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THE EXPERIENCE OF VIOLENCE AMONGST NEONATAL NURSES

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Approval Page

Approval of Thesis

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THE EXPERIENCE OF VIOLENCE AMONGST NEONATAL NURSES

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In partial fulfillment of the requirements for the degree of

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Dedication

I want to dedicate my work to my biggest supporters, my husband, Tim, and my beautiful children, Meredith, Vivian, and Brennan. First, Tim, your steadfast support and endless belief in me has kept me going over the past three years. You embody what it means to be a life partner. I could not have done this without you, thank you. My children, my personal cheerleaders. You have made so many sacrifices over the past few years and have demonstrated such understanding and maturity. I can only hope I make you proud. I love you, and I thank you.

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I also want to dedicate my work to neonatal nurses. There is no doubt in my mind that the work of a neonatal nurse is special. This study is intended to unveil a side of neonatal nursing that is not often talked about. I hope this study makes you feel heard and validated.

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Abstract

Violence in healthcare is a global concern for all health care professionals with nurses being recognized as most likely to be a target. Much of the research conducted on the experience of violence in nursing pertains to nurses working in emergency or psychiatric departments and long-term care. There is a paucity of research exploring the experience of violence among nurses in other care areas. This study intended to explore the experience of violence amongst neonatal nurses. A qualitative description methodology was used to begin to understand the complexities of violence toward neonatal nurses. Participants articulated experiencing both HV and VV and provided valuable insight into the personal impacts of such violence. Findings from this study provide important qualitative information that could be used to understand, mitigate, and address violence in the NICU. Further studies exploring the experiences of neonatal nurses would be beneficial to gain further understanding of the prevalence of violence, the influence of unit design, and the role of managers and healthcare leaders in violence prevention and response.

Keywords: Neonatal Intensive Care Unit, Nurse, Neonatal nurse, violence, horizontal violence, vertical violence

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List of Symbols, Nomenclature, or Abbreviations

Neonatal Intensive Care Unit (NICU)

Healthcare professionals (HCPs)

Horizontal violence (HV)

Vertical violence (VV)

Post-traumatic stress disorder (PTSD)

Emergency Department (ED)

Qualitative description (QD)

Canadian Federation of Nurses Union (CFNU)

Registered Nurses Association of Ontario (RNAO)

Chapter 1. Introduction

Violence in healthcare is a growing concern that impacts all clinicians in healthcare settings around the world. Healthcare has been identified as one of the most violent places to work. The Report of the Standing Committee on Health (2019) found that healthcare professionals (HCPs) in Canada are four times more likely to experience workplace violence than other professionals. Nurses are at the greatest risk of exposure to violence as they represent the largest segment of the healthcare workforce and have the most direct contact with patients (Bernardes et al., 2020). Nurses experience more violence than prison guards and police officers (International Council of Nurses, 1999 as cited in Pich & Roche, 2020). Interestingly, the media tends to report issues of violence in male-dominated professions and the trade industry while ignoring such issues within nursing, a female-dominated profession, where there is more than double the number of violent incidences that lead to lost time at work (Reichert, 2017).

Conceptualization of Violence

There is no universal definition of workplace violence in the literature. Violence toward nurses occurs in many forms and is described as physical, verbal, sexual, and psychological aggressions that lead to incidences of abuse, threats, and assault that negatively affect health and wellbeing (Al-Qadi, 2021; Chaiwuth et al., 2020; Registered Nurses Association of Ontario [RNAO], 2008). The Canadian Labour Code defines workplace violence as “any action, conduct or comment, including of a sexual nature, that can reasonably be expected to cause offence, humiliation or other physical or psychological injury or illness to an employee, including any prescribed action, conduct or comment” (Government of Canada, 2022, “Employers: Preventing harassment and

violence in the workplace" section). Specific to healthcare, the World Health Organization (2022) defines workplace violence as any physical, verbal, sexual, or psychological incident that occurs within the work of HCPs that presents as abuse or assault or poses a threat to the HCP. Violence toward HCPs is further defined by types I to IV. Type I violence occurs toward the HCP from an individual with no relationship to the worker or the organization and often involves criminal intent. Type II violence encompasses violence toward the HCP from a patient, support person or visitor. Type III violence is defined as violence between co-workers, and type IV violence refers to violence toward the HCP from a person with whom they have a personal relationship outside of the work environment (Hamblin et al., 2016). Much of the literature describing types of violence in health care and toward nurses defines violence within the parameters of horizontal and vertical violence. Violence may be horizontal (HV) in that it occurs between colleagues (Bernardes et al., 2020), this is type III violence. Vertical violence (VV) is directed toward nurses from patients, families, or support people (Bernardes et al., 2020), which according to Hamblin et al. (2016) is type II violence. Types of violence can be further broken down into forms of violence such as physical, verbal, sexual, and psychological aggressions that lead to incidences of abuse, threats, and assault (Al-Qadi, 2021; Chaiwuth et al., 2020; Registered Nurses Association of Ontario [RNAO], 2008). Most of the literature reviewed for this thesis described violence as HV or VV toward nurses. Consequently, for the purpose of this research, violence has been conceptualized as HV and VV to describe and understand the types of violence neonatal nurses experience.

Prevalence of Violence in Canada

In 2019, the Standing Committee on Health released a report on the VV faced by HCPs in Canada. The report is a summary of an in-person event where members of many organizations including but not limited to the Canadian Nurses Association, Canadian Federation of Nurses Unions, the Canadian Association of Emergency Physicians, Canadian Support Workers Association, Canadian Association for Long Term Care, Public Services, and Paramedic Chiefs of Canada had an opportunity to share their concerns regarding violence in healthcare with parliament. The report states that Canadian healthcare workers are four times more likely to be exposed to violence at work than other Canadian professionals (Standing Committee on Health, 2019). A 2010 survey conducted by the College of Family Physicians in Canada revealed that 30% of family physicians experienced aggression from patients and families in the month prior to the survey. 1, 676 paramedics participated in a study in 2014 that revealed 75% of participants experienced violence of some kind during their career, while 74% expressed experiencing violence annually (Standing Committee on Health, 2019). The report states that 62% of personal support workers experience physical violence at work every week. Lastly, the report cites Linda Silas, the president of the Canadian Federation of Nurses Union, stating that there were more than 4000 serious workplace violence incidents toward nurses reported nationally between 2014 and 2019 (Standing Committee on Health, 2019). While committee members referred to violence in healthcare as pervasive, they also recognized that there is a lack of data capturing the prevalence of violence toward HCPs in Canada, and further data is required to understand the magnitude of the phenomena. Furthermore, committee members identified HV as problematic within

healthcare but were unable to speak to the prevalence or substantiate the occurrences with data.

Clinical Problem

Violence in nursing can lead to psychological and physical consequences for nurses such as post-traumatic stress disorder (PTSD), anxiety, depression, burnout, injuries, pain, and trauma (Campana & Hammoud, 2015; Havaei, Astiva, et al., 2019; RNAO, 2008). Nurses who have suffered abuse report that the quality of care they provide is diminished which can then impact patient care, patient safety, and health outcomes (Alshehry et al., 2019; Atan et al., 2013; Bambi, Guazzini, Piredda et al., 2019; Chatziioannidis et al., 2018). Additionally, violence towards nurses is correlated with lost time at work and poor retention not only within certain care areas but within the profession which, in turn, impacts the existing nursing shortage crisis (Alshehry et al., 2019; Reichert, 2017).

Research Question

Much of the published literature on violence towards nurses is specific to the experience of nurses in the emergency department, psychiatric care, and geriatrics (Atan, et al., 2013; Bernardes et al., 2020; Brophy et al., 2017). As a nurse who works in the Neonatal Intensive Care Unit (NICU), violence towards neonatal nurses is of particular interest. It is important to understand the experience of violence from within the context where it occurs. Conducting a study among neonatal nurses serves as the beginning step in understanding and addressing the issues of violence towards nurses in the neonatal care environment. This study explores the following research question: What is the

experience of violence amongst neonatal nurses? Using a qualitative description methodology, the goals in answering this question are as follows:

- To capture the lived experience of nurses and violence in the NICU,
- Give a voice to neonatal nurses,
- Generate information to create positive systemic change,
- Support the quality of work life and retention of nurses,
- Begin to bridge a gap in existing literature on violence in nursing, and
- To contribute to scholarly nursing knowledge

Chapter 2. Review of the Literature

Using search engines PubMed, CINAHL, EBSCO, and Google Scholar, a search was undertaken using the words nurse, nursing, violence, incivility, bullying, healthcare, neonatal, neonatal intensive care unit, and NICU in various combinations. Additionally, a librarian was consulted to enrich the scholarly search. The search parameters were limited to peer-reviewed articles published in the English language between 2013 to the end of 2022. A total of 45 peer-reviewed journal articles were retrieved. These were reviewed by abstract for relevance to the topic, and 24 addressed the specifics of the experiences of violence in healthcare and/or nurses. The librarian offered 29 articles for review. After cross-referencing with the existing literature, and reviewing abstracts and references within these new articles, six additional articles were added to this literature review. Upon a thorough review of the literature, four additional articles were sought and added. In total, 38 articles were reviewed.

Of the articles selected, 8 were qualitative, 19 were quantitative, and 11 were literature or systematic reviews. The methodologies used in the qualitative studies were qualitative description, phenomenology, and narrative inquiry, with thematic analysis used to understand the generated data. Many of the quantitative studies were cross-sectional studies that used surveys and questionnaires to generate data. Few of the studies were noted to use the same survey or questionnaire. Data was analyzed within these studies using a variety of tools. Studies took place in a variety of countries including Canada, Wales, Spain, Iran, Turkey, Taiwan, Switzerland, United Kingdom, Korea, Australia, and the United States.

Intergovernmental, government and nursing body websites were also searched for grey literature on violence in health care and nursing. This search resulted in position statements from the World Health Organization, Report for the American Hospital Association, the Standing Committee on Health, the Canadian Nurses Association, the Canadian Federation of Nurses Union (CFNU), and the Registered Nurses Association of Ontario. These sources provided valuable information on the prevalence and cost of violence in health care.

Of the peer-reviewed articles analyzed here, only three were NICU-specific and none of the grey literature spoke to violence in the NICU. The absence of literature describing the experience of violence in neonatal nursing suggests that there is an opportunity to explore the lived experience of violence in the NICU. This chapter will offer a review of the literature available on violence in healthcare, violence in nursing, and, although limited, violence among neonatal nurses.

Violence in Healthcare

The most common place for violence towards employees to occur in a work setting is within a hospital, thereby making HCPs the most vulnerable to the phenomenon (Mento et al., 2020). In a systematic review and meta-analysis, Liu et al. (2019) aimed to quantify the experiences of VV among HCPs internationally. HCPs were described as nurses, doctors, and other HCPs. After a review of 253 studies, they found that 62% of the study participants experienced some workplace violence, 42.5% experienced non-physical violence, and 24.4% experienced physical violence in the year prior to their respective studies. Verbal abuse and threats accounted for the most common form of non-physical abuse experienced (Liu et al., 2019). According to this systematic

review, HCPs in Asian countries, North America, and Australia experienced more VV than in European countries (Liu et al., 2019).

In a cross-sectional study of 4, 845 HCPs by Hahn et al. (2013) there was a 51% response rate to a survey which included nurses, midwives, physical therapists, dieticians, ward clerks, and other staff in Switzerland. Eighty-five percent of survey respondents reported experiencing VV from patients and visitors throughout their careers with 50% of them experiencing violence in the last year. Verbal violence was disclosed by 46% of survey participants while physical violence and threats were experienced by 17% and 16% of the participants respectively (Hahn et al., 2013).

