on nurses' work. Verbal abuse towards ED nurses impacts nurses' work performance, including reports of losing ones' concentration leading to medication errors and lessened work productivity (Fisekovic Kremic et al., 2017; Hassankhani et al., 2017; Kilic et al., 2016). The evidence of diminished quality of nursing care as a result of verbal abuse was cited by many studies (Al Bashtawy & Aljezawi, 2016; Banda et al., 2016; Hassankhani et al., 2017; Yoon & Sok, 2016); one phenomenological study of 30 ED nurses in three Taiwanese EDs reported a tendency to "express discharge" (Han et al., 2017, p. 432), negating the possibility of pre-discharge health teaching that is vital to complete nursing care. In Suárez, Asenjo and

Sánchez's (2017) research study of 131 Spanish ED workers, the quality of healthcare provided was closely related to job satisfaction, and avoidance becomes a tool used by nurses to manage threats when problems arise. Another example of nurses using avoidance when feeling insulted from patient interactions came from a focus group of 14 Swedish trauma nurses. Avander et al. (2016) found that avoidance was a tool used by nurses after feeling insulted from patient interactions "which in turn hinders a professional relationship because of the inability of the patient and the nurse to approach each other" (p. 56). One Taiwanese ED nurse in Han et al.'s (2017) research study stated, "To be perfectly frank, I'll let my work standards sink very low when dealing with violent family members. If they can go home, I will immediately arrange for them to go, without discussing the patients' situation very much," (p. 432). Another nurse followed this sentiment saying, "I just consider myself unlucky when I'm subjected to it. I just feel that my work was particularly troublesome on the days when I received verbal violence," (Han et al., 2017, p. 431). The avoidance of complete nursing care and attention suggest that patients can and do receive reduced quality of nursing care from nurses who are victims of verbal abuse. It should serve as a signal to organizations that the ED patient experience can be compromised by the existence of verbal abuse towards nurses.

Phenomenological experiences of nurses. The lived experience of ED nurses exposed to verbal abuse has been documented in several research studies; this helps to humanize an otherwise anonymous issue. Verbal abuse towards emergency nurses is so prevalent that even victims argue that they had no choice but to bear it (Han et al., 2017; Hogarth et al., 2017). Howerton Child and Sussman (2017) captured the thoughts of one nurse who stated, "I don't know what other place in the world where they expect someone to take care of them and yet they can destroy you verbally" (p. 548). Another exasperated nurse stated, "It is exhausting for

everyone to be pissed off at you" (p. 549). Nurses verbalized that after days where they were subject to verbal abuse, they took the stress home and subsequently transferred that emotion onto family (Hassankhani et al., 2017). Some studies reported that nurses also internalized the abuse (Han et al., 2017; Hassankhani et al., 2017; Pich et al., 2017; Ramacciati et al., 2018); one nurse stated: "I went home so upset. I didn't want to talk to anybody" (Hassankhani et al., 2018, p. 4). Despite the discouragement experienced by nurses from the amount of verbal abuse they were subjected to, evidence highlighted that they still felt safe in the ED (Copeland & Henry, 2017; Partridge & Affleck, 2017) however, the feeling of security does not negate that underlying effects of verbal abuse still may permeate the nurse's psyche. Psychological trauma and stress even without physical injury can last up to 12 months following an incident (Pich et al., 2017) and as such, should be prevented.

Occupational disappointment. Occupational disappointment was identified as a novel outcome of verbal abuse and described as "the idea that RNs enter into this profession to help people and then are faced with a continued barrage of verbal abuse that disheartens nurses" (Howerton Child & Sussman, 2017, p. 547). Importantly, Howerton Child and Sussman (2017) distinguished OD from burnout and compassion fatigue; they described compassion fatigue as abrupt and a result of being exposed to someone else's trauma, where burnout was considered a more chronic response to repeated stressful exposures. Occupational disappointment is unique because it is not considered to be traumatic in nature, yet the negative stimulus is identifiable, directed to and felt by the ED nurse.

Feelings resulting from verbal abuse identified in other studies closely resemble the disheartenment felt in OD which also influenced satisfaction with career choice amongst nurses (Han et al., 2017; Hassankhani et al., 2017; Howerton Child & Sussman, 2017). Han et al.'s

(2017) research study on workplace violence among Taiwanese ED nurses discussed that continued exposure to verbal violence "diminishes the desire to work in the area of emergency care" (p. 431). It compromised nurses' compassion for their patients; "I don't really care if they live or die" says one nurse (Han et al., 2017, p. 433). Further, participants in a study of 16 Iranian ED nurses found that dealing with workplace abuse led to feelings of humiliation, insecurity and injured pride which led to loss of interest in going to work or working as a nurse (Hassankhani et al., 2017). The phenomenological experiences of 28 American ED nurses captured the feeling of being disheartened by how they were spoken to and treated by patients and family members: "Yet they expect you to be that doting person to them after they rip you apart verbally. It's just fascinating," (Howerton Child & Sussman, 2017, p. 547). Thus, persistent, unaddressed verbal abuse is evidenced to contribute to an increased feeling of OD amongst many ED nurses.

The concept of OD illustrates that a feeling of satisfaction in career choice can be lost as a result of endemic verbal abuse that is left unaddressed (Han et al., 2017; Hassankhani et al., 2017; Howerton Child & Sussman, 2017). Occupational disappointment is a newly identified outcome of verbal abuse; it remains important to distinguish OD from burnout or compassion fatigue as a unique outcome of verbal abuse from patients and/or their visitors. Despite the recent emergence of this topic, the ill effects of OD on both nurses and patients are evident and research examining this concept to address OD is warranted.

Summary

The literature suggests that ED nurses worldwide are exposed to verbal abuse often, expect it and tolerate it as part of their job. Nurses do not report it as often as they should, yet they suffer in silence and as a result patient care can be compromised. Verbal abuse contributes

to deficits in nurses' work performance, affects the patient experience as a whole and can inadvertently impact organizations due to sick time or retention issues. Further, it has been demonstrated that verbal abuse leads to OD in nurses; scholars suggest that this has a negative impact on both the delivery of care and the satisfaction with choice of career amongst nurses (Hassankhani et al., 2017; Han et al., 2017; Howerton Child & Sussman, 2017). Continued exposure to verbal abuse leads to ED nurses questioning their career choice and a potential loss of skilled nurses in their field. If patient care is to remain a priority for organizations, administrators and nurse leaders must acknowledge explicitly that verbal abuse exists and should not be tolerated. Yet OD as an outcome of verbal abuse has not been well researched and a more thorough exploration of the concept is warranted.

Occupational disappointment has been witnessed firsthand in the ED I am employed in, and as such, this thesis is reflective of my own interest in this novel concept. Feeling disheartened is palpable in my workplace and coupled with the events that occurred in 2016, are what serve as the motivation for exploration of the concept of OD. This thesis focuses on refining this concept, exploring the relationship between verbal abuse and OD and how nurses experience, manage and respond to this feeling.

Research Question

The question for this master's study is: How do emergency department nurses experience OD as a result of verbal abuse?

Chapter 3. Qualitative Descriptive Theoretical Framework

Qualitative descriptive (QD) methodology is a suitable choice to study the novel concept of OD in ED nurses. Sullivan-Bolyai, Bova and Harper (2005) argued that the use of this methodology in healthcare research is valuable because it provides clear information on how to improve practice. Qualitative descriptive methodology is appropriate for research focused on gaining insights about a poorly understood phenomenon (Kim, Sefcik & Bradway, 2017) and answers questions such as: What are the concerns of people about an event? or What are people's response toward an event (Sandelowski, 2000)? This thesis will further define OD and provide a rich, descriptive analysis of this novel phenomenon.

Qualitative descriptive methodology has been criticized for being the least theoretical among the qualitative approaches however, QD draws from naturalistic inquiry; data collection usually entails focus groups and/or individual interviews (Sandelowski, 2000). This suggests that subjectivity is valuable in the data. Sandelowski (2000) clarified that researchers embarking on any qualitative study must make explicit their philosophical orientations because it determines a suitable design to achieve the goals of the study (Sandelowski, 2010); an interpretivist paradigmatic lens is appropriate to philosophically orient this research. The following sections outline the philosophical foundation this study rests upon.

Philosophical Overview

A central tenet of the interpretivist paradigm is to understand the subjective world of human experience by understanding and interpreting the viewpoint of participants in a study (Kivunja & Kuyini, 2017) . In this research study, I will endeavour to understand ED nurses' perspective of OD, elicit themes, and uncover the social construction of themes that arise from the interview data. The nature of the interpretivist paradigm demands that researchers peer

through the lens of the nurse who experiences OD in order to understand the individual and their interpretation of the world (Kivunja & Kuyini, 2017). The interpretivist paradigm and the focus on subjectivity is well-suited to guide this research to make meaning of the data collected. The interpretivist paradigm assumes a relativist ontology, a subjectivist epistemology and a naturalist methodology (Kivunja & Kuyini, 2017).

Ontological assumptions. Ontology is concerned with the nature of reality, asking questions about what reality is and what is possible (Kivunja & Kuyini, 2017). Qualitative descriptive research seeks in-depth understanding through analysis and interpretation of the meaning people ascribe to the phenomena they experience (Bradshaw et al., 2017). The assumption of a relativist ontology suggests that there can be multiple realities which are studied through interactions between the researcher and participants (Kivunja & Kuyini, 2017). Howerton Child and Sussman (2017) have described in their study that persistent verbal abuse leads to a feeling of OD. A relativist ontology assumes that not every ED nurse who experiences verbal abuse will also experience OD; it is the individual history of the nurse that defines how verbal abuse will impact each nurse.

Epistemological assumptions. Epistemological assumptions in the interpretivist paradigm relate to subjectivism, that the reality of real-world phenomena relies on an individual's subjective awareness of it. The QD approach accepts that multiple realities exist; knowledge about OD in this instance can be discovered by speaking with those who have personally experienced OD (Bradshaw et al., 2017). The assumption is that knowledge is attained by minimizing the distance between researcher and researched. This requires researchers to get as close as possible to participants being studied in order to acknowledge the value of the contextual setting and understand participants' perspectives (Creswell & Poth,

2018). Aligning with this epistemological assumption, I will gather subjective evidence from nurses themselves who are or have identified as having experienced OD. This type of knowledge attainment is congruent with a relativist ontology, that the truth of a phenomenon like OD is contextual and based upon specific experiences of a person (Kivunja & Kuyini, 2017).

Methodology. A naturalistic methodological approach is most appropriate to understand the concept of OD; researchers learn about new phenomena by striving to learn from those who experience it firsthand (Sandelowski, 2000; Sandelowski, 2010). Naturalistic inquiry is the commitment to study something in its natural state, to the extent that research allows. In assuming a naturalist methodology, the researcher acts as participant observer and utilizes data gathered through interviews, discourses and reflective session (Kivunja & Kuyini, 2017; Sandelowski, 2000). Qualitative descriptive research is subjective, valuing the subjectivity of the participants' experience of OD and also recognizing the experiences of the researcher. As an inductive process, QD seeks to describe and understand phenomenon using an emic stance, that is, utilizing perspectives of participants who have experienced OD as a means to gain full grasp on the concept itself (Bradshaw et al., 2017; Neergaard, Olesen, Andersen & Sondergaard, 2009).