Compared to police and correctional officers collectively, direct care providers in Canada had twofold lost time at work due to violence in 2015 (Reichert, 2017). In Ontario hospitals, $23.8 million is spent annually on lost time secondary to violence (Reichert, 2017). Brophy et al. (2017) conducted a qualitative study on the experience of VV in the form of verbal, physical, and sexual assaults on HCPs in the province of Ontario. The study included 54 participants from psychiatric, emergency, forensic, dementia, acute, and chronic care areas from 16 different provincial facilities. Participants were comprised of nursing, administration, cleaners, dietary, physiotherapy, and maintenance staff. They were asked to speak of any violence they experienced throughout their careers and described physical, psychological, sexual, and verbal assaults from patients and support people in their respective care areas.

While violence may be a reality for many HCPs, it is consistently and explicitly stated in most sources that nurses are at greatest risk of all HCPs for exposure to violence at work due to their direct contact with and their accessibility to patients and families

(Al-Shamlan et al., 2017; Angland et al., 2014; Atan et al., 2013; Bernardes et al., 2020; Chaiwuth et al., 2020; Havaei et al., 2020; Havaei & MacPhee, 2019; Havaei, MacPhee & Ma, 2020; Honarvar et al., 2019; Hsu et al., 2022; Pich & Roche, 2020; Reichert, 2017; Yildiz & Yildiz, 2022).

Violence Toward Nurses

Horizontal Violence

HV in healthcare refers to negative interactions between colleagues. Specific to nursing, Griffin (2004) defined HV as nurses expressing contempt toward each other (as cited by Roberts, 2015). HV is characterized by incivility and bullying. Incivility, although deliberate, can be elusive and passive-aggressive, or in the form of verbal abuse with the intent of degrading an individual (Bambi, Guazzini, De Felippis, et al., 2017; Campana & Hammoud, 2015). Addressing incivility can be challenging due to its sometimes-subtle nature (Campana, & Hammoud, 2015). The difference between incivility and bullying is that incivility can be a singular occurrence and bullying is a targeted and repetitive effort toward another person or group intended to control, intimidate, and wield power (Chatziioannidis et al., 2018). HV in the form of incivility and bullying can occur between nurse peers, nurses and physicians, nurses and managers or any other members of the healthcare team (Alshehry et al., 2019) and can be equally as psychologically damaging as VV (Bambi, Guazzini, De Felippis, et al., 2017). HV within nursing can be explained by the powerlessness and oppression felt by the nursing community (Roberts, 2015). Oppressed groups such as nurses who feel undervalued within a medically dominated hierarchal healthcare system, may look inward with

disparagement as they feel powerless to have their voices heard and be autonomous over their profession (Roberts, 1983 as cited in Roberts, 2015).

While there is literature available that captures the experiences of HV within nursing, there is a scarcity of literature that captures the prevalence of HV in nursing (Vidal-Alves et al., 2021). Vidal-Alves et al. (2021) performed a cross-sectional study in Spain of 950 nurses from 13 different public hospital settings to explore the experiences of HV and the associated consequences. Participants worked in surgery, internal medicine, ED, daycare, and psychiatric care. The authors found that 59.2% of the nurses in the study experienced HV in the last year in the form of gossip, exclusion, and incivility (Vidal-Alves et al., 2021). Bambi, Guazzini, Piredda et al. (2019) led a study examining the prevalence of HV among nurses working in all types of care settings in Italy within three public healthcare facilities. The authors used the Negative Interactions Among Nurses Questionnaire to gather data on HV from 930 nurses. Of those who participated, 35.8% experienced HV in the previous year. HV occurred in the form of gossip, exclusion, sarcasm, criticism, degradation, inequitable treatment among peers, humiliation, intimidation, and threats (Bambi, Guazzini, Piredda et al., 2019). In a cross-sectional study conducted in Korea by Kim et al. (2019), the authors aimed to determine the prevalence of HV and its impact. The authors used the Negative Acts Questionnaire–Revised (NAQ-R) to assess the experiences of HV among 324 nurses working in hospitals in three different areas of Korea. The average score on the NAQ-R for the nurses was 39.4 out of a maximum of 110, indicating moderate exposure to HV throughout their careers.

Vertical Violence

VV is violence directed toward nurses from patients, families, or support people (Bernardes et al., 2020). Nurses may be exposed to physical, verbal, sexual, and psychological forms of VV in the workplace with verbal abuse being the most common. Patients, families, and support people are the most frequent culprits of VV and can be influenced by workplace and environmental factors (Al-Shamalan et al., 2017; Havaei, MacPhee & Ma, 2020). Demographics play a role in determining which nurses may be most at risk for violence. Nurses with less experience, who are younger in age and female are more frequently abused (Al-Shamalan et al., 2017; Brophy, et al., 2017; Havaei, MacPhee & Ma, 2020; Pich & Roche, 2020). Violence toward nurses often translates to violence against women which may reflect the societal value of women. In a systematic review of 20 articles, it was evident that female nurses are more likely to experience sexual harassment or violence than male nurses which may speak to the value of women and the sexualization of nurses (Kahsay et al., 2020).

Using qualitative description, Brophy et al., (2017) conducted group interviews to capture the experience of violence amongst healthcare workers in Ontario. Of the 54 participants in the study, half of them were nurses, and 80% were female. Female participants described sexual violence as so commonplace, that it no longer gets reported. The female participants pointed out that if they are accompanied into a room by a male, they are less likely to be sexually violated. Incidences of sexual violence were described by participants as touching, grabbing, pinching, verbal passes, and derogatory name-calling. In one occurrence, a participant described being grabbed by a patient who then held her hips and simulated intercourse. When the assault was reported to management,

the response was that the patient was likely sexually frustrated and no support was offered to the affected employee (Brophy et al., 2017). In another Canadian study by Boateng and Brown (2021), a phenomenological methodology was used to capture the experience of 66 nurses with violence in healthcare. Nurses representing visible minority groups reported being exposed to racial slurs, disrespect, and refusal of care by patients (Boateng & Brown, 2021). Some studies demonstrated that female nurses are at greater risk of verbal and emotional abuse, while male nurses are more likely to experience physical violence (Al-Shamalan et al., 2017; Edward et al., 2016). Nurses representing minority groups are also subjected to greater VV in the form of discrimination (Alshehry et al., 2019; Boateng & Brown, 2021; Brophy et al., 2017; Cukier & Vogel, 2021; Honarvar et al., 2019).

Direct care nurses in hospital settings are seemingly more likely to experience VV versus nurses who work outside of clinical practice or in the community (Chaiwuth et al., 2020; Havaei, MacPhee & Ma, 2020). However, the risk of working in the community in home environments is identified as a potential hazard by the Standing Committee on Health (2019) without presenting data to support this claim. While Mento et al. (2020) noted that hospitals are the most common place for violence to occur toward employees, nurses are at risk of experiencing violence in various locations. Most of the literature specifies that nurses working in emergency departments, psychiatric units, and long-term care experience more VV than in other departments (Al-Shamalan et al., 2017; Angland et al., 2014; Edward et al., 2016; Reichert, 2017). Violence experienced in long-term care can occur outside of the hospital setting and still present a risk for nurses. In studies conducted by Havaei et al. (2020), Havaei and MacPhee (2019), Havaei,

MacPhee, and Ma (2020), it was demonstrated that nurses working in the medical surgical field of nursing are also at high risk of experiencing violence.

Emergency Department. Of all the articles reviewed, 10 articles, including the Standing Committee on Health report, spoke specifically to the experiences of violence in the Emergency Department (ED). In Canada, 50% of attacks on HCPs occur within EDs (Standing Committee on Health, 2019). In a cross-sectional multicenter study by Alsharari et al., (2022) in Saudi Arabia, a validated and standardized questionnaire was used to measure the prevalence of violence amongst 849 ED nurses, the forms of violence experienced, the conditions under which the violence occurred and the impact of violence on nurses. The authors also collected data that would identify common characteristics among those nurses exposed to violence. Findings showed that 73% of the nurses had experienced at least one form of violence in the preceding 2 years, 94% of participants experienced verbal abuse, 74% verbal threats, 47% physical violence, and 19% sexual harassment (Alsharari et al., 2022). Pich et al., (2017) performed a cross-sectional study in Australia where 537 nurses responded to a survey capturing their experiences of violence in the ED. Nurses identified triage, nurse-patient communication, and responding to patients' complaints as placing them in the most vulnerable positions for exposure to violence (Pich et al., 2017). Bernardes et al., (2020) used the Questionnaire for Workplace Violence Experienced or Witnessed by Nursing Professionals to conduct a study on 55 nurses who worked in a single ED in Brazil. The findings of this study indicated that females in that ED were more likely to experience all forms of violence. The occurrence of physical violence was 11%, verbal abuse 38%, mobbing 25%, sexual harassment 9%, and racial discrimination 5% among participating

nurses in the 12 months before taking the survey (Bernardes et al., 2020). Interestingly, perpetrators of violence were most commonly colleagues and supervisors, however, the study was conducted in a single ED in one hospital. Two other studies led by authors Atan et al., (2013) and Chaiwuth et al., (2020), sought to measure experiences of violence in multiple settings, and both were able to identify that nurse participants in ED had an increased risk of exposure to violence.

Using a phenomenological methodology, Yildiz and Yildiz (2022) performed a study to capture the experiences of workplace violence among pediatric ED nurses in Turkey. The study was carried out in one single ED with 20 nurse participants. The nurses reported verbal violence in the form of yelling and threats from parents of patients as their most common violent experiences. The nurses felt the violence was elicited due to unmet parental expectations, parental fear and anxiety, and low nurse-to-patient ratios (Yildiz & Yildiz, 2022). Participants described feeling burnt-out secondary to VV, and ongoing worry about experiencing perpetual VV at work (Yildiz & Yildiz, 2022). Lastly, in a descriptive study, Angland et al., (2013) captured nurses' insights into preceding occurrences of violent episodes in the ED. The authors were able to discern from nurse perceptions that violent incidences occurred due to environmental factors such as wait times, overcrowding, lack of security, triage deficiencies and communication factors such as interprofessional relationships, attitudes, and fear (Angland et al., 2013).

Psychiatric Care. Psychiatric care is another frequently identified area where nurses are at increased risk for exposure to violence. (Atan et al., 2013; Bernardes et al., 2020; Brophy et al., 2017; Chaiwuth et al., 2020; Standing Committee on Health, 2019). Several studies address this phenomenon. Edward et al., (2016) conducted a systematic

review and meta-analysis of 14 studies examining the factors that contribute to violence toward nurses. In their analysis, they determined that psychiatric nurses are three times more likely to experience physical violence at work than nurses in other care areas. Hiebert et al., (2022) performed a phenomenological study of the lived experiences of workplace violence of 10 psychiatric care nurses in Western Canada. Nurse participants in this study disclosed they felt verbal violence was a part of their job, so much so that they no longer reported such incidents. They defined workplace violence as physical violence where they felt they were in danger or there was a significant risk to their well-being (Hiebert et al., 2022). Lastly, the participants unequivocally categorized VV as intentional or unintentional. If the violent incident was unintentional or secondary to a patient's diagnosis, nurses expressed empathy toward the patients who were sick and could ultimately not be held accountable for their actions (Hiebert et al., 2022).

Havaei, MacPhee, and Ma (2020) conducted a cross-sectional correlational study in British Columbia to capture the experiences of violence amongst nurses in various roles and contexts. Study recruitment was extended to all provincial unionized nurses equating to 4, 462 nurses. The response rate to an electronic survey was less than 12% and 272 respondents were from psychiatric care. In this study 77% of psychiatry nurse respondents experienced physical assault, 96% experienced the threat of assault, 93% emotional abuse, 71% verbal sexual harassment, and 8% sexual assault in the last year (Havaei, MacPhee, Ma, 2020). Patients and families were the most frequently identified perpetrators of any form of violence in this study (Havaei, MacPhee, Ma, 2020).

Long-Term Care. The Standing Committee on Health (2019) shared the greatest details outlining the difficulties with violence and the aging population. HCPs are

providing care to a growing body of aging individuals with multifaceted care needs such as dementia that can lead to aggressive behaviours (Standing Committee on Health, 2019). In the cross-sectional study by Havaei, MacPhee, and Ma (2020) 400 nurses in long-term care responded to the electronic survey. Of those who participated, 85% of them reported experiencing physical assault, 84% experienced threat of assault, 83% emotional abuse, 55% verbal sexual harassment, and lastly, a 15% rate of sexual assault in the last year.

Violence Toward Neonatal Nurses. When examining the literature available on violence toward nurses, there has been little consideration of the experiences of neonatal nurses. Of the 34 scholarly articles reviewed here, two are neonatal nurse-specific, and one is neonatal nurse/physician-focused. All three articles speak to HV rather than VV.

McKenzie et al., (2021) used narrative inquiry to examine the experience of newly graduated Australian nurses and determined many of the study participants were exposed to HV throughout their first six months on the job in NICU. The HV directed toward the new nurses was from more experienced senior nurses by way of being unavailable, seemingly uninterested in supporting the new nurses, outward rudeness, and incivility. One nurse participant felt that, due to the HV, they could not go to senior nurses for help or to ask questions out of fear of humiliation (McKenzie et al., 2021).

In another qualitative study, Bry and Wigert (2022) used semi-structured interviews and thematic analysis to capture the role of organizational climate and interpersonal relations among registered nurses in the NICU. Although not the primary purpose of the study, the authors discovered that all the nurses who identified as new-grads experienced incivility in the NICU. High turnover of nurses in the NICU

contributed to lower levels of trust amongst colleagues and senior staff reported feeling a lot of pressure to continually train new staff who would then leave the care area. Senior nurses felt their workload was exacerbated by having to support new staff. New nurses experienced mocking and exclusion, open criticism and cruelty from other nurses which contributed to the avoidance of these nurses including when assistance was needed, thus leading to patient safety concerns (Bry & Wigert, 2022).

The third and final study specific to the NICU was done by Chatziioannidis et al., (2018) to examine the prevalence, causes and impacts on mental health of bullying in the NICU. Participants were drawn from 20 different neonatal units in Greece and included 163 doctors and 235 nurses who responded to the study questionnaire. Eighty-seven percent of participants identified as female. Data analysis demonstrated equal amounts of bullying experienced by both physicians and nurses at a rate of 53% in the participating NICU environments. Female participants experienced more bullying than males at 56% and 36% respectively. Survey respondents identified being bullied most by supervisors/senior colleagues, peers, managers, and least frequently, parents. Perpetrators of bullying were recognized as females between the ages of 45 and 54 years old 63% of the time, and men between 45 and 64 years old 61% of the time. Almost 93% of the participants experienced bullying in the last six months, and 37% of participants experienced bullying as a daily or weekly occurrence.

These three studies reviewed contribute to our understanding of the experience of violence amongst neonatal nurses, however, there is much left to discover. Two of these studies did not intentionally seek out the experiences of violence in neonatal nurses, and the other included both physicians and nurses. The emphasis of all three studies was on

HV with little mention of VV in the NICU. Conducting a qualitative description study to capture the lived experience of nurses and violence in the NICU will contribute to scholarly nursing knowledge, begin to bridge a gap in existing literature on violence in nursing, give a voice to neonatal nurses, generate information to create positive systemic change, and ultimately support the quality of work life and retention of nurses.

Predictors of Violence

The incidence of violence can be somewhat predictable based on consistencies in precursor events. Nurses who have less experience, are less educated, who are younger, and are female, are more likely to experience VV (Al-Shamalan et al., 2017; Brophy, et al., 2017; Havaei, MacPhee & Ma, 2020; Nowrouzi-Kai et al., 2019; Pich & Roche, 2020). VV can be elicited by long wait times, overcrowding, low nurse-to-patient ratios due to poor staffing, dissatisfaction with care, and wait times are cited as preceding events of violence (Alshehry et al., 2019; Angland et al., 2014; Chaiwuth et al., 2020; Havaei & MacPhee, 2019; Nowrouzi-Kai et al., 2019; Pich et al., 2017). VV is more likely to occur on later shifts in the evening or overnight (Nowrouzi-Kai et al., 2019). A lack of security and the geography of care areas is said to place nurses in vulnerable positions without safe spaces (Hiebert et al., 2022; RNAO, 2008). Sudden changes in patient status and poor communication between the healthcare team and the patient are also risks for provoking VV (Edward et al., 2016; Nowrouzi-Kai, 2019; Pich et al., 2017). Inappropriate admission of patients to care areas ill-equipped to manage their care due to system deficiencies can precede violent acts from patients and families (Reichert, 2017). Similarly, assigning high-acuity patients to inexperienced nurses due to resource constraints can lead to VV (Reichert, 2017). Nurses describe patient fear, pain, trauma,

use of substances, and cognitive state as forecasters of VV (Brophy et al., 2017; Hiebert et al., 2022). In a study by Pich et al. (2017), patients most likely to exhibit violence were under the influence of alcohol or substances or had mental health concerns. Other factors that stimulate VV include lack of cleanliness, crowded spaces, limited access to food, noise level, working alone, and transferring patients (Alshehry et al., 2019). Concerning HV, predictors of violence include staffing shortages, job dissatisfaction, an absence of team cohesiveness, and poor management (Nowrouzi-Kai et al., 2019). High staff turnover and staff comprised of junior nurses requiring preceptors and mentorship are described as factors that elicit HV from more senior staff (Bry & Wigert, 2022). Lastly, organizations without policies or legislation to protect staff place nurses at risk for both HV and VV (Chaiwuth et al., 2020).

None of the predictors of violence are specific to the NICU environment. It would be of benefit to explore the preceding events of violence in the NICU. Of particular interest would be any differences in experiences between open bay and single room care units, substance use amongst families, the role of family integrated care, the ongoing COVID-19 pandemic, communication with families with multiple services involved in the care, and length of stay.

Implications of Violence Toward Nurses

Violence directed at nurses, whether HV or VV, has serious implications for nurses, patients, and the healthcare system. Nurses who experience both verbal and physical VV may experience pain, somatic symptoms, and injuries (Havaei, Astiva, et al., 2019; Lanctôt, & Guay, 2014). Nurses who have been exposed to VV report psychological impacts such as post-traumatic stress disorder (PTSD), anxiety,

depression, and burnout (Campana & Hammoud, 2015; RNAO, 2008). Nurses working in psychiatric care described experiencing "insomnia, decreased appetite, social isolation, frustration, anger, fear, guilt, headaches, nightmares, self-blame, negative physical health outcomes or injuries, being scared when out in public, and poor substance use choices, including alcohol and smoking" because of VV (Hiebert et al., 2022, p. 150). In addition to these impacts, nurses reported difficulty being relational with patients, consideration of leaving the nursing profession, and poor job dissatisfaction (Hiebert et al., 2022). Furthermore, abused nurses report disengagement, reduced productivity and deficiencies in practice (Alshehry et al., 2019; Atan et al., 2013) which may lead to poorer quality of care, deviations, and errors thus impacting patient safety and health outcomes (Bambi, Guazzini, Piredda et al., 2019; Chatziioannidis et al., 2018). Nurses exposed to HV experienced emotional exhaustion, cynicism, somatic symptoms, anxiety, social dysfunction, and depression (Vidal-Alves et al., 2021). Alshehry et al., (2019) found horizontal workplace incivility for nurses in Saudi Arabia was positively associated with higher rates of burnout and secondary trauma. Both VV and HV can cause nurses to feel a lack of confidence, fear, sadness, vulnerability, and poorer quality of life (Angland et al., 2014; Atan et al., 2013; Brophy et al., 2017).

With the deterioration in the health of abused nurses, there is lost time at work (Alshehry et al., 2019; Reichert, 2017). According to the CFNU, the amount of time lost secondary to violence has increased by 66% in the last 10 years in Canada (Reichert, 2017). Canadian costs secondary to violence are described by Reichert, (2017) as close to $24 million just in Ontario alone. In an American study, it was disclosed that over $1.5 billion was spent on violence-related costs in 2016 (Van Den Bos et al., 2017). Alshehry

et al., (2019) state that time lost due to violence costs a health centre $30 000 to $100 000 per affected person. Furthermore, exposure to violence contributes to nurses' desire to leave their place of work and potentially the profession itself (Alshehry et al., 2019). In the Atan et al., (2013) study, almost 14% of nurses surveyed considered leaving the nursing profession after violent experiences. Retention of nurses is inversely correlated with poor work environments and as violent incidents increase, there is a growing nursing shortage across our country (Boateng et al., 2021). Given the current strain on our healthcare system and the widespread national nursing shortage (CNA, 2022), lost time at work and loss of nurses to the profession because of violence is detrimental.

Conclusion

Existing literature on the experience of violence among nurses is sobering. Many violent events go unreported suggesting that the prevalence of violence in the workplace is grossly underestimated (Alsharari et al., 2022; Brophy et al., 2017). Much of the research on violence toward nurses is quantitative, capturing the number of nurses who have been abused, increases in violence are expressed by percentage, and victim demographics are represented with numbers. There is an opportunity for more qualitative research that captures the lived experience of nurses exposed to violence. While quantitative research helps to understand the prevalence of violence in healthcare, qualitative studies capture the essence of the human experience of a phenomenon in its literal and descriptive nature that is reflective of participants' reality (Neergaard et al., 2009). Qualitative studies use an inductive process to contribute to knowledge of a phenomenon not well understood (Neergaard et al., 2009).

Additionally, the findings in the literature identify emergency departments, psychiatric care, and geriatrics as the highest-risk areas for violence toward nurses. There is limited research on nurses' exposure to violence in the NICU. Without this data, the experience of neonatal nurses will continue to go unrecognized and without intervention. It is well documented in the literature that qualitative research can be used in healthcare to create positive change reflective of HCPs' experiences (Chafe, 2017; Doyle et al., 2020; Sullivan-Bolyai & Bova, 2021). Therefore, pursuing qualitative research to explore the experience of violence among neonatal nurses will begin to bridge a gap in knowledge of this phenomenon and contribute to the development of strategies to enhance support for neonatal nurses.

Chapter 3. Methodology

Introduction

In the quest to understand the experience of violence amongst neonatal nurses, the methodology chosen to explore this phenomenon is qualitative description (QD). QD is a valid and rigorous methodology recognized for making a significant contribution to healthcare by capturing the experiences of research participants in a meaningful way that affects change (Chafe, 2017; Doyle et al., 2020; Sullivan-Bolyai & Bova, 2021).

Qualitative Description

QD is a methodology widely used in the field of healthcare to capture nursing and healthcare phenomena (Kim et al., 2017). The purpose of QD is to provide an in-depth description of a chosen phenomenon generated directly from those with the experience (Bradshaw, et al., 2017; Neergaard, et al., 2009). QD studies look to determine the who, what, why, and where of an experience not yet understood. Researchers utilizing QD provide a straightforward yet comprehensive summary of data findings that is easy to comprehend and true to the generated data without a lot of inference (Kim et al., 2017; Lambert & Lambert, 2012; Neergaard et al., 2009; Sandelowski, 2000, 2010). QD produces insight into the experiences of a phenomenon through a naturalistic approach to research and is often referred to as the most flexible and least theoretical methodology (Doyle et al., 2020; Kim et al., 2017; Milne & Oberle, 2005; Neergaard et al., 2009; Sandelowski, 2000). QD offers descriptive validity in the sense that the narrative is so true to the data, that most researchers would be able to agree with the findings of the study (Sandelowski, 2000). While there is some interpretation of the data, the low inference and descriptive validity are what makes QD findings effective in initiating

policy change in healthcare (Chafe, 2017). Given the paucity of research on the experience of violence amongst neonatal nurses and the objective of QD to gain insight into a phenomenon not well understood, QD was felt to be an appropriate choice of methodology to explore the proposed research question.