Arguably, a phenomenological approach could also apply in this study. An emphasis on the phenomenon to be explored with a group of individuals all experiencing the phenomenon, summarizing 'what' and 'how' the individuals have experienced it are described as features of a phenomenological approach (Creswell & Poth, 2018; Smythe, 2012). Qualitative descriptive research also is well suited for 'why', 'how' and 'what' questions about behaviour, yet, when I examine my own study goals, QD research generates a focused summary and understanding of a health-related event shaped by context and experiences. Phenomenological research, on the

other hand, provides understanding of the essence of a phenomenon and how it is to be meaningfully aware of one's experiences (Willis, Sullivan-Bolyai, Knafl & Cohen, 2016). Thus, for the purposes of this study, QD research helps meet the goals of this research, to have sufficient understanding of OD that will guide future decisions rather than to advance theorizing.

In analysis, this type of research methodology yields a rich description of the experience; in essence, findings will be reported in language similar to informants' own language (Bradshaw et al., 2017; Sandelowski, 2000). Qualitative descriptive research is the right approach when the inquirer is "aiming to describe the informant's perception and experience of the world and its phenomena" (Neergaard et al., 2009, p. 2). My interest lies in linking emerging findings of OD with the clinical experience of participants. By utilizing the methodological framework of QD to uncover the subjective details of OD and any pertinent outcomes and experiences that follow, there is opportunity to elicit themes which provide clarity to this novel phenomenon.

Criticisms. Sandelowski's seminal QD article has been used as a guide for researchers employing this methodology. Sandelowski (2000) stated that this methodology was the "least theoretical" (p. 337) and though this scholar clarified this stance a decade later, it has been incorrectly interpreted following the author's earlier writings. In Kim et al.'s (2017) systematic review of 55 studies that utilized QD methodology, most (n=48) did not specify a theoretical or philosophical framework. The lack of a theoretical foundation in research is a limitation because the research paradigm defines a researchers' philosophical orientation and has significant implications for every decision made in the research process (Kivunja & Kuyini, 2017). I have addressed this criticism by indicating that this study is situated in the interpretivist paradigm and align myself as researcher utilizing a lens that values subjectivity in the data and study design

methods that optimize this goal. This explicit philosophical orientation and my study goals of gaining a rich, descriptive understanding about OD remain congruent with the goals of QD methodology.

Another criticism of QD is the limited discussion regarding QD in textbooks or publications (Kim et al., 2017). The systematic review conducted by Kim et al. (2017) found only seven articles with specific guidance on how to execute this sort of research methodology. Without a precise blueprint available to a novice researcher like myself, it can become easy to stray from QD methodology and into methods utilized in other research traditions. However, in their review, the authors were able to describe specific characteristics of methods and findings common amongst most QD literature. These features include:

- drawing from a naturalistic perspective by examining phenomenon in its natural state,
- typically individual or focus group interviews used as data collection strategies,
- employing purposeful sampling techniques such as maximum variation sampling which is advantageous for obtaining broad insight and rich information, and,
- content analysis as a primary strategy for data analysis allowing researchers to stay close to the data (Kim et al., 2017).

These features are useful to provide a framework in this research process in order to meet study goals. Adherence to these strategies will also aid in meeting the four aspects of research trustworthiness: credibility, dependability, conformability and transferability (Cronin, 2014) which is discussed in Chapter 4.

Bias. As both researcher and frontline ED nurse who has previously experienced verbal abuse from patients, it is important to discuss my own biases at the outset. I have a keen interest

in exploring and understanding OD, not only as a researcher seeking to identify a niche in nursing literature, but also as a career ED nurse. The findings of this study may lead to a renewed interest in enhancing the nursing experience in the ED, however, there is a pressure that exists within myself to uncover positive findings in what appears to be a phenomenon that highlights the deficits in this type of nursing. To address this, I will incorporate a strengths-based approach as I discuss the findings. Strengths-based nursing provides a balance to situations that are deficit-based, instead focusing on understanding perceived deficits in nursing within a broader context that promotes inner and outer strengths (Gottlieb, 2014). As researcher, incorporating this philosophy into reporting the data, recognizing that instances of seemingly negative events are opportunities, in fact, to look at possibilities for growth, is vital to changing what can appear to be an undesirable narrative, instead focusing on the strengths of ED nurses themselves. Adopting a strengths-based filter in the discussion of the reported data highlights instances where there are "more things that are right than are wrong" (Gottlieb, 2014, p. 24).

Contribution to Nursing Literature

A rich description of an event from those who experience it, in easily understood language about a little-known phenomenon is the goal of QD research (Bradshaw et al., 2017; Kim et al., 2017). The goals of this research are not to advance theorizing but rather, to gain a deep understanding of how nurses experience OD in their practice and utilize their insights to guide nursing decisions. Though researchers strive to stay close to the data itself (Bradshaw et al., 2017; Sandelowski, 2000), this does not suggest a mere summarizing of the data or that there is no interpretive process completed. Instead, the contribution of this QD study is the development of themes drawn from the rich description of participants' experiences of OD (Bradshaw et al., 2017). Thematic findings from these nurses can enable recommendations in

similar practice settings and may lay the foundation for future theoretical work moving the literature about OD closer to the point of influencing nursing interventions and improving patient outcomes in all practice settings.

Chapter 4. Qualitative Descriptive Methods

This section provides an overview of QD study design with overview of sampling and the sample, data collection, data analysis, ethical considerations as well as insight on how I maintained a rigorous study.

Sampling and the Sample

Sound knowledge of population characteristics and sampling methods are necessary to ensure that the sample is appropriate for study goals. In QD research, a purposive or purposeful sampling strategy is utilized (Bradshaw et al., 2017; Kim et al., 2017); a review of QD studies found that authors use any combination of convenience, maximum variation and snowball sampling (Kim et al., 2017).

Sampling.

Convenience sampling. Convenience sampling involves the selection of participants from a population because they are available (Bradshaw et al., 2017; Kandola et al., 2014). Convenience sampling was used to identify those who were willing to participate and fit inclusion criteria. A recruitment poster with a request for participants was emailed to all nurses in four EDs within the Lakeridge Health Corporation was sent and those who expressed interest in participating were contacted. A copy of the recruitment poster can be found in Appendix A.

Maximum variation sampling. Maximum variation sampling is a purposeful sampling technique and a popular approach in qualitative studies (Creswell & Poth, 2018; Kim et al., 2017). Maximum variation sampling consists of predetermining inclusion criteria and then selecting participants that are quite different on the criteria, thus maximizing differences (Sandelowski, 2000). This type of sampling was not utilized in this study due to the small sample of respondents via email.

Snowball sampling. Snowball sampling is used when there is a requirement for a wider sample of study participants. This is a method used if the sample is hard to find or access (Kandola et al., 2014). This strategy was attempted as a means to reinitiate contact with respondents who had initially offered interest in participation but then subsequently difficult to reach. It was also proposed to all participants who consented to the study. One nurse reported their intent to forward study details to colleagues she believed would fit inclusion criteria however, no additional participants were recruited using snowball sampling.

Sample size. In terms of sample size in qualitative case studies, Bradshaw et al. (2017) stated that qualitative sample sizes tend to be small "because of the emphasis on intensive contact with participants" (p. 4). Of importance in qualitative designs, is the concept of data saturation, the point at which, no new concepts emerge from the data, no new coding occurs, or no new information is attained from participants. Yet, because there is no fixed rule to establish that data saturation has occurred, an adequate sample size is one that sufficiently answers the question with the sampling size goal of obtaining cases that are rich in information (Bradshaw et al., 2017; Sandelowski, 2000). I endeavoured to reach a point of data saturation amongst my small sample size. I projected to interview four to eight nurses; the data gathered from my sample of six nurses potentially allowed for a degree of relevance to other nurses who experience OD in similar contextual situations.

Inclusion criteria. In QD research, participants are chosen because they represent a combination of pre-selected variables (Bradshaw et al., 2017; Sandelowski, 2000). The variables or inclusion criteria in this study are nurses who: (a) have experienced verbal abuse from patients or their visitors, (b) are able to provide contextual insight into the event (c) are employed at

Lakeridge Health EDs, and (d) self-identify as experiencing or have experienced OD. Nurses who met these inclusion criteria and consented to the study were invited to participate.

Sample characteristics. Data was collected from six currently or previously employed ED nurses. Three nurses were employed full-time, one employed casually, one was part-time employed, and one had previously (within the year) been employed as a full-time ED nurse but now worked full-time in the intensive care unit. The part-time nurse had previously been employed full-time and was transitioning out of the ED to begin a contractual role in another city at the time of interview. All nurses interviewed were female (n=6) and ages of the nurses ranged from 24 to 43 years. Total years of nursing work experience ranged from 2 to 18 years. Cumulative nursing experience varied from nurse to nurse; three nurse participants had solely spent the entirety of their nursing careers within one or more EDs where the remaining participants had garnered experience from various other nursing areas such as surgery, orthopedics, float pool, medicine or outpatient plastics clinic.

Data Collection Methods

An email outlining a request for participants in this study (see Appendix A) was forwarded to the registered nurse and registered practical nurse group at four EDs within the Lakeridge Health Corporation. I contacted the nurses who responded to the email. Participants in this study met inclusion criteria and informed consent was obtained. Initially, the primary source of data collection was planned to be face-to-face, individual interviews but adjustments to the method of data collection were made in light of the global coronavirus pandemic which forced the closures of businesses and schools and enforced mandatory protocols related to physical and social distancing (Public Health Agency of Canada, 2020). Six respondents

voluntarily agreed to participate in this study, one potential participant was contacted twice after proposing initial interest in study engagement but did not provide consent to participate.

Interviewing. The primary source of data collection in QD research is semi-structured, in-depth interviews (Bradshaw et al., 2017; Neergaard et al., 2009; Sandelowski, 2000). Interviewing is a qualitative data collection tool that allows study participants to discuss their experiences. It also enables researchers to ask questions within the predetermined boundaries of the case. Qu and Dumay (2011) described the utility of semi-structured interviews as a common qualitative research method which involves prepared questioning guided by identified themes with periods of probing to elicit more elaborate responses. The flexibility of this type of interviewing allows participants to respond in their own ways so that I can fully comprehend the social world in which they experience OD.

These types of interviews typically range in duration between 30 minutes to several hours to complete (DiCicco-Bloom & Crabtree, 2006) and each hour of recorded data can require as much as four to eight hours of transcription for novice researchers (McGrath et al., 2019). Though I aimed to maintain the duration of interviews with participants from 30 to 90 minutes, each interview I conducted lasted approximately 20 to 40 minutes in length.

A total of six in-depth interviews were conducted with six participants in September and October 2020. The interviews were digitally audio-recorded following informed consent from participants. Interviews were pre-arranged for dates and times that were convenient for the participants. Efforts to arrange for secure video-conferencing options as a method of data collection were made and preference for either telephone or secure video-conferencing was offered to participants; all nurses in this study opted to be interviewed via telephone. An

interview protocol with six questions was used as a guide for each interview. Questions included:

- What is your interpretation or understanding of the term occupational disappointment?
- Tell me about a time when you experienced verbal abuse from a patient and/or their visitor that led to a feeling of occupational disappointment.
- What were the actions you took, or didn't take, in response to a patients' verbal abuse directed towards you?
- How did the feeling of occupational disappointment change or alter your nursing practice?
- Do you think that occupational disappointment amongst emergency nursing staff is addressed by those in leadership?
- What are some suggestions you think would be effective in managing emergency nurses' experiences of occupational disappointment?

These questions or a slight variation of these questions were asked of each participant, however any opportunity to elaborate or explore a concept was taken in order to gather a richer description of each participants' experience of OD. Examples including encouraging participants to describe personal experiences to the best of their recollection, describing the context of the interaction between nurse and patient, examining the personal feelings that followed each event or discussing the ideas that developed from the negative or positive interpretation each participant had of OD.