Philosophical Underpinnings

Philosophical perspectives in research inform all aspects of the research process (Cresswell & Poth, 2018). Central to the philosophical underpinnings of QD methodology is that it is conducted via naturalistic inquiry, meaning there are no preconceived variables to study and no commitments to adhere to; the goal is to have participants reveal their experiences naturally, as though they are not even part of a study (Bradshaw et al., 2017; Sandelowski, 2000; Sullivan-Bolyai & Bova, 2021). Knowledge of a phenomenon occurs through an understanding of the meaning research participants assign to that phenomenon (Bradshaw et al., 2017). Reality is a unique perception of the individual research participants that is contextual and subjective (Lincoln et al. 2017 as cited in Doyle et al., 2020; Latifnejad Roudsari, 2019). The participants' perspectives and words build the foundation of the research and provide what is referred to as an emic or insider view (Bradshaw et al., 2017). Researchers aim to understand a phenomenon through individual experiences without further interpreting the data beyond its' true meaning (Ormston et al. 2014 as cited in Doyle et al, 2017; Sandelowski, 2010). In this way, QD is an inductive process whereby knowledge is generated, and a phenomenon is described rather than contributing to an existing body of knowledge or theory (Bradshaw et al., 2017).

Ontology and Epistemology

Ontology is concerned with the nature of reality (Cresswell & Poth, 2018). Being a naturalistic approach to research, in QD reality is seen as a subjective or relative experience of the individual. Reality can vary from person to person with similar experiences because individuals ascribe to their interpretation and meaning of an occurrence (Bradshaw et al., 2017). QD attempts to capture the reality of research participants by sharing literal descriptions of experiences followed by minimal interpretation of the meaning of those experiences (Bradshaw et al., 2017; Sandelowski, 2010).

Epistemology refers to how knowledge is known (Cresswell & Poth, 2018). There is a relationship between the one who knows, and how they have come to know (Denzin & Lincoln, 2011 as cited in Bradshaw et al., 2017). There are many influences on how we come to know. Thus, knowledge can be subjective, socially constructed, and contextual (Bradshaw et al., 2017). QD is conducted recognizing that knowledge is subjective, and many versions of reality may exist. The researcher adds subjectivity to the study in their being, knowledge, axiology, and interpretation of the data (Bradshaw et al., 2017; Creswell & Poth, 2018).

The philosophical perspectives of QD supported the goals of this research study. Utilization of QD methodology to determine the experience of violence amongst neonatal nurses has contributed to generating knowledge of the phenomenon from an emic perspective and can be used to affect change.

Methods

Methods in qualitative research refer to how a study is conducted to generate and interpret evidence. Under the umbrella of methods, a researcher can expect to address the use of a theoretical framework, sampling, data collection, data analysis, ethics, and rigour (Bradshaw et al., 2017; Sandelowski, 2000; Sullivan-Bolyai & Bova, 2021).

Sampling

To answer the proposed research question, purposive sampling of a heterogeneous group of neonatal nurses was the preferred sampling strategy. Purposive sampling is used to gather information from a targeted group of individuals (Bradshaw et al., 2017; Sullivan-Bolyai & Bova, 2021) which in this case was neonatal nurses who experienced workplace violence. Heterogeneous sampling was utilized to generate maximum variation in data collection (Palinkas et al., 2015) and to collect and share a wide range of stories from the participants. In an attempt to increase study participation, snowball sampling, whereby research participants referred other potential participants who can contribute to the body of knowledge (Cresswell & Poth, 2018) was employed. To answer the research question, purposive and heterogeneous sampling are both appropriate strategies that align with the philosophical underpinnings of QD. By intentionally pursuing nurses with the experience of violence in the NICU data was generated that contributes to new knowledge about this phenomenon that has not yet been well understood.

Sample Size. The goal of a QD sample size is to reach data saturation or data redundancy (Doyle et al., 2020; Magilvy & Thomas, 2009; Sullivan-Bolyai & Bova, 2021) where no new information can be garnered through data collection, there is enough

information that the study could be replicated, and when no new codes emerge from the data (Fusch & Ness, 2015 as cited in Doyle et al., 2020; Guest et al., 2006 as cited in Sullivan-Bolyai & Bova, 2021). In ascribing to the ontology and epistemology of QD and honouring that each participant holds their reality and knowledge of their experience of violence, it was determined that data saturation may not be achievable. It was felt that information power was of utmost importance to this study. Information power refers to the amount of relevant information generated from participants rather than a predetermined number of participants (Malterud et al., 2016 as cited in Doyle et al., 2020).

Knowing sample size in QD can vary greatly in size (Kim et al., 2017; Magilvy and Thomas, 2009), for this study, 4 to 8 participants were sought, and 8 participants were obtained. It was felt that with this sample size, there were enough participants to contribute to information power while being appropriate for a master's level thesis.

Inclusion Criteria. To be eligible to be included in the study, participants had to be or have been neonatal nurses within the last 5 years who experienced violence, either HV or VV, in the workplace. Knowing that the experience of violence can contribute to one's desire to leave the work environment (Alshehry et al., 2019), it was thought to be important to include those who previously worked in the NICU. These participants were limited to having worked in the NICU in the past 5 years due to the potential for recall bias. Recall bias can impact participants' ability to recall information from a prior event, this can be affected by the length of time between the event and the recall and is a larger concern when asking participants about routine or frequent events (Althubaiti, 2016). The literature demonstrates that experiencing violence is a traumatic experience, recall

bias may not be an issue in this case. Nevertheless, the time frame of 5 years was implemented to mitigate this risk.

Exclusion Criteria. Initially, nurses working in the same NICU as the lead investigator of the research were excluded from participation so as not to compromise confidentiality or anonymity. However, some nurses in the same NICU expressed interest in the study and a desire to participate. In consultation with the Athabasca research ethics office and supervisors, the exclusion criteria were removed.

Recruitment. Using a recruitment poster, as attached in Appendix A, Canadian neonatal nurse participants were recruited via networks such as the Canadian Association of Neonatal Nurses, the International Council of Nurses, through known contacts in neonatal centers around the country, and neonatal nurse social media sites. Once interested parties became available, the formal consent process ensued and a mutually agreed upon interview time was scheduled.

Data Collection

The literature describes the most common type of data collection used in QD as semi-structured interviews (Doyle et al., 2020; Lambert & Lambert, 2012; Neergaard et al., 2017; Sullivan-Bolyai & Bova, 2021). The interview guide developed for this research reflected key concepts identified in the literature review. It was clear from the literature that demographics play a role in violence in nursing. Years of experience, age, and gender were determined to be risk factors for abuse in the studies conducted by Al-Shamalan et al. (2017), and Pich and Roche (2020). With this in mind, five demographic questions were included in the interview guide to capture this information. The unit

design was determined to be a risk factor for violence by Brophy et al. (2017), therefore participants were also asked about their respective NICU designs.

Additionally, because this study was being conducted nationwide, it was felt to be important to capture the general location of the participants. The six open-ended questions asked of the participants were constructed based on themes found in the literature review such as experiences, contributing factors, personal and professional impacts, and responses to violence. Once the questions were developed, they were shared with the supervisory committee for review and feedback. One supervisor was a Neonatal Nurse Practitioner and was able to offer the perspective of the NICU nurse regarding the relevance of the questions.

Interviews were conducted virtually using the Microsoft Teams platform and lasted 30 to 90 minutes in length. A benefit of using a virtual platform was the ability to easily record and transcribe the interviews. Recordings were kept within Microsoft Teams files on a password-protected computer for two weeks after which the recording was set to expire and be deleted from Microsoft Teams. A secondary recording source was employed as a backup option in the event there was an error in the virtual recording. This backup option was a password-protected phone with a recording option. Once it was determined that the virtual recording was intact, the secondary recording was immediately deleted from the phone.

Before commencing interviews, an introduction was provided to participants reviewing the purpose of the study and their rights. This introduction can be found in the form of a script in Appendix B. Interview questions were open-ended to allow

participants to expand on their personal experiences. The interview guide is included below and as Appendix C.

Demographic questions included:

- What is your age?
- What region of Canada do you live and work in? Example: Atlantic, Central, Prairies, West Coast, Northern Territories,
- Do you identify with a specific gender, if so, with what gender do you identify? (optional)
- How long have you been or were you a neonatal nurse?
- Do you or did you work in an open bay unit or single room care unit?

The six open-ended interview questions:

- How do you define violence toward nurses?
- Can you share with me a time you experienced violence at work?
- What factors do you think might have contributed to the incidence of violence?
- What did you do after the incident?
- How did this experience impact you as a nurse?
- What do you think should be done to address workplace violence?

Further probing and expansion on questions were performed as necessary to generate rich data. While there were no specific questions to differentiate between HV and VV, this information emerged organically.

Data analysis

QD analysis results in a descriptive summary of the research participants' experiences that is reflective of their language (Neergaard et al., 2009). The

interpretation of the data by the researcher seeks to understand the meanings attached to an experienced phenomenon by the participants (Neergaard et al., 2009), not to create inferences. Data analysis began as soon as data became available and continued concurrently with data collection (Lambert & Lambert, 2012; Sullivan-Bolyai & Bova, 2021). Recorded interviews were reviewed and transcribed verbatim. The accuracy of the transcription was re-assessed, and data was uploaded into NVivo for organization, management of data, and analysis. Reflections and field notes were added to the data. All components of data including interview recordings, transcripts, uploads into NVivo, field notes, and analysis were stored on the same password-protected computer. Data analysis occurred over five months. After the initial upload of data into NVivo for analysis, the proceeding analysis was conducted outside of NVivo using Word documents to further organize and interpret the findings.

There are two formal means of analyzing QD data, content analysis and thematic analysis. For this study, the preferred choice of data analysis was thematic.

Thematic Analysis. Thematic analysis is said to be the first type of qualitative analysis researchers should learn as it serves to build skills in the analysis process that will benefit the learner (Braun & Clarke, 2006). It is a purely qualitative and inductive method to identify patterns and themes within the data that remain true to participant descriptions (Willis et al, 2017 as cited in Doyle et al., 2020; Vaismoradi et al., 2013). Thematic analysis aligns with the philosophical underpinnings of QD in that it captures experiences, meanings, context, and the reality of research participants (Braun & Clarke, 2006). In this study, to ensure data analysis was conducted strategically and rigorously,

Braun's and Clarke's (2006) phases of thematic analysis were utilized. Following their guidelines, the steps taken to analyze the data were as follows:

- Familiarize oneself with the data,
- Transcribe the verbal data into written form,
- Generate initial codes,
- Search for themes,
- Review themes,
- Define and name themes, and
- Produce the narrative report.

Member checking was used throughout the data analysis to not only enhance rigour but also to ensure participants were comfortable with the findings presented. After each interview was conducted and transcribed, the transcription was sent to the participant for review. Participants had an opportunity to offer clarity or request certain statements be removed from the transcript. Each participant reviewed their transcription and provided feedback. After the data analysis was complete, it was once again sent to the participants for final review to ensure they were comfortable with the interpretation of the data and the generated themes. Participants were given a two-week time frame to provide feedback should they wish to do so, only two participants responded to this request.
In addition to member checking, consultation with research experts and thesis supervisors was ongoing to ensure accurate interpretation of the data.

Ethical Considerations

Ethical considerations penetrated every aspect of this research study. Researchers must always consider their position within the study, their values, beliefs, biases,

relationships, power imbalances, goals of the study, vulnerable populations, and maintaining anonymity (Cresswell & Poth, 2018). Bradshaw et al. (2017) identify three key aspects of maintaining an ethical qualitative study: (a) maintaining anonymity, (b) informed consent, and (c) nonmaleficence. Orb et al. (2001) echo these same principles of ethical qualitative research and add justice as an important aspect of ethical considerations. Every effort was made to conduct an ethical study of high quality. In addition to adhering to the recommendations of Cresswell and Poth (2018), Bradshaw et al. (2017), and Orb et al. (2001) approval from the Athabasca Research Ethics Board was sought and granted to conduct this study.

Maintaining anonymity

Gathering data via face-to-face semi-structured interviews impacts the ability of participants to remain anonymous (Bradshaw et al., 2017; Orb et al., 2001). The more detail a participant shares, the greater the difficulty in maintaining anonymity (Bradshaw et al., 2017). It is the role of the researcher to protect the participant (Orb et al., 2001). To enhance confidentiality and anonymity throughout this study, data collected, and transcriptions were maintained within password-protected devices. Video recordings were deleted from Microsoft Teams two weeks after the interview took place. This was to ensure adequate time for comparison and accuracy between the video recording and the written transcription. Data will be kept for five years on this same password-protected computer and then destroyed by the principal investigator. Participants' names were removed from the transcription and participants were logged by number, for instance, Participant 1. Anonymity was maintained throughout member checking. Each participant was sent their transcript via email after identifiers were removed. Emails were sent

privately; no group emails were sent. Any potential identifying information was not included in the results of the study and although direct quotes were used, findings were also grouped together to create a narrative.

Informed consent

Under informed consent, research participants are viewed as autonomous humans with the ability to make an informed decision to participate in and withdraw from research (Orb et al., 2001). Using a formal consent form, potential participants were informed of:

- The purpose of the study,
- The risks, and benefits of participating in the study,
- The measures taken to maintain anonymity,
- The research process includes use of Microsoft Teams, recording, transcription,
- The plan for disseminating the information generated from the study,
- They are not obligated to partake in the study,
- They are free to withdraw at any point without penalty,
- The need to breach confidentiality should any illegal or potentially harmful information be shared with the researcher such as plans for harming others or self-harm,
- The role of the research participant, including member checking and
- Contact information of the researcher and supervisory committee

The informed autonomous participants then decided if involvement in this study was appropriate for them. Those who chose to participate were required to sign the consent form demonstrating their desired participation. Respondents were from across the

country; therefore, the consent form was emailed to participants to read and sign and scanned back to the researcher for record keeping. The consent form is attached as Appendix D.

Nonmaleficence

Sharing stories of vulnerable experiences can cause emotional and psychological distress to participants (Bradshaw et al., 2017). Sanjari et al., (2014) suggest there should be protocols put in place to offer emotional support in response to visible psychological distress. To mitigate the risk of distress, a supportive and non-judgmental environment was created between the researcher and the participant. Participants were offered breaks as needed throughout the interview and the right to withdraw from the interview was explicit. Prior to study participation, the nurses were asked to identify existing support systems they could rely on should they require support after the interview. A tool was provided to participants to document these support systems and is attached as Appendix E. This was designed to ensure study participants had a plan for seeking support post-interview should it be needed. Participants were also provided a list of available psychological supports in their geographical area.

Justice

Justice according to Orb et al. (2001) refers to equity and fairness among research participants and encompasses all efforts taken to protect the respondents including consent, confidentiality, anonymity, and nonmaleficence. Each participant was treated respectfully and provided the same information, consent options, and support system strategies.

Rigour

There are six standards identified in the literature that are said to be required to achieve a highly rigorous qualitative study. They are known as objectivity, dependability, credibility, confirmability, transferability, and application (Bradshaw et al., 2017; Colorafi & Evans, 2016; Milne & Oberle, 2005; Sullivan-Bolyai & Bova, 2021). The following steps were taken to achieve a high-quality and rigorous research study.

Objectivity

To achieve objectivity the researcher must maintain a neutral position within a study to avoid creating bias. Colorafi and Evans (2016) advise to achieve this, one must be transparent in information sharing with participants and research colleagues and acknowledge personal bias through reflection. In this study, it was important to separate existing personal knowledge and experiences as a nurse from the generated data of the participants. Throughout the data analysis, reflections were documented as notes in the margins of transcripts to document study decision-making, to compare findings to the literature, to ensure a neutral position was sustained, and to identify any potential bias infusing the study.

Dependability

Dependability refers to the reliability of the study. The study must be conducted in a way that should another researcher perform the same study, they would achieve the same results (Sullivan-Bolyai & Bova, 2021). Dependability in this research was achieved by staying close to the philosophical underpinnings of the methodology and honouring the reality and knowledge of the participants as they see it without interpretation or bias. Field notes were utilized within transcripts to capture important

points that were not apparent in the transcript such as emotions, facial expressions, and personal clarifications. Continued engagement in the QD research process, ensuring transcription accuracy, and utilization of field notes enhanced the dependability of the study. Additionally, collaborating with research participants through member checking heightened the dependability of the work.

Credibility

A study is deemed to be credible when the findings are close to reality and reflect the data correctly from an emic perspective (Colorafi & Evans, 2016; Milne & Oberle, 2005). Credibility in this study was achieved once again via member checking and validation of findings with research participants and thesis supervisors. Furthermore, study findings are validated using existing published and peer-reviewed literature.

Confirmability

Confirmability speaks again to the ability to produce a narrative without researcher bias, assumptions, and judgements (Bradshaw, et al., 2017; Sullivan-Bolyai & Bova, 2021). Here, member checking, collaboration with supervisors, field notes, and reflection were utilized to achieve confirmability. The reflective notes served a dual purpose in safeguarding a bias-free study and tracking processes and decision-making throughout the research, thus adding to the confirmability of the study.

Transferability

Purposeful sampling, reflection, dependability, and an accurate portrayal of the data contribute to achieving the transferability of a study (Bradshaw, et al., 2017; Colorafi & Evans, 2016). Deliberate steps were taken to ensure this study would be

transferable. A purposeful sampling of a heterogeneous group of nurses who can speak to the experience of violence in the NICU was utilized. This small group of participants represents a larger group of individuals with the same experience. Additionally, findings are validated by the literature. Transferability is further enhanced via member checking, the provision of a narrative that remains close to the data, and a study free of bias.

Application

Achieving the application of a study is to create a study that is meaningful to the participants (Miles et al., 2014 as cited in Colorafi & Evans, 2016). Collaborating with participants in the interview process and member checking immersed them in the research process thus making their role in the study meaningful and important. Their words contribute to achieving the goals of the study, including giving neonatal nurses a voice, contributing to nursing literature, retention, and support of nurses, and creating positive change.

Limitations

The major strength of QD lies in its accurate depiction of the human experience of a particular phenomenon (Bradshaw, et al., 2017; Neergaard, et al., 2009; Sandelowski, 2000). Some challenges in utilizing QD can contribute to weaknesses of the methodology; with appropriate utilization of skillful methods, they can be overcome. Firstly, QD can be perceived as being a less rigorous approach to research (Vaismoradi et al., 2013). Through the use of reflection, member checking, and consultation with expert qualitative researchers, one can speak to the decisions made throughout the research process and enhance overall rigour (Bradshaw, et al., 2017; Sullivan-Bolyai & Bova, 2021). Each of these strategies has been utilized in this study. Another critique of QD is

the absence of theory, however, using QD for the reason it was intended, to understand and create knowledge of an unknown phenomenon, negates this criticism (Neergaard et al., 2009). QD is depicted as being easy and a default methodology for those with limited time or knowledge of qualitative research (Sandelowski, 2010). Again, providing rationalization for the use of QD to contribute to new knowledge addresses this claim. Lastly, QD has less representation in the literature which can make learning and utilizing the methodology challenging for researchers (Kim et al., 2017). Consulting both the literature and experienced qualitative researchers were employed to overcome this challenge.

Summary

QD is a valid and rigorous methodology with a commitment to naturalistic inquiry designed to capture the subjective and contextual reality of research participants and contribute to the knowledge of a phenomenon not well understood (Bradshaw, et al., 2017; Neergaard, et al., 2009; Sandelowski, 2000; Sullivan-Bolyai & Bova, 2021). Skillful use of QD methods and intentional strategies of reflection contribute to a rigorous and meaningful study (Bradshaw, et al., 2017; Sullivan-Bolyai & Bova, 2021). QD research provides accurate and literal descriptions of the participant-generated data without a lot of interpretation or inference (Sandelowski, 2000, 2010; Neergaard et al., 2009). Findings depict participant reality in a manner which can be used to contribute to responsive intervention in healthcare (Chafe, 2017; Doyle et al., 2020; Sullivan-Bolyai & Bova, 2021). Using a QD methodology to explore the phenomenon of violence in neonatal nursing has contributed to knowledge and may lead to policy development and

support systems to improve the work life of nurses and create meaningful change in nursing practice environments.

Chapter 4. Results

A total of eight women, aged 22 to 43, from five provinces participated in the study. Years of experience as a neonatal nurse ranged from 4 months to 16 years. When asked at which point the participants experienced violence, the responses varied. Some participants felt they experienced violence throughout their entire career as a neonatal nurse, while others could pinpoint it happening at the 1-year, 3-, 8-, and 11-year mark. Four participants stated they worked in an open bay NICU setting, two participants worked in a hybrid model where their unit had both single-room care and open bay, one participant worked in both single-room and open bay units, and one participant worked in a single-room care environment.

The findings of this study are consistent with what has been learned in the literature about violence in nursing in general, however, there are also new learnings in this study. Participants experienced HV and VV and spoke about secondary exposure to violence. The following section presents the data within common themes of nurses' experiences of violence, contributing factors, addressing violence, and job satisfaction. The themes are further deconstructed into subthemes to provide greater accuracy and understanding of the nurses' experience of the phenomenon of violence in the NICU. Throughout the analysis, ellipses are used within direct quotes in place of words such as "like", "you know", and "um", or for repetitive statements.

Horizontal Violence

Three nurses described incidences of HV in their respective neonatal care units. There are three subthemes identified within the findings including those experiences of HV, hierarchy, and the impact of the violence. Within the experiences of the HV theme

lie six concepts including shaming, gossip, feeling disregarded, criticism, absence of support, and isolation. The hierarchy subtheme has no further concepts and the impact of the HV subtheme is broken down into four concepts, life changes, professional help, personal burden, and sense of responsibility.

Participant 1(P1), a Registered Nurse with 10 years' experience as a neonatal nurse, spoke extensively about how she was targeted by two of her colleagues at the 4- and 8-year mark of her career. Participant 2 (P2) has 2.5 years of experience as a neonatal nurse. She describes an experience of being targeted by a group of nurses who were friends in the NICU when she first began working there. She defines the main culprit of HV as her assigned preceptor. Participant 7 (P7), a neonatal nurse for 5 years, is the final participant to describe HV directed toward herself and other nurses new to the neonatal care team.

Experiences of Horizontal Violence

Shaming. Two of the participants described interactions where they were publicly shamed within the unit where they work. In one example provided by P1, she responded to an acutely ill baby whose alarms were ringing. Upon assessment, it was noted that the baby was not breathing and did not respond to stimulation. P1 provided positive pressure ventilation to the baby. The assigned nurse saw the participant responding to the baby and reacted,

> She yelled at me from across the room in front of the family and she said, 'Stop bagging him'. And then she came over to…me, slapped the bag out of my hand, took the mask off and said, 'We're not supposed to bag him, he can't get positive pressure'.

Adding further to the public shaming, at the end of the shift, P1 describes hearing the assigned nurse telling the oncoming nurse what P1 did and how wrong she was to do so. After the incident, P1 stated that "[nurse] did not speak to me for an entire year. She ignored me and did not really acknowledge my presence".

P2 describes a similar outward display of shaming. On one shift, while orientating to the unit P2 recalls her preceptor being exceedingly frustrated with her performance. She states,

> She took me by the hand and marched me through the whole open unit…to where she wanted me to get something. And then literally marched and walked me back by the hand to my patients, to my baby and then left me at the bedside all by myself…and told me to figure out what it is you need to do.

The participant describes this as a "really horrible feeling" that was then exacerbated by her preceptor sharing details of the incident with other staff.

Gossip. A portion of the HV experiences for P1 and 2 included being talked about amongst their peers. P2 describes feeling as though senior nurses were relentless in talking about her. After a negative interaction with her preceptor, she stated she sought her preceptor out for further assistance and found her, "gossiping with another group of nurses about [the] interaction and what I was doing wrong with my patient". She said, "Then they go out and tell all the other nurses and then you…get that [feeling] everybody's been talking…about you".