Data Analysis

Data collected from six in-depth telephone interviews from ED nurses exploring their experiences with OD were recorded. I transcribed each digital audio recording to a word-processed document by hand. Each transcribed document was anonymized and stripped of identifying names and descriptions of any participant, staff or colleague. Any identifiable contextual factors that could potentially lead to participants identity being revealed was noted at this time.

Interview data was analyzed using content analysis, a strategy frequently employed by those researching using QD methodology. Content analysis is an inductive approach with the purpose of deriving concepts, themes or a model through interpretation from raw data. Listening to voices of participants and then transcribing of collected data from interviews helps the data to come alive. It is in doing this that researchers are able to reduce the data to coded units and cluster them into categories of shared characteristics (Vaismoradi & Snelgrove, 2019). This was done keeping in mind what the data said and how it was said, staying close to the data and meeting the goals of the QD methodology (Bradshaw et al., 2017; Sandelowski, 2000).

The initial transcribed recording was imported into NVivo and codes were identified from themes prominent in the initial recording. This process of constant comparison, helped to identify events, compared them to emerging themes, highlighted main ideas as codes related to the phenomenon ultimately leading to theme development (Vaismoradi & Snelgrove, 2019). Once all recordings were imported into NVivo and codes developed were deemed to have been satisfactorily exhausted, each recording was then reanalyzed to ensure that data from the first imported recording was categorized into codes developed from later recordings. The iterative

process of reading, reviewing and refining data was repeated with each subsequent transcribed recording. Codes were further reduced into clustered categories of similar characteristics.

Revisiting the goals of the study at this point helped narrow the total codes into more specific categories that capture the prominent themes of OD as experienced by participants. Three prominent themes were identified that correlate with study goals of understanding the issue of OD as it relates to ED nurses as well as to answer questions from Sandelowski's (2000) seminal QD work: What are the concerns of people about an event? What are people's response toward an event? Codes were reorganized with this renewed focus on study goals.

Memoing. Memoing also helps facilitate data analysis; these short ideas or concepts help synthesize the data and can also serve as an additional data source (Kim et al., 2017). The act of writing notes or phrases in the field notes as the researcher explores the data collected. It contributes to codes and theme development and can also represent researchers' thoughts in action (Creswell & Poth, 2018; Kim et al., 2017).

I collected memos during data collection as interviews occurred in a journal for many reasons including to note issues that were discussed that piqued my interest, to capture themes that had not previously been identified by other nurses and upon which I wanted to explore, as well as strengths or notable aspects unique to each participant. These notes were transcribed onto a word-processed document and also imported into NVivo and subsequently coded into appropriate thematic categories.

Memoing is something I incorporated during data collection and analysis. In analysis, memos were noted in the margins of the transcribed interviews. Memoing during data analysis represented my own piecing together of themes and subthemes and linked similar concepts discussed by different participants. This action also served to remind me to revisit certain

aspects of the data to ensure nurses' voices were adequately captured. All noted memos during data collection and analysis were handwritten.

Ethics

Explicit discussion of ethics is vital to safeguard participants and maintain integrity of the study. Bradshaw et al. (2017) argued that participants' confidentiality and anonymity is at risk of compromise due to the data collection method of face-to-face interview required in a naturalistic methodology. Additionally, the more information researchers give in detailing rich description, the greater the chance of participant identification. Research Ethics Board approval was obtained from the Athabasca University Research Ethics Board and Lakeridge Health Research Ethics Board. In the context of ethical considerations, I will outline the processes adopted which relate to confidentiality and anonymity, informed consent, and avoiding harm.

Confidentiality and anonymity. Confidentiality refers to the fact that researchers know the identity of participants but remain committed to withholding both the persons' identity and participation in the study (Surmiak, 2018). Confidentiality is the guarantee to participants that identities are protected from the public. Pseudonyms applied to participants at the outset of data collection removed gender and human-identifiable features in the data, ensuring confidentiality (Petrova, Dening & Camilleri, 2016). Additionally, I maintained confidentiality by not reporting data that could lead to a participant's identity. The context in which data is discussed was masked to some degree to ensure that study findings were as close to the meaning literally described by participants, a fundamental goal of QD research (Bradshaw et al., 2017).

Roth and von Unger (2018) discussed the issue of confidentiality and anonymity. Protecting anonymity involves deleting identifiable data so participants and/or their place of work are not able to be determined; the most common technique to do this is the use of

pseudonyms (Surmiak, 2018). Surmiak stated that anonymization of participants may also serve as a guarantee of authenticity of participant statements (2018). In this study, pseudonyms were adopted to maintain anonymity and prevent negative consequences for participants, such as jeopardizing employment in the instance of reporting unfavourable data (Creswell & Poth, 2018). The pseudonyms applied to participants were securely stored in an encrypted password-protected file on a password-protected computer along with a master key linking pseudonyms to participants. I de-identified participants at the onset of data collection, prior to each interview. All recordings transcribed omitted identifiable data as well as anonymized participants concurrently.

Informed consent. The *Tri-Council Policy Statement* (TCPS) guides Canadian researchers in the conduct of research involving humans (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research, 2014). The TCPS states that consent shall be informed meaning that participants shall have full disclosure of all info necessary to make an informed decision to participate in the study. I provided informed consent at the outset to prospective participants outlining details of the study. See Appendix B for a copy of the informed consent document. This included the purpose of the research, risks and potential benefits that could arise from participation, measures taken for dissemination of results, contact information as well as an assurance that participants are under no obligation to participate and able to fully withdraw at any time without prejudice. Participants in this study were viewed as autonomous with the right to voluntarily accept or decline to participate in the study, in addition to, ceasing participation at any stage without prejudice (Bradshaw et al., 2017).

Avoiding harm. As a healthcare worker conducting research in the field in which I am employed, it is noteworthy that such research can contribute to a positive difference in the lives of the researched, improving delivery of care in the emergency setting and can provide a framework to challenge the notions of OD. The opportunity to engage in such sensitive topics can also pose emotional risks to participants. A protocol is recommended to be in place should it become necessary to deal with distress (Bradshaw et al., 2017; Sanjari, Bahramnezhad, Fomani, Shoghi & Cheraghi, 2014). Considering that the in-depth discussion of OD indeed was a topic that stirred up many emotions, I made available the information for the employment assistance program (EAP) at Lakeridge Health which provides professional confidential counselling for participants who wished to access these services following the research interview.

Avoiding harm to the researcher was also considered. In a similar way, researchers also can suffer ill effects during data collection. These can include exhaustion, fatigue as well as exposure to the vicarious trauma of nurses recounting their experiences of verbal abuse, of which I am familiar and have previously experienced. Sanjari et al. (2014) stated that researchers should reduce the risk of encountering these effects by properly scheduling interviews, allowing ample recovery time between interviews and to be aware of the precise reason for involvement in a study. Throughout this study, the ability to turn to my own research supervisor at any time was a useful strategy to address these or any issues. The challenges I personally faced often related to balancing full-time employment with part-time research. I was able to connect and reconnect often through email and virtually with my supervisor. I found that setting task deadlines for myself helped me carve out necessary blocks of time designated for research work.

Incidentally, this study was conducted during a global pandemic and there were many challenges that came with researching during this time period. The research proposal that

outlined steps to complete this research was prepared prior to the beginning of the pandemic and needed to be revised as it was submitted to my institutional ethics board during the height of the pandemic. Various aspects of this study's methods needed to be renegotiated in light of social and physical distancing policies in place both federally and locally. Additionally, secure methods of communication needed to be reimagined in order to ensure anonymity and confidentiality were upheld within distancing requirements. The added logistical requirements created additional stressors for both researcher and participants but necessary in light of the seriousness of this global health crisis.

Self-reflection also helped me to identify my own concerns related to data collection and analysis and reassess how these issues affect data interpretation. Of greatest issue to me during the time of data collection and analysis was not the task at hand but finding the time to accomplish the work itself. Again, creating deadlines were important here, but also taking time to look at the research daily, regardless of the time spent looking. This act allowed me to think more often of the work and reflect upon it daily. I believe this reflexive act contributed substantively to the study.

Rigor

Lincoln and Guba (2000) proposed criteria to assess the rigor of qualitative research: credibility, dependability, confirmability and transferability. Quality in the research process and data collected is an absolute requirement for all approaches to research. In this section, I discuss the approaches I used to maintain a rigorous study.

Credibility. Credibility refers to the value and believability of the findings (Houghton et al., 2013). Strategies used to enhance credibility include establishing rapport and developing a trusting relationship (Bradshaw et al., 2017). Hamilton (2020) stated that trust in the researcher-

participant relationship cannot be assumed, yet when it is achieved, it allows for open dialogue during interviews and enables researchers to elicit quality data. One strategy I used to aid in trust development was by connecting to the participants through kinship ties. By revealing to participants my experience as an ED nurse as well as my interest in OD and commitment to change in ED nursing culture, allowed for a connection that led to a trusting relationship. Rapport between the researcher and participant is also vital because it too contributes to a trusting relationship (Hamilton, 2020). A clear understanding by participants of my role both collegially and academically was imperative, and this was established at the outset of interviews by explaining the background of my interest as well as goals for the research as a whole. Demonstrating respect for the time given through participation in the study and showing sincere interest in the stories of participants as valuable and important were of importance. These strategies contributed to the credibility of research.

Transferability. Transferability is the ability to apply findings from a particular study to another in a similar context or situation (Houghton et al., 2013; Thomas & Magilvy, 2011). To achieve this, researchers use rich, thick description, which are detailed contextual summaries for the reader to make informed decisions about the transferability of the findings (Thomas & Magilvy, 2011). For this study, thick description was achieved when including a detailed account of participants' experiences of OD in their own words. Contextual information was reported detailing situations leading to episodes of OD as allowable to preserve anonymity. I endeavoured to explore each response provided by participants so that clarity in each contextual situation could be achieved. Clarity provided in thick description served to enhance the transferability of this study. Additionally, study details that provide a clear outline of steps taken in the research process enrich the transferability of research (Bradshaw et al., 2017). I have

endeavoured to justify my choices in all aspects of this study; this enhances the possibility that findings will be transferable to another similar contextual setting.

Dependability. Dependability refers to the consistency of the findings or whether one researcher can follow the decisions of another researcher (Houghton et al., 2013; Thomas & Magilvy, 2011). Strategies used to establish this criterion include having peers participate in the analysis process and providing information about research methods so that others can following in the decision-making process. The following criteria are outlined in detail within this thesis so that others may follow my thought processes as I explored the concept of OD:

- describing the purpose of the study;
- discussing sampling protocols and rationale;
- describing in detail data collection processes;
- explaining how data analysis occurred;
- detailing the interpretation and presentation of the findings; and
- outlining the specific techniques used that meet the credibility requirements of the study (Thomas & Magilvy, 2011).

An audit trail, an essential part of a rigorous study, was maintained through notes in a reflexive journal as well as through memos and notes made in the processes of data collection and analysis. An audit trail is achieved by logging processes which explain how connections in analysis are made which contribute to the analysis as a whole (Creswell & Poth, 2018). For myself, this process began by looking at memos noted during data collection because at the outset, there were themes that were greatly consistent among nurses. These prominent themes were pulled from these notes, topics that were always discussed among participants when asked about OD. Themes were also generated from one or two participants who highlighted new

concepts related to OD that others did not. Often, these were written down at the time of interview so I could remember to inquire upon it further. At times, they were ideas not yet considered to be related to the concept of OD but identified as being so by participants. This collection of ideas derived from my written notes were adopted as codes and entered into NVivo. Interviews transcribed from digital audio-recordings were added as files in NVivo and the software was used to code into the existing themes. A revisit of interview data then generated several more themes and subthemes and interview data was coded to these headings. Finally, a reconsideration of study goals was needed to both narrow my focus as to address the methodological requirements of this QD study. Accompanying these tasks are the handwritten notes in my reflexive journal that support my thinking at the time and can be examined by those who endeavour to seek clarity on the rigorous nature of this study.