During a performance review with P1, her manager spoke to one of the incidents of violence she experienced, indicating she had heard about it. She said, "Looking back, no one ever approached me about this situation, it was obviously talked about behind my

back with the manager”. This contributed to feelings of mistrust toward her colleagues, creating a gap between herself and her peers.

Feeling Disregarded. For P1, there was a sense of being intentionally disregarded by one nurse who repeatedly targeted her with disdain and unkindness. She says the nurse was reluctant to ask her for assistance with procedures even when she was the most appropriate person to help. For example, P1 was proficient at inserting peripherally inserted central catheters (PICC) and would be formally assigned to do so on some shifts. However, this nurse would disregard the participant and ask another nurse to put in a PICC on her assigned patient stating, “She can do it instead, so you don’t have to”. P1 said,

> It’s my PICC day, I’m supposed to put in the PICC, but she asked her roommate, who was another senior nurse…and that hurts because I’m very skilled, I’m very good at it…and to not be…seen as an equal but seen as lesser because I’m newer and I haven’t been doing it as long, it’s hurtful.

The disregard of the participant was subtle but felt targeted and intentional thus adding to her experience of HV.

Criticism. The feeling of being overly criticized dominated the findings of the study. In P7’s experience, she described finding her way as a new nurse and feeling proud of the work she did only to have an oncoming senior nurse question and criticize her at shift handover,

> There were times when I just started that I really felt like I did a good job. But then I would give report and these particular senior people would always…have

> things to say about what I did…not questioning in a curious way but questioning…with the intent to make you feel bad.

As a new nurse, P2 says the criticism she received from her preceptor and peers was constant,

> [They were] incredibly nit-picky about all the things that I would do…it always felt like it was never…ever good enough…nurses standing literally over top of me as I'm charting and pointing to every single little thing…if I was doing it right, if I was doing it wrong, making me go back and redo it.

For P2, this targeted criticism went on for six months, when the preceptor failed her on her preceptorship. She said, "The nurse who was my preceptor, she had failed me on my preceptorship, and that was huge…then it came down to whether or not they were going to keep me in the program and give me another chance." The criticism impacted the participant to the point where it influenced her career.

Absence of Support. Another common subtheme identified was the absence of support offered in an acute care environment that felt very intentional. P1 recalls times when she needed help with her workload but was knowingly left unsupported by those in a position to do so. In one example, P1 was caring for a patient at the end of life. To enhance their privacy, she moved the baby to a single room at the earliest convenience for the family. Given the circumstances, she did not plan for a break schedule with her colleagues. The charge nurse (CN) came to the participant mid-morning to ask if breaks were covered. P1 said, "No", and stated that the CN became visibly upset and said, "Now I have to find people to cover your breaks". The CN did not return to the patient room for

the rest of the day, leaving the participant to perform all end-of-life care alone. Participant 1 described,

> No help [was] offered in a difficult time. Then around 5:00…I took the baby to the morgue…I distinctly remember it was a very sad case…it was my first one that I felt very attached to. And I remember when the family left, the fellow and I just kind of looked at the baby, looked at each other, gave each other a hug, teared up a bit, and then wiped our tears away and continued.

The participant felt penalized for taking measures to support the family in a difficult time. This perceived deliberate absence of support left her feeling alone in a distressing circumstance.

Isolation. As per the participants, the offenders did not treat all staff in the same way. They had long-standing friendships and relationships in their respective NICUs and were admired by many. Consequently, for those targeted it felt very personal and isolating. When P1 would try to talk about her experiences with whom she felt were friends, she would then feel dismissed and unsupported because her friends did not share the same sentiment. She said,

> I can only confide in maybe one of my friends who had the same experiences because anytime I would say anything to complain about this person, my friends would [say], 'But she's very good at her job,' or 'she does this,' or 'I'm very surprised she's like that.'

On the contrary, P7 found solace in comradery with other inexperienced staff with similar bullying experiences. Rather than feeling isolated, she felt supported by her peers.

Hierarchy

All three participants spoke to a hierarchy between senior and junior nurses that ultimately breeds HV. Nurses describe being pressured by senior staff to care for patients or perform tasks they were not yet ready for early in their neonatal careers. It was felt that unrealistic performance expectations were placed on junior nurses by the senior staff. P7 said,

> Senior staff would kind of pressure the younger nurses to care for patients they weren't ready to care for and…attend deliveries…when they weren't ready…there would be comments that the new people need to start taking more initiative and become more independent…sometimes this was done in an encouraging manner, but sometimes it was done in a pressuring and unkind one.

P1 expressed that junior staff are often discredited while senior staff are thought to be superior. This creates a hierarchy between the two groups that can enable bullying. In her words she said,

> I think this senior-junior dynamic…happens a lot…the assumption is that junior nurses make more mistakes than senior nurses. So, when a junior nurse sees senior nurses make mistakes, they can't come forward. But the moment a junior nurse makes a mistake, they get condemned…Both people can make mistakes, but it's not acknowledged enough, which gives senior staff…more power…that inevitably…perpetuates bullying.

The Impact of Horizontal Violence

Life Changes. Experiencing HV had far-reaching impacts on Participants 1 and 2. They both decided to leave their jobs in their corresponding NICUs and articulated that bullying was the driving factor in doing so. P1 left her job and her province, she said,

> [Those nurses were] one of the driving forces for wanting to leave…it's unfortunate. I think there [are] bullies everywhere, but I…was at a point in time where I [felt] like I needed more opportunities for myself [outside an] environment where these people are known bullies.

In response to her experience of violence, P2 left her job, her town, and direct care nursing for almost three years. P2 stated,

> I was spiraling, and I was in a really deep dark place…that was when I knew I had to give my notice and get out of there because it wasn't good. So, then I took a break from bedside nursing altogether for almost three years…I moved far into a small little town and just spent a lot of time outside and doing a lot of self-reflection and got myself into a nicer job that wasn't so crazy and hectic and just took a step back for a while.

She states she considered leaving the nursing profession altogether but eventually went back to a bedside nursing position. Currently, she maintains one full-time job and works casual in a different NICU on the premise that should she have a negative experience she has control over her schedule and can limit her exposure to bullying. In her own words, "I'm just casual there and…pick up when I want which is kind of nice…it's easier to take one day of negative interactions than it is to take four days of it."

Professional Help. The experience of HV had a profound effect on the emotional well-being of the participants. P1 and 2 sought professional counselling to help them process their experiences of bullying. For P1, she sought professional help 8-years into her career,

> At that time when I was seeking a therapist my whole body was breaking out in a rash…my arms were raw, my neck was raw…I found out afterwards that it was my body telling me this is…too much and I need to take a break.

Two years after her experience in the NICU P2 sought professional support to help her deal with residual anxiety and lack of self-confidence secondary to the bullying she encountered. She said,

> Eventually, I did talk to somebody about it, but it did take me a little while…[I]…chatted with a counsellor about things and, you know, [the bullying] seems to have been a stem of a lot of my anxiety with nursing in general.

Personal Burden. The impact of experiencing HV and being targeted by peers has had a prolonged effect on participants 1 and 2. Years later, P1 still carries the weight of being bullied with her. She stated that by not directly addressing the violence herself she was left with a tremendous sense of guilt and that in not reporting the behavior it was perpetuated,

> Not being able to speak up to…stop the bullies…has kind of trickled down to them bullying other people and me feeling responsible for not speaking up sooner and stopping things. I [didn't] feel safe to come forward about it, but not coming forward and bearing the burden of that person continuing to perpetuate what they're doing to other people…it's a lot of guilt that I carry.

Furthermore, her sense of self has been impacted. Upon entering a new work environment, she found herself worried that her new colleagues would see her in the same light as those who targeted her in her previous centre. She said, “I’m constantly worrying about what other people think of me”.

P2 describes feeling anxious and on edge for a long time after experiencing HV. She finds it difficult to decipher between constructive feedback and criticism. The slightest comment about her nursing practice brings back all the feelings of being targeted at her previous centre and can even now completely derail her day. In one example she described,

> If somebody were to make some small comment…like…, why did you swaddle your baby like that, it would have sent me into being incredibly upset over something really simple…it wasn’t a big deal, but to me, it was a big deal.

Having been scrutinized for what is described as every day for 6 months at work has affected P2’s self-esteem. She says,

> “It really, really took a big toll on my self-esteem…it makes you feel like you’re not a good nurse…when you’re hearing it every single day…for six months that you’re not good at your job…your patients are at risk…it’s a really terrible, awful feeling.”

Sense of Responsibility. All three participants who experienced HV expressed a desire to model the appropriate professional and collegial behaviour in their practice to stop violence and support colleagues. P1invested in being a strong and reliable mentor to others. While she recognized the importance of teaching practical skills and knowledge, she also intertwined life lessons such as the need for compassion and empathy into the

preceptorship. Additionally, she built strong supportive relationships with those she mentored to ensure they felt supported not just throughout their preceptorship, but on an ongoing basis,

> I think it made me want to be a better mentor, it was…my philosophy on precepting not to just teach you to be independent on the unit…it's not just about information sharing…I want to teach valuable lessons. I see these bullies and I think they're great at their jobs, but I think that you can be great at your job and still be a good person.

P7 took a similar approach to P1 in that she became actively involved in mentoring and supporting junior staff on the unit. She said, "I did a lot of precepting…and informal mentoring…because I knew how I was treated and didn't want other people to go through that…I wanted other new staff to feel supported."

Vertical Violence

Six of the eight participants spoke about their experiences of VV in the NICU. Family, primarily parents, of the neonates were identified as most likely to engage in violence. This was predominantly verbal abuse, although two participants experienced physical violence and secondary violence in witnessing or hearing about assaults. There was also a component of psychological abuse described by one participant. This analysis provides descriptions of the acts of violence and the immediate and long-term impacts of the violence. Acts of violence are further broken down into the concepts of verbal, physical, and secondary experiences of violence. The impacts of violence are divided into the concepts of feeling unsafe, emotional burden, changed perception of families, and compassion toward co-existing families.

Acts of Violence

Verbal Abuse. Verbal abuse toward nurses was described as yelling, name-calling, degrading, and condescending remarks, questioning their ability, making threats, obstruction of care, and withholding information. Participants described different elements of these acts within each of their experiences.

Upon admission to the NICU and after explaining the rule of only 2 visitors at a time at the bedside, participant 8 (P8) described a father reacting by demanding to see the policy, yelling at the nurse, and demanding an administrator be called,

> I set [him] up on the phone [with the on-call administrator] …he proceeded to be on the phone for 20 to 30 minutes…the whole time he berated me. He called me down to the lowest...he told me I was an idiot, he told her I was an idiot, that I didn’t know what I was doing.

The participant reported continued harassment by the father during the 6–8-week admission. In a meeting with the participant and the administrator, he threatened a human rights violation lawsuit, that they'd rather have their baby die than be taken care of by the participant, and that if the participant touched their baby, he would physically remove her from the unit.

Participant 3 (P3) describes being yelled at by a father of twins born premature, he said, “You guys are so stupid, these babies aren’t even supposed to be here yet”. P7 experienced verbal violence from the mother of an admitted infant. This mother had her parental rights taken away and the nurse was consequently unable to provide the mother with an update on the baby’s status over the phone. The mother became verbally abusive, “[She was] cursing at me, screaming at me, telling us that we were incompetent and that

she was coming back to report us”. This same participant described an interaction with a mother who was feeding her baby. When the nurse asked how well and how much the baby fed orally, the mother “would just say he did fine, or question why I needed to know, or deliberately just not respond”. While the nurse stated that this interaction did not feel like outward verbal abuse, the withholding of information felt like a deliberate obstruction to nursing care.

Participant 4 (P4) states that she was a primary nurse to a long-term patient in the NICU whose mother was relentlessly volatile and abusive in her treatment of nurses, including herself. She recalls being spoken to condescendingly while trying to teach infant safety to the mother who said, “Just because you’re a mother you think you can tell me what to do or you know better”. The participant also described being called “stupid” and being yelled at by the mother when stress was heightened.