Confirmability. Confirmability occurs when credibility, transferability and dependability have been achieved. Creswell and Poth (2018) suggested that qualitative research must be reflective, and the researcher shall maintain a sense of self-awareness regarding the data collected and findings that are uncovered. This was a continuing goal of mine, to remain open within the process of data collection and analysis. I also adopted a process following each interview where I documented field notes regarding my personal feelings, biases and beliefs that were elicited. This helped support my own reflexivity. Houghton et al. (2013) reported on the importance of the researcher in qualitative research, to be self-aware in the research process as well as methodical in the processes carried out in the study. The reflective diary was prioritized during the data collection and analysis phase to ensure transparency in my audit trail. This practice also promotes dependability; allowing other researchers into my documentation allows them to understand the decision-making process within this study.

Chapter 5. Study Findings

ED nurses who experienced verbal abuse from patients and/or their visitors also may experience OD. The findings of this study were supported by what has been previously understood in the literature related to nurses and verbal abuse. Findings indicate that these nurses frequently encountered verbal abuse from patients and/or their visitors and acknowledged that OD results from the many unprovoked and unmitigated events of verbal abuse. Nurses all agreed that they experienced OD intermittently as a result of verbal abuse. The following section discusses the findings from nurses in this study including nurses' experiences of OD, nurses' concerns regarding OD and nurses' responses to OD.

Nurses' Experiences of OD

Nurses in this study were able to concisely describe their experiences of OD as a result of verbal abuse. Every nurse interviewed readily stated that OD was common and prevalent among that it was often left unaddressed. Erika, an ED nurse of three years stated,

> [management] likes to say a lot of things like "that's the nature of emerg [*sic*]" but my issue is it's not emerg [*sic*] nursing that is my problem. You're always going to have people who are aggressive, you're always going to have that no matter where you go, and I did expect that to some level, but it's the lack of support that makes it unmanageable for staff. We don't leave because somebody swore at us, we leave because we don't feel supported by management.

Verbal abuse from patients and/or their visitors was expected from the nurses interviewed, it was a well-known side effect of working in a high-acuity, high-volume and unpredictable field, yet the feeling itself of OD was often compounded by this reality and by the lack of support felt

directly by nurses in this field. Another ED nurse, Sabrina, with two years of ED experience agreed that,

> It's definitely multifactorial, it's not just one…it can come from verbal abuse…but I think there's also factors that play into it…if the department was run better or we were better staffed then that can help mitigate those feelings, but…they compound onto each other and then you get that occupational disappointment.

Occupational disappointment was found to be a concept that required deconstruction; data collected from study participants showed subthemes were evident within a larger concept of OD.

Powerlessness. The feeling of powerlessness was a common subtheme when analyzing the interview data. As a response to verbal abuse in the ED, participants often described their knowledge of department policy in relation to abuse but challenged that it was rarely enforced due to the rights of patients to seek medical care. Nurses interviewed challenged the legitimacy of such a policy if it was not enforced. Nurses also expressed a lack of ability to respond to verbal abuse in a way that was overtly supported by their leadership team. Dale, an ED nurse of eight years stated,

> We have this code of conduct…and there is a whole nice paper on the wall posted all over the place about patient conduct and nurse conduct, except theirs is tolerated and ours isn't…it will always come down to we should have done something differently.

In an ever technologically advancing era, the threat of recording exchanges between nurses and patients loomed heavily over nurses interviewed. Social media and the implications of being outed, labelled as a bad nurse on social media contributed to the feeling of powerlessness in ED nurses.

> The people get to just leave with this video of you just standing there…and now there's a storyline in the world that's fake and your face is attached to it…you don't get the opportunity to defend yourself in any way, so I feel like the deck is stacked against you in terms of your ability to say, "that's not actually what happened."

Dale also supported this belief: "The person gets their side of the story, but the other person doesn't get their side of the story and it gets blown out of proportion." Arguably, the notion of powerlessness in the face of a social media giant was often spoken about at length by the nurses interviewed. Regarding a public Facebook forum that often criticized the ED the nurses were employed in, Stephanie, with 14 years of ED experience said,

> I think there's a lot of fear with the whole Facebook thing…a lot of management's reactions is based out of fear…instead of the whole corporation…saying "this is our mission, if patients are unsatisfied, then they're unsatisfied but we're not going to let our nurses get hurt or endure any more of this behaviour." I don't know if it's the corporation or if it's out of fear, of losing jobs, being named and that.

Feeling alone. Associated with the feeling of powerlessness was the feeling of being alone when experiencing verbal abuse and when mitigating the effects of OD on oneself. It was unfortunate for nurses to be at the brunt of verbal abuse because other colleagues did not want to get involved or "get in the line sight of it." Erika confirmed that in her ED experience, "People are reluctant to get involved in situations like that and they kind of stand and continue on about their work. I would say nurses pay attention in case we have to call a code white." Code white refers to the departmental overhead page of a potentially violent patient or situation that requires the immediate response of security guards and additional ED team members.

The collective response also contributed to a feeling of being alone in the situation that had just occurred, Erika describing "once he was outside of the department people were over it. But that kind of stuff bothers me." Internalizing the effects of verbal abuse, where others can simply overcome it can follow nurses even after they complete their shift for the day. Karen, with two years of ED experience reported,

> It definitely sits in the back of my mind…I typically find that I'll think that for maybe half an hour before I fall asleep or before I have a glass of wine or jump in the shower or get home…I don't feel very supported at work.

Normalizing. The act of normalizing verbal abuse by nurses is well-documented in literature, however, the act of also normalizing ones' experience of OD was a subtheme described by some nurses participating in this study. Here, one nurse describes how normalizing of OD is associated, for her, with lack of consequences for the abusive behaviour originating from patients.

> I find the consequences to their behaviour are very minimal so then it becomes normalized because people come in and they do it all the time and there's no consequence for their actions. Nurses see that and therefore, it limits your reaction because you do get used to it. It is very normalized.

Further, nurses questioned how they were expected to succeed in overcoming persistent abuse when there was no overt direction or discussion about the topic. They often proceed on with their work, never effectively dealing with the issues or developing resolutions. Karen aptly affirmed many of the inquiries this research is seeking to understand,

> I don't think that it is addressed… "maybe, what happens when a patient yells at you? How do you get over this? How do you not let this affect your care? How do you

> approach the patient? Let's have the discussion, how do you approach the patient after this? How have you found that it affects what you do and your actions and whether you go into the room as frequently or not?" You know? Those discussions are not, even on an open-ended basis, they're just not happening at all.

Again, what is often discussed is the frank association with the feeling of OD with the perceived lack of support from nursing leaders.

Further to this is the recognition that normalizing OD as a workplace burden can change a nurses' own attributes.

> I think that's based on the person, but I definitely think that it hardens someone. We've all heard the phrase that you need to have a thick skin and I think that's proven very true since the time I've been in emerg [*sic*]. You have to be able to take it.

This appropriately leads to the subtheme of self-preservation that became evident in interviews as a result of the frank acceptance of OD in ED nurses' work.

Self-preservation. Self-preservation as a subtheme became evident as one of the multiple facets of OD. Nurses reported that there lacked a clear method in which to respond to verbal abuse, as such, this instinctual behaviour became a way to manage emotions in response to verbal abuse while being able to continue to complete work. There were a variety of ways that nurses achieved this—Erika would often take an outspoken approach:

> Sometimes I find when I stand up for myself, "I absolutely won't stand this, you will not treat me this way," sometimes they won't turn into the most pleasant person but maybe they will scale it back a bit because this person won't take it from me. But I don't like that. I don't go to work because I want to be aggressive or confrontational towards people. It's mentally and emotionally exhausting to act that way.

Shannon, with 14 years of ED experience took a more restrained approach:

> I'm like flatter than flat, I will not have the same response and I know I do this; I see myself and I say, "why do you do this?" However, I just can't help it. I can't help but just be very flat. It's terrible.

Karen stated, "So if I can calmly and objectively state where I am coming from and try and communicate as best as possible, that sort of is where I start. I'm not going to lie, it's not always where I end up." This is another demonstrable example of how self-preservation is utilized by nurses who experience OD. Evident in these responses is the notion that despite nurses' experience of OD, they were aware that their approaches were not always suitable in managing both verbal abuse and OD in their workplace.

Nurses' Concerns Regarding OD

The interviews with ED nurses in this study indicated that nurses practicing in the ED recognize the issues that lead to OD. They identified systemic roots of OD that extended beyond the department they were employed within as well as the misalignment of what is taught in nursing foundational education compared to what is reality. Nurses also openly discussed their mandated association with their regulatory college that they believed failed to advocate effectively on their behalf.

Lack of organizational supports. Overwhelmingly, nurse participants readily agreed that their experience of OD was ineffectively addressed by their immediate leadership team both in the aspects of acknowledgement of events nor did strategies exist to address when they occurred. When verbal abuse is addressed by leadership, it is with signage, found to be an unacceptable measure for Erika who stated, "They put signs up in the department that say

absolutely no verbal abuse is going to be tolerated but they don't stand behind that which is frustrating. I don't care about the signs."

The acknowledgement of verbal abuse was of great concern to nurses in this study. Stephanie, with 14 years ED experience discussed how poor behaviour from patients was disregarded despite leadership dealing with the issue in real time.

> I've seen many times where we've been verbally assaulted by a patient and you go get management and they're shaking hands and walking them out the front door. To me you're just saying, "it's okay to do what you want to do here" instead of saying (if you say this is zero tolerance) "you have to leave." I think if we were more consistent with that all the time, then maybe that would curb the behaviour of patients or visitors.

Erika agreed that there was a lack of nurse leader support when addressing OD, "I think one, the corporation doesn't support us but, two, they actively undermine the situation." The hesitation to offend the public was viewed to be a root cause for the lack of overt leadership denunciation of verbal abuse towards nursing staff. Dale stated, "It's not very often addressed to the top and if it happens, then the patient may end up calming down, there's no consequence or anything for the patient, they just go about their day after that." Shannon agrees: "I feel they're too afraid to step on the publics' toes as opposed to protecting their workers."

The lack of clear strategies for nurses to enact in response to verbal abuse was discussed by Dale, who stated, "We don't really have a clear, concise role written out as to what the steps are if a patient acts like this, because some people will just stand there…and some of us get upset." The differences in nurses' behaviours highlighted by Dale suggests that nurses respond inconsistently to verbal abuse, mitigating the ill-effects by managing the situation in the moment,

rather than employing established strategies that prevent verbal abuse from occurring at all. Shannon echoed,

> I don't know that it's very well supported especially that there's really not a full policy of what to do when A, B and C happen. If this is happening, what do you do, where they say, "no we don't tolerate it" but what is the "don't tolerate it?" What are the steps we take where there's no clear why?

Nurses who recalled certain events leading to OD in their ED working life often spoke about EAP that they had been directed to as a perceived organizational attempt to address OD. This program is described as a short-term support service providing counselling for staff addressing many issues including financial, emotional and legal. Two nurses in this study openly challenged the lack of utility of this program.

> What is the result of EAP? I've been to EAP and it's a very nice woman who sits in a room and you rant, and she nods her head and says, "wow that must be so frustrating, that sounds like it was very hard for you." Then you all stand up and walk out of the room.

Shannon questioned how useful limited counselling benefits were to tackle the pervasive and ongoing issue of OD.

> I don't see it being addressed in the way it should be. I think the corporation…is not always the best at looking forward and being preventative at stuff like this. I don't think that they would ever want to even address the way our staff are feeling towards patients when we are abused. There's nothing in place for, even EAP you have to reach out to them, but you get like what? Three sessions of counselling and that's it, and it's not enough and there could be other things that our corporation could do to assist us with verbal abuse, but it's not done.

She continued to describe her dismay,

> Obviously, those feelings don't go away that easily after just a quick little "oh, hope you're doing okay," you know what I mean? No, I don't feel it's addressed, and I don't feel management, or the corporation take that in any way. It's just about their image to the public, that's all. It's not about their staff.

The perceived lapse in support from nurse leaders is evident in the statements given by the nurses involved in this study. They state that it affects both prevention and acknowledgement of OD and the tools that are given to them are inadequate to address the chronicity of OD in ED nurses.

Emergency department issues. Some statements were made regarding overall ED environmental issues that led to verbal abuse and consequently OD. Issues such as staffing shortages, overcrowding and bed flow management were identified as precipitants of verbal abuse. Nurses in this study recognized that these were issues that could not be mitigated as frontline staff, but rather needed to be managed by nurse leaders. Karen, with a couple years of ED experience identified that OD exists as a consequence of many issues, not only verbal abuse.

> I like to think that they try, I don't think that it's meeting our needs. I think that our occupational disappointment is influenced by many things, some of which is highlighted by leadership, but the rest is swept under the rug, so to speak. I know patient flow in our department is a huge thing and that's a huge factor in verbal abuse, and then following, occupational disappointment…Us on the front line, we cannot control that, and we are absolutely sorry and please don't take it out on us.

Gaps in education. The lack of explicit training for nurses to knowledgeably respond to verbal abuse and alleviate the OD experience in the ED nurse was often described by the nurses

involved in this study. Erika stated, "I don't think you receive any kind of training so when, not if, when, you're verbally attacked in this department, this is how you can and should respond." Dale's response seemed to parallel this thought,

> We don't really have a clear, concise role written out as to what the steps are if a patient acts like this because some people will just stand there and not say anything and just let the patient rant, and some of us get upset. I'm probably one of those people.

Of significance is the attributing of OD to the gaps in nursing baccalaureate education which neglected to include teaching about the realities of nursing today. Erika felt that new graduates' expectations of what ED nursing entailed differed from what was actually occurring. The experience of OD in this particular nurse was clear in this response:

> I'm super disappointed in how this has turned out for me because I am a new nurse. I have only worked for over two years and when I graduated nursing school, I knew I wanted to be an emerg [*sic*] nurse and it was my dream job and when I got hired, I was like, yes, I made it! This is what I want to do with my life.

She continued,

> I'm struggling with right now that I'm two years into a profession that I need to do for 30 years. I started so excited. I got so much education. I was the poster child for: Yes! I'm going to rock this! Now every time I have to get in my car and go to work, every second I'm googling other things I can do with my life.

Beliefs about the College of Nurses of Ontario. The College of Nurses of Ontario (CNO) is the regulatory body whose mission is "regulating nursing in the public interest" (CNO, 2020). Two nurses in the study expressed concern regarding a perceived threat of the college imposing penalties upon nurses who are reported to challenge patients and their behaviours.

> I do think there is this threatening. The College of Nurses is a big threat all the time. You can't do or say anything or else you're going to get called in front of the College…I do find that the College of Nurses gets thrown at you a lot and I really struggle that I joined a profession where I have no ability to defend myself. People say you have a right to feel safe and I don't understand why apparently that doesn't apply to nursing.

Here, this nurse identifies that OD not only occurs when verbal abuse occurs but can result even after the event from the punitive threat of being reported to the college by a disgruntled patient. Evident in her response is the feeling that there was only one side being presented, the side of the complainant. This belief was seconded by Dale, herself with eight years of ED experience.

> The other problem is the CNO does not back us up. We pay them every year and they back up the public, they do not back up the nurse…it's ridiculous that we pay so much money into that and the patient is always, it's like the customer is always right. It's a business.

The mention of the CNO in relation to OD demonstrates that support for nurses in the nursing profession beyond the organization they work for is imperative when issues of OD are being discussed.

Nurses' Responses to OD

The findings of this study illustrate that there are clear responses related specifically to how nurses experience OD. Of interest in this study is how OD influences the nurse, their practice and their decisions related to patient care.

Changes in nursing tolerance. A primary finding in many interviews was the notion that verbal abuse or more generally, bad behaviour from patients, became increasingly less tolerated as nurses' experience levels increased. Some nurses expressed that they adopted a

personal zero tolerance level despite not knowing how to execute the departments' zero tolerance policy. "The first thing I say is 'your tone of voice is not acceptable and the way you're talking to me is not going to be tolerated' and to be honest, I don't know if that helps or makes it worse," says Sabrina, with two years' ED experience. She continued,

> I've definitely changed how I interact and if someone does start verbally abusing me or becoming aggressive, I definitely think before, I definitely had more tolerance to it. I'd say, "Oh, I'm sorry, how can I help you?" but now I just have zero tolerance towards it you know?

Shannon, a seasoned ED nurse, when describing her sentinel OD event in her career, discussed the point at which her tolerance shifted. She discussed her experience as a new nursing graduate in the ED.

> I pretty well bent over backwards and called the anesthesiologist, however, now I would just be, "this is the way it is, if you don't like it you can leave," and I would have gotten rid of the father because he was quite abusive, where back then I wouldn't have taken that person out of that toxic environment. Now I know you don't have the right to speak to anybody that way and I don't have a problem removing you from the situation, right? If it impedes my ability to give care to your loved one, then I'm not going to stand it, right, when back then I would never have done that. Not even thought of doing that so, that changes over time. Your 20-year-old self doesn't think of these things because you don't think its within your rights. You just think you're supposed to take it.

She continued, "There's a point where you are like, 'No, I don't have to take it.'" Evident in these descriptions is the idea that the point at which a nurse decides to adopt their own zero

tolerance policy is entirely subjective and dependent on the myriad experiences leading up to it. It is clear there is an effect on nurses' disposition that coincides with this shift in tolerance.

Nurse-client relationships. Relationships between nurses and their patients were often discussed in this study when nurses were questioned about how OD impacts their work. At the forefront is the admission that OD changes the way patients are cared for. The caring relationship often depicted between nurse and patient at times can cease to exist as nurses experience OD. Sabrina, a nurse in the early years of her career stated, "I'll do all the tasks that I need to do. I'll give you your meds and all the interventions that I need, but I'm not going to spend that extra time in that room getting to know you." Sabrina admitted, "I feel like I'd have a harder time developing that nurse-client relationship."

Dale also agreed that OD led to an alteration in how she delivered patient care. She disclosed the following:

> Well, to be honest, I try not to let it affect what I'm going to do with other patients, but it really, I have to be honest, it wouldn't make me go above and beyond for that patient, which I would do for most patients but at that point, I generally let you get what you came for and I'm not going above and beyond for you. I don't want to go into the room…I only want to see them if I have to see them. I would rather pass them off to somebody else.

She concluded, "I would never treat them unfairly, but I definitely wouldn't go above and beyond for a patient after that."

The deterioration of the nurse-client relationship is outlined by Shannon, who admitted to an alteration in her demeanor due to OD as a result of verbal abuse. She outlined that the pervasive experience leads to having "my back up a little bit more." She continued,

> I never give fully myself to somebody right? You always hold back a little bit (because) if I don't give of myself you can't really bother me. If I hold back, then I've done nothing and I'm not losing anything, you know?

The deliberate restraint this nurse adopted as a result of OD can seem trivial and irrelevant at the outset, yet when probed further, there was a recognition that these mitigation practices potentially affected patient care. "It's hard to be unbiased when you go to deal with that person. So even though I'm reserved already at work, I give even less of myself," Shannon admitted. She continued, "Yes, it does change your practice and your care for that person, right? You just do the bare minimum to get through that."

Nursing practice. Findings from nurses interviewed were clear that not only did nursing practice change as a result of OD but also so did patient care. When nurses change their practice, however minutely, patients were impacted. An example of this is in the waiting room, where Sabrina often is assigned. She disclosed,

> You see the patients' chart and you think he's so rude, he can probably wait, but you try not to, but it's very hard when someone is personally attacking you and then you have to go care for them. But you have to sometimes.

This represents a punitive measure towards patients who have displayed poor behaviour towards nurses and a reactive strategy for nurses. Erika admitted to giving the utmost minimum in care necessary for that patient. She also highlighted that the OD suffered during an event impacted care for other patients also.

> It's not medical, it's not necessary, they're causing you so much more work. What they're doing is monopolizing your time because they're being difficult, and the other patients end up suffering because you have less time for them. It becomes more

> frustrating because it's the one behaviour that causes a ripple effect within your zone or your team.

Stephanie, with almost two decades of nursing experience agreed that even her practice changed, saying, "You're [*sic*] already red-flagged that person in your mind, which can be a bad thing, because sometimes you have to look at the medical thing," referring to the need to still treat the medical needs of difficult patients. Yet she admitted,

> I don't think you'd spend idle time, maybe chitchatting with patients where you could probably find out more information in your assessment by doing that…why would you want to spend time with somebody who's just cussed you out. In life you wouldn't do that, you wouldn't choose to be friends with that person.

The "idle time" that Stephanie refers to is often a time for health teaching and promotion or uncovering patients' health histories and the elimination of this time can deleteriously affect holistic patient care. The recognition of this impact is evident in Shannon's comments:

> Go through with your checks, "This is what you're getting, this is what it's for, you don't want it? Okay, bye." I don't ask you; I don't encourage it. Okay fine, they don't want their treatment. I wouldn't bother to health teach, which is terrible, however it's very, very hard to be unbiased when somebody… has already been unkind to you.

Retention. The nurses interviewed continue to endure and experience OD in the ED setting; some nurses continue to work in full-time employment solely in the ED, others have moved on because of the persistent OD. Few nurses in this study work elsewhere but retain their role in the ED in a limited capacity. Erika is clear that the perceived lack of support and lack of nurses' ability to implement effective change in response to verbal abuse and OD is a reason for

leaving a full-time job in the ED saying, "I left in less than two years because I was consistently let down." Her frustration is evident:

> As a nurse, you cannot get a restraining order on a patient. No matter what. They can fully assault you and you're the one who has to get a new job if you're uncomfortable because you can't deny access to somebody into an emergency department so…you will never get a restraining order, you're the one who has to get a new job.

Dale often questioned her eight years in the ED: "Sometimes I am like why do I come here? It's part of the reason I don't work full-time in emergency, to me it's not worth it." She continued:

> There's some days I do work and wonder, "I don't even know why I came to work today." I'm sure there's many of us that take mental health days some days after a rough day, because sometimes it's not worth it, I'd rather make no money the next day than be yelled at and be treated inappropriately and it's never, nothing is ever done about it.

Nurses' mental health. It was apparent that a consequence of OD was an unintentional but certain impact on nurses' own mental health. Nurses interviewed compared how difficult cases involving pediatric patients or critical events were debriefed and addressed, yet the persistent feeling of OD from everyday encounters were always left unaddressed. Erika, referring to episodes of patient aggression that have potential to escalate admitted, "I do find that I get anxious. I'm anxious for a period of time after that. It makes me very uncomfortable."