While caring for a baby experiencing neonatal opioid withdrawal syndrome, Participant 5 (P5) described being threatened, yelled at, and sworn at by the father of the baby. He yelled, “Don’t you dare touch my…baby. I will fucking kill you”.

Physical Abuse. Two participants described their experience with physical violence from a parent of a baby in the NICU. P3 described a physical altercation with a father who she said did not agree that his baby should be admitted to the NICU. Her story is as follows,

> I had an altercation with a male parent at bedside who didn’t agree that his baby had to stay in our unit…he became verbally aggressive …saying that I was stupid and I didn’t know what I was talking about and he was the father and he knew

> what was best…and then as I went to attend his baby because alarms were going off, he…shoved me into the desk.

P4 was exposed to physical violence from the mother to a baby in the NICU when the infant was taken into custody by Child Protection Services. She stated, “The day her baby was [taken into care], there was a confrontation at the door…of the room where she tried to leave with the baby…[she] pushed me…to get out of the room”.

Secondary Experiences of Violence. P3 and P4 also talked about being vicariously exposed to physical violence in the NICU. Years after her experience of verbal violence with one father, P3 learned that he went on to murder the mother of the infants. She said, “He ended up murdering his girlfriend two years later…I remember at that time when that came out in the news…it was very traumatic, actually”. P4 explains that the relationship between the parents of the infant to whom she was a primary nurse, was abusive, and she was exposed to domestic abuse in the patient room. She stated, “They were fighting, then pushing, screaming, grabbing, [there were] noticeable marks on bodies, with baby in the room”. The participant also witnessed the mother being physically violent toward others, “she bit a security guard’s arm, broke the skin…and had to be carried out of the room to get her away from…everybody else”. She said, “Witnessing her violence toward other people was pretty bad”.

Impacts of Violence

Feeling Unsafe. One of the most identified impacts of VV amongst the participants was a feeling of being unsafe. Participant 5 (P5) described an experience on a night shift with the father of an infant in the NICU,

> …this dad was escalated in his behaviour. He had just decided that everything was terrible…he was pacing in this open bay entryway…I could see that he had a knife on him…he's yelling, he's swearing, I'm like, I don't know what we're going to do, what if he comes after us, we've got six babies in here, his kid is over there, what are we going to do?...it was the first time at work that I was actually afraid.

P8 was exposed to persistent and outward disdain from a father in the NICU for weeks. She recalls the events of the evening when she was working and went to fill her water bottle,

> I was only just getting to the water machine when the door whips open and it was him…he came and sat at the table right directly behind me…I have my back to him and I'm filling up my water bottle and nothing happened…I could feel my heart just pounding, pounding through my chest because I'm like, is he going to attack me?...he did that to intimidate me, to sit there and watch me…I felt he took measures to deliberately intimidate me.

Not only did she feel unsafe, but she says her colleagues also worried for her safety. Executive leadership for the hospital became involved and spoke with the nurse. They disclosed that the father was seeking to determine her last name which was being withheld for her safety. Knowing this added to the participant's unease. Feelings of being unsafe impacted both her professional and personal life,

> We only lived 5 minutes from the hospital and the little shopping area where we usually do our groceries…is close to the hospital…I would have these intrusive thoughts what if…I ran into him in the parking lot somewhere. Or what if he

> finds me somewhere…for a little while I changed where I got groceries. I was afraid [to] walk into him somewhere… [At work] I had made emergency plans in my head like if I had to escape, I knew where the stairwells were that I would take…I was very on edge.

P3 describes feeling scared on a night shift when a father was present in the unit and appeared to be under the influence of drugs,

> It was a night shift and I think that was why he was so verbally aggressive with us, because when he came in the unit he [saw] three female nurses, it was obvious there was no one else around…the way he spoke was just like he was trying to intimidate us and just knowing that he wasn't in his right state of mind was very, very scary…that was the only time I ever felt unsafe and scared.

In the night shift following P3's experience of physical violence she states, "I remember the next night working with the same co-workers and…watching the camera of the door all night because we were scared that he was going to come back". In the weeks following the experience, she said, "I got my husband to drive me to work and…drop me off at the front doors…because I felt like what if he's…waiting outside?".

Emotional Burden. In speaking with the participants, it was evident that there was an emotional burden associated with the experience of VV. Participants began to question themselves, their nursing practice, and their reaction to the violence in the following days, weeks, and years to come.

P4 spoke extensively about her involvement with a family in the NICU whose baby was eventually taken into child custody due to perpetual violence between the

parents. She said she felt the baby going into care was appropriate but continued to question her role in that and if she did right by the family. In her words,

> Having their baby [taken into care] was a big deal, and was it the right thing? It took me a while to be okay with what happened in the end…I blamed myself for a good part of six months. Coming back and talking about it now, I know I didn't make that decision on my own, but there was deep hope that it wouldn't have turned out that way.

In addition to her self-doubt, P4 describes conversations within the NICU between colleagues that further contributed to her questioning her practice. She stated,

> I struggled for a while because people talked about it for a long time…with [me] sitting right there, but not part of the conversation. People that weren't a part of it, talking about it, it just kind of makes you worry, did I handle it the right way?

Eventually, P4 sought out professional counselling to help her heal after her experience.

When P5 was faced with an escalated father on a night shift who had a knife visible on his body, she and her colleague encouraged the father to do skin-to-skin care with his infant but questioned if this was the right decision at that time. She stated,

> The least bad place was to get him in the room…holding his baby…he actually felt the most calm when he was holding his baby. So even though that felt super bad and super dangerous…and terrible to do that, the one place he…was the most settled was when he was…skin-to-skin with his baby. I still don't know if that was the right thing to do but it felt like the least bad thing to do in that moment.

Participant 6 (P6) spoke of a time when a family she was caring for was felt to be verbally and emotionally abusive to nurses. She stated that they would split nurses by

comparing their nursing practices to create feelings of inadequacy and insult. The participant recalled the following story,

> Of course, it's easy to question myself…words have a bigger impact than a lot of people think…in those moments when [parents] say those things, it's still hurtful. It's hard not to take it personally and it's hard not to doubt yourself…it definitely impacts my confidence.

Changed Perception of Families. The experience of VV for some participants subsequently changed the way they perceived families in the NICU. P3 stated that experiencing violence changed her as a nurse and how she sees families. She said,

> I was always just a little bit more like my guard was up…realizing you know that things can happen…after that…if I went into a room alone…with the family…I remember wanting to stay right by the door…planning my escape, that something could happen to me. I actually felt safer in the open bay than I did when I had to go to the parent room because I knew there were other people around.

A similar sentiment was shared by P6, "[Experiencing violence] makes me kind of have doubts in general toward the…parents…I'm a bit more suspicious…there's more of a lack of trust". After her experience of violence, P8 reports having a lower tolerance for disrespectful conduct from families,

> I think it's made me a bit more apprehensive…I do think I'm a bit more jaded now…there's not really any reason that we can't expect respectful behaviour from family members. And if they refuse to do that, then we don't really have to take that…I feel like we should hold parents to a higher level of accountability.

The experience of violence for P4 ignited a greater desire to support families who she felt might be more likely to engage in violence,

> I look at it from a perspective of like, so what do I need to do in the beginning that maybe wasn't [done] for the [previous] family so that his next [family] can be more successful…It [elicits] more compassion and…wanting to help those people who have backgrounds that maybe don't set them up for…success.

Compassion Toward Co-Existing Families. Several of the participants expressed concern for the burden of violence on co-existing families in the NICU who were aware of violence directed toward nurses. P6 shared that having to navigate experiences of violence as a nurse in the NICU has implications for other families present in the unit. She said,

> …the other families, they can hear the way that…we're being spoken to…sometimes they actually apologize to us and they're like, 'I'm sorry…that you experienced this, but you know you're doing a great job', and it really shouldn't be on them to have to do that.

She further elaborated by saying that managing violence from some families is time-consuming and can ultimately compromise the care of other families,

> Sometimes having to deal with those families and deal with [violence], they take away from other [families]…so maybe you didn't have time to do a return bath and you [the nurse] had to do the bath [rather than the parents]…and then that gets pushed off to the next time…it's the small things but things that do make a difference.

P3 also identified the unfortunate impact of violence on surrounding NICU families as a concern. Regarding her experience of physical violence, she said,

> There was…another dad in the unit at the time…listening to what [the other father] was doing…he was looking behind the curtain…like, ‘do you need me to come?’…he was quite upset after…The next couple of days when I [saw him], he kept [asking], ‘You ok?’.

Although touched by the care expressed by the father, the participant felt saddened that he was exposed to that and wondered if he should have intervened noting that families should not have to feel responsible for the violence of others in the unit.

Job Satisfaction. Despite experiencing VV as a NICU nurse, some of the participants expressed their love for the role. P3 said, “I…always feel so blessed…NICU is such…a wonderful, amazing place to work and usually the families are wonderful…all the other aspects of being a nurse, you know, are more positive and…outweigh those…bad experiences”. P5 said, “There’s just something really beautiful about coming to work, looking after these babies and families”. Lastly, regardless of her prolonged exposure to VV, P4 stated, “I still have a deep purpose to help”.

Contributing Factors to Violence

The nurses articulated what they felt to be contributing factors to the occurrence of both HV and VV. There were notable differences in risk factors between the two types of violence. Contributing factors to HV included burnout, anxiety, and learned behaviour and VV included psychosocial factors, inconsistencies in care, fear, and environment.

Horizontal Violence

Burnout. A common concept was burnout secondary to retention and recruitment issues in nursing. Participants felt that staff turnover in the NICU contributed to nurse burnout which would then exacerbate HV. P2 felt there was a level of exhaustion associated with precepting new staff who would decide not to stay in the NICU only for staff to then have to precept more new hires. She said, "I think staffing is a huge issue and turnover…nurses just get tired of people constantly coming in and not staying…nurses get burnt out from constantly having to be the preceptor". Participant 1 spoke to this point as well when she said senior staff get frustrated with constantly having to precept,

> People [are] feeling very burnt out…sick of teaching…none of the senior staff want to precept anymore so you have new staff precepting new staff, and then there's gaps in knowledge…and the senior nurses feeling like they have to pick up the pieces.

Anxiety. P7 interpreted the bullying from senior staff in her NICU as secondary to the anxiety associated with being a senior nurse who relies on colleagues for collaboration,

> They were used to working with each other and were very experienced…they always had that backup…I think the anxiety of having new staff and…being the one that was in charge caused a lot of anxiety for the more experienced staff.

Learned Behaviour. P1 indicated that bullying perpetuates bullying, "you have junior staff coming in, who hear senior staff speak a certain way and then they're emulating what they're saying to fit in".

Vertical Violence

Psychosocial Factors. Participants described several psychosocial factors as commonalities among those who committed acts of VV toward nurses. Risk factors included mental illness, substance use, history of violence, child welfare involvement, low socioeconomic status, and a history of trauma. In the experience of P4, she described several psychosocial factors that she felt contributed to the occurrence of VV in the NICU, “history and background…right back to childhood…a history of domestic [violence]”. She also identified the “stress and…trauma” of having a sick child in the NICU as an important contributing factor to violence. Lastly, she shared her thoughts that having child services involved with the family can elicit violence. P5 expressed the same opinion in saying most of the violence experienced in the NICU within which she works comes from families of “the substance-exposed babies”, “kids who are being apprehended”, those who live in “poverty”, and those with a history of “trauma”, “intergenerational trauma…and mistrust of the hospital system”.

Inconsistencies in Care. P5 stated that she felt inconsistencies in care can be frustrating for families and can provoke violence at times. She gave two examples,

> You get that one nurse who is going to do it her way and that’s just it, then you get another nurse who’s like, yeah, you can cuddle your baby…it’s your baby, of course. And then this other nurse who’s like no, you’re over handling that kid…so I think that can cause problems.

Followed by, “We get babies back from other level 3 [centres]…we see a lot of the ‘well that’s not how they did it there’…so that can cause some escalations sometimes”.