Dale, who recently left the ED to pursue other nursing opportunities discussed about the impact on a colleague who recently also left the ED. She described that the nurses' departure was in response to allegations of mistreatment on a Facebook post,

> I haven't seen that nurse back since she did that. She pushed a great, experienced nurse out of our emergency department because of a bunch of comments she wrote…I think it's

> just opening up wounds for people to be threatened and abused on a whole different level. I never want my picture to be on there, because how embarrassing for that nurse.

Dale's statement depicts a concern that lingers over nurses demonstrating that OD can be created not only at work but persist on virtual platforms after the event has ended.

The stressors of OD can transfer into the personal lives of nurses after their shifts have ended. Karen acknowledged when she described how OD can interfere with her own activities of daily living:

> I think it does affect me in my personal life because these things come up. As much as I try to block things out, they come out. They come up in your dreams, or you're out with your friend and suddenly, oh! You're explaining a situation and they look at you like you're in a different planet. They are like, "that doesn't happen to me at work."

She continued to describe the aftereffects of persistent OD as a result of unaddressed verbal abuse, as well as her own personality transformation:

> I think they're just little things that gnaw away at you and the more it happens the more it gnaws away at you and it takes away certain aspects of yourself. It takes away certain parts of your personality. You have to develop a hard shell and maybe that transfers over to your personal life, and you're known as "you're so cynical" and all of that, by people in your personal life, and you are like "oh when did I change, when did this start happening?"

Importantly, not all nurses who experienced OD believed that it affected their mental health, demonstrating that coping mechanisms differed from person to person. "I think I would probably let it go," Stephanie said. "I might be upset in the moment, but I think I'd have to look at the whole situation and is it worth getting upset about. So do I carry it around? I would say

no." Notably, Stephanie, a seasoned nurse, believed that the mental health of ED nurses only became important to leaders when it became fiscally significant:

> I don't think there's ever conversation (about OD), like checking in to see how your staff is doing. Like the mental health piece of dealing with all of it. I think they only do if you're costing dollars. If you're off on mental health, if you're off because of an incident at work, then they're concerned about you, but not concerned about the people who are just coping. They're coping through the day to try to get through it. It only seems like if it's affecting the budget then maybe we will look at it.

The mental health impacts upon the nurses in this study as a result of OD were apparent. They can manifest in the personal lives of nurses who, though may cope in different ways, also understand that it needs to be addressed in more explicit and overt ways.

The manner in which nurses respond to OD are varied and it remains unclear the most appropriate method to manage OD. All nurses interviewed declared that they required their leaders to not only acknowledge that OD exists in the ED but also required the provision of support and enactment of policy to effectively mitigate verbal abuse at the onset.

Summary

The findings from this study demonstrate that OD is a complex concept. The findings provide clarity about the manner in which nurses experience OD, describes nurses' concerns regarding OD, and illustrates that nurses' responses to OD can influence nurses' work and patient care. It is evident the themes elicited from nurses' responses paint a rich description of OD. These findings demonstrate that the antecedents and circumstances of OD are as important to the nurses in this study as are the consequences of OD. The following section examines these

findings in the context of implications related to nursing practice, nursing leadership, nursing education and research.

Chapter 6. Discussion

Occupational disappointment is a newly defined concept experienced by ED nurses and only recently identified in literature to be a result of verbal abuse from patients and/or their visitors (Howerton Child & Sussman, 2017). This study demonstrated that nurses experienced OD as a result of persistent, unaddressed verbal abuse on the job, but also continue to experience it vicariously through online forums that existed which allowed an often, one-sided account. The feeling of OD was identified also to be an indirect result of the failure of organizations from nursing schools to nursing employers to empower nurses with the skills to address verbal abuse (and subsequently their own OD) with definitive, consistent, and effective processes. Nurses in this study learned instead to cope with OD with various strategies which included adjusting their own behaviours when managing verbally abusive patients, altering established nursing practice to minimize the effect OD had on oneself or leaving the ED in search of alternate areas of employment. The implications of this study suggest that there are areas for improvement for nurses, nurse leaders and healthcare organizations as a whole, when considering how to mitigate OD in ED nurses in a proficient manner.

Implications for Nursing Practice

The literature reviewed suggested that nurses worldwide experience verbal abuse (Al-Shamlan et al., 2017; Ashton et al., 2017; Baig et al., 2018; Banda et al., 2016; Copeland & Henry, 2017; Hogarth et al., 2016; Hyland et al., 2016; Partridge & Affleck, 2017; Pich et al., 2017; Zhang et al., 2017); nurses in this study similarly admitted to persistent, unaddressed verbal abuse in their ED. Furthermore, nurses in this study acknowledged that they too experienced OD as a result of verbal abuse and recognized the challenges of unaddressed verbal abuse but also, unaddressed OD. Normalizing verbal abuse contributed to development of OD in

these nurses because increasingly, nurses directly or indirectly accepted it as an expectation of the ED environment rather that distinguishing it as intolerable activity necessitating immediate management to quell the negative aftereffects. As a result, the nursing culture in the ED transitions from caring-focused to one that is refocused on task-oriented care. This too, became an unrecognized outcome described in the literature that compromises nursing quality of care (Ashton et al., 2017; Howerton Child & Sussman, 2017; Yoon & Sok, 2016).

Despite the nurses in this study recounting a strong desire to become an ED nurse, they also described how the concept of OD included a self-realization that the role of the nurse was often unnecessarily denigrated despite the highly specialized work it entailed. The ineffective mitigation of verbal abuse exacerbated OD in nurses and there was potential for nurses to become more antagonistic and less caring which perpetuated the overall demise in the quality of nursing care in the ED. Ineffective mitigation of OD lead to doubts in the capability of nurse leaders to prioritize staff wellbeing and beliefs that the role of the nurse in the ED is devalued and reduced to simply another faceless number. The implications for nursing are that in EDs where verbal abuse is prevalent and where OD is identified by staff nurses on the front line, there is potential for nurses' practice to alter and the overall patient experience to suffer should leaders neglect to prevent nor acknowledge the existence of OD in the ED environment.

To address the apparent changes in nursing practice evident from discussions with nurses in this study, a viable option may be to replace those nurses who become vulnerable to verbal abuse by removing the nurse from the negative stimulus. Similarly discussed in Crilly et al. (2017), this allows for another nurse to assume care that has not been subject to abuse from the patient thereby allowing for unbiased care to resume. These opportunities have the potential to positively impact the patient experience while reducing the experience of OD from occurring.

Moreover, initiatives that allow sufficient time to document and report incidences of verbal abuse have been suggested (Copeland & Henry, 2017) and must be advertised openly within the ED so that nurses report every event, providing accurate data for leaders and patient advocates who may then effectively create specialized patient care plans unique to those patients who frequently abuse staff in the ED.

Implications for Nursing Leaders

The findings of this study paralleled findings in the literature, that is, there is gap in leadership involvement in dealing with verbal abuse and OD in nurses. Where the literature described a need for organizations to encourage nurses to report verbal abuse (Al-Shamlan et al., 2017; Fisekovic Kremic et al., 2017; Hogarth et al., 2017; Lenaghan et al., 2018), this study highlights the need for the organization to simply acknowledge the existence of nurses' experiences of OD.

The nurses in this study discussed that they needed to have strategies, or a plan in place that they could employ when they addressed verbal abuse or aggression. Moreover, they wanted policies to be developed that encouraged open dialogue about OD. For these nurses, OD happened not only because of verbal abuse but also in spite of it, often due to the multiple ED issues that co-existed in addition to verbal abuse from patients. Their individual contributions to the skilled care of the patients and the department as a whole were perceived to be undervalued and to this particular group of nurses, their existence felt to be reduced to just a number. These findings echo research by Ostaszkiewicz et al. (2015) which examined nurses experiences caring for people with symptoms of dementia such as physical and verbal aggression, albeit in a long-term care setting. The feeling of being undervalued was a theme highlighted in their study and was related to nurses feeling undermined by leaders and made to feel responsible for resident

behaviours; this has been similarly discussed by nurses in this study in response to verbal abuse. Yet where the nurses in Ostaszkiewicz et al. (2015) were able to discuss a range of strategies to care for people who exhibited symptoms of dementia, the nurses in this study were unaware of any concise strategy to address patient and/or visitor verbal abuse. This should be appropriately prioritized.

Retention was identified in the literature to increase costs and create staffing challenges due to recruitment of unskilled nurses compromising quality of care (Ashton et al., 2017; Howerton Child & Sussman, 2017; Yoon & Sok, 2016); two nurses in this study decreased their work hours in the ED and one left for an educator role in an alternate institution in response to the lack of leaders' support in the EDs they were employed in. Important to highlight here is that nurses who decreased their work hours in the ED assumed roles in higher-acuity practice settings. Thus nurses here left not due to the intensity of work but due to the intensity of the OD that they experienced in this specific practice setting. Nurse leaders must step forward and recognize OD to exist in nurses in order to optimize ED nurses' mental wellbeing. The dynamic nature of the ED demands skilled nurses be retained and continued inattention to OD in ED nurses will contribute to additional staffing challenges and will ultimately negatively affect patient care in this department.

In response to the incident in 2016 that inspired this research, recommendations were developed to help improve the patient experience and can be extrapolated to this OD research. Specifically, in terms of improving service excellence, the Lakeridge Health Patient Experience Panel recommended implementation of an education process reflecting a culture of caring and compassion which collaborates with patients "to develop behavioural standards to promote staff and physician accountability" (2016, p. 17). Similarly, this organization could employ parallel

methods of engagement to develop a joint strategy between frontline ED nurses and patient advocates that establish algorithms that can be employed when verbal abuse occurs that both nurses and patients and their families are educated upon. An organized and thoughtful strategy to address the realities of OD should be prioritized which include explicit acknowledgement that OD exists and is detrimental to nurses' work. An opportunity for nurse leaders to demonstrate continued investment in their skilled staff would be to enact clear and direct policies related to intolerance of abuse, both verbal and physical. Leaders' adherence to these policies should verbal abuse occur is essential to ensuring nurses in this specialized department feel valued as essential contributing members of the staff. Occupational disappointment has been demonstrated to exist due to many reasons including verbal abuse; explicit acknowledgement that leaders remain invested in quelling this phenomenon among staff nurses would be of benefit.

Implications for Nursing Education

Less experienced nurses in this study discussed their responses to OD where a decision to leave the ED for alternate high-acuity practice settings were made; this is akin to what is known in literature as Kramer's theory of 'reality shock.' Reality shock describes the phenomenon of finding out that the professional reality differs from what one expected after years of studying in preparation for a role (Kramer, Brewer & Maguire, 2011; Wakefield, 2018); the resolution phase of Kramer's theory is described as either positive or negative; the negative aspect of which a decision to leave is made (Wakefield, 2018). For some nurses in this study of OD, this was the decision made and reflects the impact of OD on emergency nursing practice.

Foundational education for registered nurses' entry-to-practice provides both didactic and practical teaching to nursing students. The nurses in this study recognized that there lacked a component within this education that neither addressed reality shock nor how to proficiently

lessen the effects of stressors in settings as complex as the ED. This lapse in education persisted as nurses entered the ED environment; there was no discussion upon hire about the complexities of the ED, specifically the prevalence of verbal abuse from patients or experiences of OD. It can be surmised that introduction of theory of reality shock in the last year of nurses' entry-to-practice education could provide adequate preparation for novice nurses to, at a minimum, be introduced to the potential reality of contentious work environments. Subsequent teaching about conflict management within patient settings could provide novice nurses with tools useful for when these situations inevitably arise.

Finally, the nurses in this study recognized that they wanted the skills to deal with their own OD after encounters with difficult patients. They appreciated episodes of debriefing when difficult cases presented in the ED, yet none were held when nurses faced verbal abuse from patients and/or their visitors. The departure of some nurses demonstrates that opportunities for organizational leaders to prevent OD may yield increased retention in ED staff. Educational nursing orientation to the ED must require that leaders admit that verbal abuse from patients is intolerable, an anomaly and should be dealt with immediately. The absence of any discourse about verbally abusive situations between staff nurses and patients can be remedied with opportunities for discussion during nursing huddles or at educational sessions where ED nurses are required to update their critical life-saving skills. As often as nurses are required to refresh their skills on cardiac life-saving events, so too should nurses be encouraged to renew knowledge on addressing the abusive patient and any OD that may result.

Limitations

It is important to acknowledge several limitations in this study. The first limitation was the length of time spent with each participant during the interview process. I endeavoured to

conduct interviews that were between 30 to 90 minutes; interview times ranged instead between 20 to 40 minutes. This limitation was attributed to me being a novice interviewer, as the length of interview time increased with each new participant and interviewer ease. All questions within the interview protocol that were planned to be asked were asked of each participant. Data saturation was reached despite interview length as all study questions were answered by all participants.

A second limitation of this study was sample size. Findings in this study may not be generalizable to situations other than those in close contextual similarity. However, the experiences of OD were uncovered as articulated by the ED nurses interviewed in this study. Due to the sample size, maximum variation sampling, a common and useful tool to maximize the differences of participants was not utilized. Nevertheless, there remained participants of varying age and nursing experience from two different EDs within the Lakeridge Health Corporation.

With respect to the pandemic that began in 2020, interviews traditionally held in a face-to-face setting instead were held over the telephone. Though virtual conferencing was offered, all participants chose to be interviewed over the phone. This presented a limitation as the researcher-participant engagement that could typically be noted and captured via in person or audio-visual platform when discussions of a sensitive topic such as OD are held, could not optimally be captured over telephone interviews. The slight nuances in body language or facial expression perhaps would be missed as a result.

Recommendations for Future Research

There are opportunities for future research. This qualitative descriptive research study examined the experience of OD and elicited themes that could be explored in future research studies. The findings in this study contributed to a clearer understanding of OD, how ED nurses

experienced it, their concerns about the concept and the manner in which nurses responded to these experiences of OD. However, gaps in this research remain. Future studies might be centred on developing a framework that nurses can follow to both address verbal abuse as well as dealing with ones' own OD. Future research is needed to establish if applying a framework might be a useful strategy to determine if OD can in fact be reduced among ED nurses. Future studies should also take into account whether there is an impact on the patient experience as a result of mitigated OD amongst ED nurses.

The inspiration for this research centred around a Facebook forum that ED nurses found contained one-sided accounts of perceived negligence of the Lakeridge Health ED. Nurses discussed their OD resulting from the online aspect of this type of abuse which could not be properly dealt with when the sources became nameless and faceless behind keyboards and screens. As an added source of OD, this importantly represents an opportunity for exploration into how online forums create stressors for frontline staff and whether the forums themselves are in fact a detriment to the care provided to the patient. The online aspect that inspired this research continues to be active at the time of this writing, future research may explore how organizations address this type of open and online patient feedback.

I believe that a simple first step that I could undertake is to discuss with ED nursing educators the importance of educating new hires, especially new nursing graduate hires, about the realities of the ED and the potential for contentious encounters with patients or visitors, even in well-meaning instances. Despite a clear strategic plan outlining how to effectively manage a verbally abusive situation, perhaps the discussion regarding the potential hardships in environment the ED can become is enough to mitigate nurses' OD so that they do not feel to be suffering OD in isolation. As for the impact that this research places on the Lakeridge Health

Corporation and the ED nurses who work tirelessly for this institution, my hope is for initiation of discussion between nursing leaders and frontline staff addressing realities of verbal abuse and the aftereffects. The dialogue generated from this is vital for the recognition of OD as an outcome of verbal abuse and would help leaders to recognize the ill-effects to patients, nurses and the ED collectively were they to continue with current ineffective verbal abuse mitigation practices.

Chapter 7. Conclusion

Occupational disappointment was demonstrated in this study to be a newly identified yet common element of the ED nursing experience due to the frequent occurrence of verbal abuse in this environment. Though verbal abuse from patients and/or their visitors was the precipitating factor and inspiration for initiation of this study, this research has highlighted that OD also occurs in spite of verbal abuse. It warranted recognition and the nurses who admittedly endured OD demanded that it be recognized as importantly in the ED as medically critical events are.

The experience of OD was demonstrated to vary in intensity amongst nurses in this study, however all who participated readily agreed that OD was a viable source of frustration which impacted the work required of them. Occupational disappointment originated from the subtle acceptance of poorly addressed verbal abuse and was highlighted in nurses' vivid and emotional recounting of abuse experiences on internet forums from those who witnessed the detrimental effects on themselves and their colleagues. Their ability to cope with OD demonstrated an innate strength to continue. Occupational disappointment for these nurses, though so broadly experienced, was isolating and lonely.

Occupational disappointment was also identified to be of great concern for nurses who recognized that the systemic roots of OD extended beyond their immediate ED. Nurses' concerns about the existence of OD in their work centred around their inability to effectively address verbal abuse which was due to gaps in knowledge not addressed from their time in nursing school to their time in nursing orientation. As a result, OD influenced nurses in ways that altered their practice and practice-related decisions in ways they otherwise would not have, had they not been experiencing OD. Occupational disappointment was demonstrated to not only affect the nurses involved in this study but also created delays in patient care, diminished

opportunities for health teaching and compromised the vital nurse-client relationship that patients received.

Yet when the entirety of nurses' testimonies about verbal abuse and subsequent OD are examined, it is evident that their accounts of these events paint a relatively positive picture. This is where OD is demonstrably unique from burnout. Where burnout remains a chronic response to repeated stressful exposures in the work setting and compassion fatigue an abrupt response to chronic exposures to someone else's trauma (Howerton Child & Sussman, 2017), nurses in this study discussed episodic responses unique to each episode of verbal abuse. The recounting of institutional lapses in acknowledgement of verbal abuse that further exacerbated OD led some to leave the ED but not nursing as a whole, because they aspired to continue to care for the critically ill patient in high-acuity settings. The nurses in this study persisted in their desire to provide a high degree of care for their patients, albeit with the hope of not being verbally abused. Occupational disappointment is a direct result of verbal abuse and an indirect result of organizational failures to prepare nurses and empower them to ably mitigate verbal abuse. The nurses in this study demonstrated a yearning to continue in a profession they enjoy despite the disheartenment; their requests for additional education from nursing leaders demonstrates nurses' desire to improve outcomes for both themselves and their patients. Though OD may be perceived to be a consequence of ED employment, the nurses in this study recognized their affinity to learn and develop their nursing careers in the ED. These nurses demonstrated a yearning for suitable measures to address recurrent OD and believed that strategies could be developed. Occupational disappointment is less a detriment to this highly specialized group of nurses but rather an opportunity for partnerships for improvement in both the patient and nursing experience.

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Appendix A

PARTICIPANTS NEEDED FOR RESEARCH ON EMERGENCY DEPARTMENT NURSES

Volunteers are needed to take part in a study of the experiences of occupational disappointment in emergency department nurses as a result of verbal abuse from patients and/or their visitors. OCCUPATIONAL DISAPPOINTMENT is described in literature as a feeling of disheartenment in the profession as a result of persistent, pervasive and unaddressed verbal abuse.

As a participant in this study, you would be asked to participate in short interviews in order to provide greater understanding of emergency nurses' personal and practical experiences of occupational disappointment.

Your participation is **entirely voluntary** and would take up approximately 30-90 minutes of your time. By participating in this study you will help advance the literature about occupational disappointment, carving a niche for this novel concept in scholarly nursing literature.

To learn more about this study, or to participate in this study, please contact:

Principal Investigator:
Jiun Zullo, Master of Nursing student, Athabasca University
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This study is supervised by: Dr. Lynn Corcoran
lynnc@athabascau.ca – 1 888 281 5812

This study has been reviewed by the Athabasca University Research Ethics Board

Lakeridge Health

Athabasca University

Lakeridge Health

Athabasca University

Appendix B

LETTER OF INFORMATION / INFORMED CONSENT FORM

Occupational Disappointment in Emergency Nurses as a Result of Verbal Abuse

Principal Investigator (Researcher):
Jiun Zullo
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416 316 0924

Supervisor:
Lynn Corcoran
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1 833 445 3722

You are invited to take part in a research project entitled 'Occupational Disappointment in Emergency Nurses as a Result of Verbal Abuse'.

This form is part of the process of informed consent. The information presented should give you the basic idea of what this research is about and what your participation will involve, should you choose to participate. It also describes your right to withdraw from the project. In order to decide whether you wish to participate in this research project, you should understand enough about its risks, benefits and what it requires of you to be able to make an informed decision. This is the informed consent process. Take time to read this carefully as it is important that you understand the information given to you. Please contact me, (Jiun Zullo, principal investigator) if you have any questions about the project or would like more information before you consent to participate. Your confidentiality will be maintained through this informed consent process.

It is entirely up to you whether or not you take part in this research. If you choose not to take part, or if you decide to withdraw from the research once it has started, there will be no negative consequences for you now, or in the future.

Introduction

My name is **Jiun Zullo** and I am a Master of Nursing student at Athabasca University. I am conducting a research project about the experiences of disheartenment in the field of emergency nursing that emergency department nurses feel as a result of verbal abuse from patients and/or their visitors. Scholarly literature has termed this feeling 'occupational disappointment'. I am conducting this project under the supervision of Dr. Lynn Corcoran.

Why are you being asked to take part in this research project?

You are invited to participate in this project because there is potential that you have experienced episodes of verbal abuse from patients and/or their visitors while you have been employed as a nurse in the emergency department. You may have also experienced occupational disappointment as a result of this.

What is the purpose of this research project?

I am interested in defining this concept in order to further understand it. It is my goal to gather the valuable insight of nurses who think they have experienced it in order to learn from it, understand how nurses respond to it and how it affects patient care.

The purpose of this research is to refine the concept of occupational disappointment, explore the relationship between verbal abuse and occupational disappointment and understand how nurses experience, manage and respond to this feeling. Future research goals stemming from this research would include the ability to understand how verbal abuse from patients and/or their visitors can impact nursing decisions in patient care.

What will you be asked to do?

The primary source of data collection in this study will be via online virtual-conferencing or phone interview respecting physical distancing requirements. With your consent, the expected length of time it will take will be between 30 to 90 minutes. With your consent, one interview held through follow-up emails or phone call may be necessary for clarity in data analysis. Initial interview can be arranged at a time that is convenient to your schedule. Any follow-up conversation will allow opportunity for you to alter or clarify their comments.

What are the risks and benefits?

Risks in this study may occur because I will inquire about your experiences with direct verbal abuse from patients and/or their visitors. You will be asked to describe in great detail as much contextual information that you can provide. This may create a feeling of discontent or psychological difficulties; therefore, it may be necessary to make arrangements for those difficulties to be supported by a professional. To the best of my knowledge, there will be no more risk of harm than you would normally experience in daily life. The anticipated risks associated with participation in this research will be minimal, however there may be unforeseeable risks.

In contrast, there is potential that the interview process, in exploring the experience of verbal abuse towards emergency nurses, may benefit participants because it is an opportunity to reflect on a past experience, discuss what was learned and discuss if there were positive changes in practice or policy that resulted from it.

Do you have to take part in this project?

As stated earlier in this letter, involvement in this project is entirely voluntary. If at any time you wish to end involvement with this study after it begins, please contact me through the contact information available. You may also decline to answer any interview question. Unless indicated otherwise, data will be retained by the principal investigator. All recordings will be deleted after transcription.

If you choose to withdraw involvement in this study, your already-collected data can be removed from the study, if requested, only until the point in which your digital recordings are completely transcribed. If I have not transcribed your data in its entirety at the time of withdrawal of participation, then I will destroy your already-collected data, if so requested. At that time, data from the withdrawing participant will be destroyed.

How will your confidentiality be protected?

The ethical duty of confidentiality includes safeguarding your identity, personal information, and data from unauthorized access, use or disclosure. I will endeavour to maintain your confidentiality. Pseudonyms will be applied at the outset of data collection and will remove gender or human-identifiable features in the data, ensuring confidentiality. However, a key will be maintained linking your pseudonym to your data and your identity so that should you decide to withdraw from this study, your data can easily be withdrawn. This key will be kept in a secure, password-protected file.

Additionally, confidentiality will be maintained by not publishing data that can lead to your identity. I will endeavour to mask the environment(s) or situation(s) that are described, to some degree, in order to provide privacy for those involved. I request that patients are not identified by participants involved in this study.

How will my anonymity be protected?

Anonymity refers to protecting your identifying characteristics, such as name or description of physical appearance. Every reasonable effort will be made to ensure your anonymity; you will not be identified in publications without your explicit permission.

In this study, pseudonyms will be utilized to maintain anonymity as well as to prevent any negative consequences for your contribution, such as jeopardizing employment in the instance of publishing unfavourable data. As described above, a key will be maintained linking your pseudonym to your data and your identity so that should you withdraw your data from this study, it can be easily withdrawn.

Should you oppose your own anonymity, this will also be respected. This request will be considered as long as there is no foreseeable risk of harm to patients or other participants in the study.

How will the data collected be stored?

With your consent, digital recordings collected during interviews will be securely stored in a locked filing cabinet that is only accessible by myself, the principal investigator until transcription. Transcribed data will be kept on a password-protected file within a password-protected laptop. Documents, pseudonyms, data codes and any other hard copy data will be stored also in a locked filing cabinet.

At the time of this writing, there is no anticipated future secondary use of this data. If this is to change, Research Ethics Board approval and a separate consent will be sought should a later project be designed.

All data used in the study will be kept for five years, as per Athabasca University policy, and then irreversibly destroyed by myself, the principal investigator.

Who will receive the results of the research project?

Results of this research will be made available to interested participants. As part of a Master's thesis, results will be published as a research paper and submitted to scholarly journals for publication consideration. With your consent, direct quotations may be added into the final research paper but personally identifying information will be withheld and the quotations will contain no patient information.

The existence of the research will be listed in an abstract posted online at the Athabasca University Library's Digital Thesis and Project Room and the final research paper will be publicly available. A link to this will be provided to all participants.

Who can you contact for more information or to indicate your interest in participating in the research project?

Thank you for considering this invitation. If you have any questions or would like more information, please contact me, Jiun Zullo (the principal investigator) by e-mail: **jzullo1@athabasca.edu** or my supervisor, Dr. Lynn Corcoran at: **lynnc@athabasca.edu** or **1 833 445 3722**. If you are ready to participate in this project, please reply to me by email and I will provide you further information on how to submit a signed consent form via email./.

This project has been reviewed by the Lakeridge Health Research Ethics Board. Should you have any questions or concerns regarding your rights as a participant in this research study, or if you wish to speak with someone who is not related to the study, you may contact the Chair of the Research Ethics Board of Lakeridge Health at (905) 576-8711.

This project has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns regarding your treatment as a participant in this project, please contact the Research Ethics Office by e-mail at rebsec@athabascau.ca or by telephone at 1-800-788-9041, ext. 6718.

Occupational Disappointment in Emergency Nurses as a Result of Verbal Abuse

Informed Consent

Your signature on this form means that:

- You have read the information about the research project.
- You have been able to ask questions about this project.
- You are satisfied with the answers to any questions you may have had.
- You understand what the research project is about and what you will be asked to do.
- You understand that you are free to withdraw your participation in the research project without having to give a reason, and that doing so will not affect you now, or in the future.
- You understand that if you choose to end your participation **during** data collection, any data collected from you up to that point will be retained by the researcher, unless you indicate otherwise.
- You understand that if you choose to withdraw **after** data collection has ended, your data can be removed from the project until the point at which your digital recordings are fully transcribed.
- You understand that by signing this consent form, you do **not** waive your legal rights.
- You have been given a signed copy of this Informed Consent form for your records; and
- You agree to participate in this research project.

	YES	**NO**
I am willing to be contacted following the interview to verify that my comments are accurately reflected in the transcript.		
I agree to be digitally audio-recorded		
I agree to the use of direct quotations		

_____ _____

Signature of Participant Date

Principal Investigator's Signature:

I have explained this project to the best of my ability. I invited questions and responded to any that were asked. I believe that the participant fully understands what is involved in participating in the research project, any potential risks and that he or she has freely chosen to participate.

_____ _____

Signature of Principal Investigator Date

Appendix C

Interview Protocol

- What is your interpretation or understanding of the term ‘occupational disappointment’?
- Tell me about a time when you experienced verbal abuse from a patient and/or their visitor that led to a feeling of occupational disappointment.
- What were the actions you took, or didn’t take, in response to a patients directed verbal abuse towards you?
- How did the feeling of occupational disappointment change or alter your nursing practice?
- Do you think that occupational disappointment amongst emergency nursing staff is addressed by those in leadership?
- What are some suggestions you think would be effective in managing emergency nurses’ experiences of occupational disappointment?

Appendix D

Athabasca University Ethical Approval

Athabasca University
RESEARCH CENTRE

CERTIFICATION OF ETHICAL APPROVAL

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

Ethics File No.: **23900**

Principal Investigator:
Mrs. Jiun-yi Zullo, Graduate Student
Faculty of Health Disciplines\Master of Nursing

Supervisor:
Dr. Lynn Corcoran (Supervisor)

Project Title:
Occupational Disappointment in Emergency Department Nurses as a Result of Verbal Abuse: A Qualitative Descriptive Study

Effective Date: May 11, 2020 **Expiry Date**: May 10, 2021

Restrictions:

Any modification or amendment to the approved research must be submitted to the AUREB for approval.

Ethical approval is valid *for a period of one year*. An annual request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

A Project Completion (Final) Report must be submitted when the research is complete *(i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable))* or the research is terminated.

Approved by: **Date: May 11, 2020**

Barbara Wilson-Keates, Chair
Faculty of Health Disciplines, Departmental Ethics Review Committee

Athabasca University Research Ethics Board
University Research Services, Research Centre
1 University Drive, Athabasca AB Canada T9S 3A3
E-mail rebsec@athabascau.ca
Telephone: 780.675.6718

Appendix E

Lakeridge Health Ethical Approval

1 Hospital Court
Oshawa, ON
L1G 2B9

NOTIFICATION OF RESEARCH STUDY TO COMMENCE

To the Principal Investigator:	Jiun Zullo Lakeridge Health
cc:	Janice Jansen-Pereira, Acting Director of Research Department Lakeridge Health
Attach:	Research Team Form
From:	Vice President, Medical and Academic Affairs Lakeridge Health (for Administrative Approval) Chair, Lakeridge Health Research Ethics Board (for Research Ethics Board Approval)

RID#:	2020-005
Study Title:	Occupational Disappointment in Emergency Nurses as a Result of Verbal Abuse.
Funding Source:	N/A

All research studies must receive both Administrative Approval and Research Ethics Board Approval prior to commencement. Administrative Approval requires approval of the department impact, resource utilization (including sufficient funds to cover all expenses related to the study), and execution of a research Contract/Agreement. The above named study has been approved for administrative and resource utilization merit by Lakeridge Health under the current funding agreement. Any changes to the agreed funding, or protocol revisions that have an impact on resources, will require re-approval.

Please feel free to contact the Research Liaison if there are any questions.

Sincerely,

George Buldo
George Buldo (Jul 16, 2020 12:48 EDT)

Jul 16, 2020

George Buldo, MD, MHCM, FRCPC
Vice President, Medical and Academic Affairs
Lakeridge Health

Commence Release Date

1 Hospital Court
Oshawa, ON
L1G 2B9

In addition to Administrative Approval, the above named study has been approved for ethical and scientific merit by the Research Ethics Board (REB). This research study may now commence, contingent upon the following:

(i) As a reminder, the REB and LH operate in compliance with applicable laws and regulations including, but not limited to, the International Conference on Harmonization for Good Clinical Practice (ICH/GCP) Guidelines as set forth in Part C Division 5 under the Canadian Food and Drugs Act and the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans Version 2 (TCPS). Lakeridge Health is registered with the U.S. Department of Health & Human Service under IRB registration number IRB00003507. As the Principal Investigator, you are responsible for the ethical conduct of all research team members during the course of the study, and for cooperating with monitoring activities determined by the REB. As such, you and your Research Team (see attached) agree to undertake the study in conformity with the approved protocol, and to immediately report to the REB:

- any revisions, additions, deletions or other amendments via the *Amendment/Revised Consent Form;*
- any local, and specifically relevant external serious adverse events via the *Internal Serious Adverse Event (SAE)Report Form;* and
- any deviation or new information with respect to the protocol via the *Protocol Deviation Form*

(ii) In the event of confidentiality concerns or privacy breach, such as inappropriate and/or unauthorized use of information, you are to immediately report these to both the REB and to the LH Privacy Officer (in accordance with Ontario health privacy legislation – *Personal Health Information Protection Act, 2004*) via the *Privacy Breach Report Form.*

(iii) As the Principal Investigator, you are further expected to submit:

- an annual progress report and annual re-approval via the *Annual Report/Re-Approval Form* if the study is expected to continue beyond the Expiry Date; and
- a *Study Closure Form* along with a copy of the final report when the study has been completed.

Contact Information:

CONTACT	NAME	PHONE
Principal Investigator	Jiun Zullo	905.576.8711
LH Research Department	Research Liaison	905.576.8711 x32745
Research Ethics Board	Office of the Chair	905.576.8711 x32745

1 Hospital Court
Oshawa, ON
L1G 2B9

REB Meeting Date(s):	May 04, 2020 (Deferred) June 01, 2020 (Deferred) June 22, 2020 (Approved Pending Changes)
REB Review Type:	☒ A Full Board Meeting ☐ The Chair with Notification to All Board Members
REB Approval Date:	June 22, 2020
REB Approval Expiry Date:	June 22, 2021

The Research Ethics Board has received the following documentation for study entitled:

"Occupational Disappointment in Emergency Nurses as a Result of Verbal Abuse."

Documents approved until the expiry date noted above:

Document	Version	Date
Research Proposal		Jun2020
Interview Protocol		19May2020
Informed Consent Form		27Jun2020
References		18Mar2020
Athabasca Ethics Approval		11May2020

Documents Acknowledged:

Document
LH REB Application Form
DIA Form
Research Team Form
CORE Certificate
LH Statement of Confidentiality
Jiun Zullo Resume 2020

Lakeridge Health

1 Hospital Court
Oshawa, ON
L1G 2B9

Signed: _____

John Montgomery, BA, LLB
Chair, LH-REB

Please quote your file number (RID#2020-005) on all future correspondence.