Fear. Having a baby in the NICU can be upsetting to parents especially when it is not anticipated. P5 states that "fear" while in the NICU can evoke violence,

> For a lot of these families, it's not what they expect, it's not…the beautiful delivery that they thought it was going to be and they are scared and it's often…the worst day of their life and…fear often presents like anger.

P7 reiterates this by saying, "[parents] are very stressed and they're anxious…fear of the unknown…nobody wants their baby to be in NICU". P3 stated she felt a parental sense of a "loss of control" due to a NICU admission contributed to VV.

NICU Environment. NICUs are typically either an open bay style or single room care although some units are a hybrid between the two. The style of the unit is thought to impact VV by some participants. P3 felt being in an open bay NICU environment exacerbated VV,

> Because we're an open bay unit, that in itself often was stressful…I found the parents were always so much different when they got to the parent room…they felt like…the baby's doing ok.

P3 reiterated that the open bay setting in the NICU contributed to the experience of violence for nurses in that there is no reprieve. She said, "We're in the open bay concept…you're always in contact or in the vicinity of the parents, which…can increase the incidence of violence".

Responding to Violence

There was an overarching theme of responding to violence throughout the findings. Much of this data pertains to the barriers to reporting violence, the permittance of violence, and lastly, strategies to address violence.

Barriers to Reporting Violence

Healthcare Strain. P1 articulated the feeling that she could not report the HV she experienced given the potential ramifications for patients. She stated that those who targeted her were expert clinicians and she did not want to be responsible for impacting their career by reporting them for violence and consequently affecting patient care. She said,

> How do you bring those people to light when they have so much power and they're doing so much good in patient care…if you are the person responsible for the worst-case scenario, this person being let go, and then if people knew that you were responsible for that…I just find it so hard to tackle bullies within healthcare for that reason.

Relationships. Several participants spoke about a reluctance to address VV due to their understanding of the role of parent/infant attachment in neonatal outcomes. P6 said, "They're the parents of the patients and you know it's important to have that interaction with the children, and…we know of course there are so many benefits of them being there". P3 shared a similar sentiment when she said,

> Those are their parents, and we want to respect that and…support that relationship…that was the struggle and I feel… that baby needs that parent…For me to…cause something to impact that relationship that they have with them…that could have detrimental outcomes for that baby"**.**

While not specific to the parent/infant relationship, one nurse spoke about her willingness to endure violence due to her established relationship with the family. Despite the abuse, P4 felt she was able to have a positive influence,

> You just always hope you can make a difference…you've established that relationship so to cut it off would add even more failure to them…if you take that relationship away from them, it's almost as if you're just continuing to let them fail. I felt like I still needed to be there.

Futility. P1 expressed that reporting HV felt futile, and this prevented her from coming forward. She said,

> It just felt like nothing is going to change because they're still going to be there, their personalities are not going to change and now it is made even worse [if they] know you complained about them. I feel like it was just something that I couldn't tackle on my own.

Permitting the Violence

All participants who experienced VV spoke about the permittance of violence toward nurses both by them and the system in which they work.

Acceptance. A common concept was the acceptance of violence in nursing. P5 stated that nurses explain away violence and justify its occurrence which in turn permits it to continue and prohibits it from being addressed. She said,

> I think there is a lot we try and explain away and try to justify…we look after people all the time who are scared for their babies…I would be scared too…I can see why they're behaving like that…I'm justifying it, right?... It's almost this thing where you…give permission for them to treat you like that.

P6 talked about allowances for violence toward nurses. She said that reported verbal and emotional violence from families is often responded to with such statements as, "Yeah, they do that to everybody", or "That's not new". She then said, "I guess it's just basically

saying that it's ok and that there's nothing different that we can do about it…". P3 talks about accepting the violence given the nature of the NICU environment,

> I don't expect parents to always be kind…it's a very stressful time for them…I can't imagine what they're going through so I…take it like they weren't trying to be mean…it's just a situation they're in.

Similarly, P7 refers to VV as "part of the job" and acknowledges that "parents are upset sometimes and it's a vulnerable time and it's a vulnerable situation that they're in and sometimes we [nurses]…take the brunt of that".

The Role of the Manager. In speaking with the participants, it is clear there is no structured or standard approach to responding to violence toward nurses. However, participants consistently voiced expectations that nursing managers respond to and mitigate violence toward nurses. They articulated wanting to feel supported by their manager in times of distress.

P5 expressed that she is expected and at times requested to accept violence from families. She says that after having a father in the NICU threaten to kill her if she touched his baby, she was asked by the Indigenous liaison, child protection, and her manager to tolerate that behaviour. She expressed being disappointed in her manager and the lack of support she received after being threatened. She said,

> I was more upset at the reaction from people who are supposed to be there to support us…our manager's job is to advocate for us...I almost felt like the violence toward me in that situation was more from the hospital…than it was from the dad.

P5 also stated that those in leadership positions do not prioritize addressing verbal violence,

> The problem is in the NICU [there isn't] the same degree of physical violence as…on pediatric floors or the…emergency [department]…it's often…verbal…I feel like [management] just kind of justify it a little…no one's getting hurt you know…it's not great to be yelled at but it's so much worse everywhere else that they're not going to fix our problem because they're trying to fix all the other problems.

Adding further to her perspective that addressing violence is not a priority for hospital leadership, she spoke of a time when she experienced violence on a night shift. She was left feeling very vulnerable due to a lack of resources available to her and her colleagues in a time of danger. She said,

> We have no phone in here, we have no call bells that are going to do anything for us, we have no way of calling for help, we can't get protection services in here…we have duress alarms that…sometimes work and sometimes they don't…Our protection services [staff] numbers…go down at night…why are there more protection services staff on during the day than at night?

After this incident, P5 filed an incident report and informed her management team via email of the occurrence. She was then invited to meet with management to discuss the incident and to have what she thought was an opportunity to strategize to respond to violence in the NICU. She described the following,

> It went to a big review…management was involved, site leadership was involved, director of operations was involved, the leadership for protection services was

> involved, and nothing changed. They [said], 'That was really scary for you and that is terrible, and you should probably do another online module about violence in the workplace.'

P2 states the violence she experienced was known to her manager and educator when she met with them to discuss her failed preceptorship, but there was no consequence for the abuse. The manager explicitly identified that the participant was being bullied. She said, "[The manager] …dropped the token word…bullying…," however P2 said there was no follow-up with the original preceptor who bullied her and failed her on her preceptorship. Despite recognizing that she was bullied, without addressing the perpetrator the participant was left feeling unsupported. She said, "It just makes you wonder…were they more concerned about themselves…I don't know really if they…had 100% my interest at heart".

P6 also spoke about the role of management in supporting nurses who experience violence. She told a story of one family making negative comments about another family in the NICU and compared the response to that incident to the response toward nurses who are targeted with violence,

> [The family] had made comments about another family…blaming them for something, of course, that wasn't appropriate and [the family] was spoken to at that time by management…which…was the appropriate move. But it was...also disheartening to see…that's never done for nursing staff.

Offering a different perspective, P3 says her manager was supportive after her experience with physical violence. She stated,

> Our manager…came down and he was like, is everyone ok? We…told him what happened and then he [talked] to security at the hospital and [said] '…we're banning him, he's not allowed back in the building'.

Similarly, P7 states that her manager is always very supportive of the nursing staff,

> …our manager has always been really good to say…we shouldn't be putting up with…violence…if there are times we were being threatened…or that we feel unsafe then that can be reported…family members won't be allowed to stay on the unit if they're acting in a way that is abusive.

Some participants shared specifics regarding how managers could be supportive of staff exposed to violence. P5 said, "I think we need our leadership, our managers, our clinical leadership to support us and back us up and sometimes I think they need to step in and maybe have that conversation with families so that we can maintain that therapeutic relationship". P6 felt similarly. Due to the nature of the work environment, especially an open-bay style NICU, she voiced that having management address violence would be preferred. She stated,

> It's probably not a conversation that is appropriate to have in a room of six other babies if other parents are present, and you might not always have the resources or ability to step out of the room and have a private conversation…a charge nurse or a manager…can come speak to those individuals and [having] that conversation outside of the room would be helpful.

The vast amount of data collected that pertains to the manager's role in addressing violence speaks to the nurses' fervent desire to be supported by their managers.

Strategies

When asked what could be done to address workplace violence, the participants offered several solutions. P1 felt that bullying could be counteracted with a platform to celebrate each other. She suggested making it easy to treat each other with kindness with unit initiatives. P2 felt that creating transparency about existing bullying in the NICU would help prevent it from continuing. This would require nursing leadership to acknowledge what is happening in the unit, to talk about it openly, and to set the expectation that it is not acceptable or does not occur. She also stated that working toward a civil work environment needs to be a consistent priority to be fully effective.

Participants 1 and 2 both felt that there needs to be capacity building within nursing to learn how to navigate these demanding situations. P1 said, "I think capacity building with people to know when to come forward and know when to confront certain situations is a lot easier than making [bullies] change…". P3 stated that she feels nurses are not equipped with adequate knowledge or skills to respond to violence. She feels nurses would benefit from "some sort of training on de-escalating situations…specific to the area you work because depending on the area things may look significantly different." P5 echoed this recommendation when she suggested NICU nurses need more "formal training around code white specific to [the NICU]". P5 also suggested "roleplaying" VV and improving upon communication skills as strategies to help support nurses in preparing and responding to violence.

P7 felt there must be a safe and supportive way by which bullying can be reported with a guarantee that there will be no negative ramifications for the victim. She said,

"…there's always that fear…that when you report it, …you'll pay for that kind of thing by that person."

P8 stated there needs to be an improved process to respond to verbal abuse, she said, "I feel we do need to take [verbal abuse] more seriously…we need to have rules in place that don't [allow] this". P7 stated that a no-tolerance policy that could ultimately lead to a lack of access to the NICU would help alleviate VV. She stated, "I think…[VV] shouldn't be tolerated, they should lose the privilege…to continue visiting". P6 also felt that a no-tolerance policy would be helpful to mitigate violence but would have to be dutifully enforced "We…need to have a no tolerance…policy…implemented and enforced". Consistency in approach to addressing violence was identified by P3, "having a…plan in place…when someone starts to [be] aggressive" would be beneficial.

P4 felt that having unit resources available to help staff work through experiences of violence could be of benefit, "resources I would love in [the] unit would be a clinical psychologist available…to…offer support from that trauma-informed lens".

Participants also addressed what they felt were futile strategies to mitigate VV. For instance, P5 said, "I think we need to not do so many…online learning modules about violence in the workplace". P8 stated she felt posters hung in the unit deterring VV are not helpful, "we can post the picture…the posters that say violence isn't tolerated here, but what does that really mean?".

Lastly, multiple participants felt that more research on the experience of violence toward neonatal nurses is needed to raise awareness of the issue with P2 stating, "…studies like this and getting [this] information out there…might help at least one or two people sit back and reflect on the words coming out of their mouth and their

actions…and…how it can really affect people”. P5 stated that “we need more research, I think we need to talk more about our lived experiences, we need to learn from each other…we need qualitative…and quantitative work”.

The plenitude of data generated from this study reflects nurses’ desire to share their stories of violence and be heard. It also demonstrates the complexities of violence in the NICU. The following chapter will further discuss the findings of this study relative to the literature. The significance of the findings will be explored and interpreted to generate further understanding of the experiences of violence amongst neonatal nurses.

Chapter 5. Discussion

Violence toward nurses is a phenomenon that is well described in the literature, predominantly in the areas of long-term, psychiatric, and emergent care. This study focused on the experience of violence among neonatal nurses. Participants shared experiences of both HV and VV with verbal abuse being the most commonly described concept. The impacts of violence on the participants were similar amongst those who experienced the same type of violence but varied between HV and VV experiences. While the findings were generally similar to what has been described in the literature, new concepts did arise which is not surprising given the sparsity of qualitative literature on violence toward neonatal nurses. Novel concepts in this study include the role of healthcare strain and relationships as barriers to addressing violence, concern for co-existing families in the NICU and sense of responsibility. The participants clearly articulated how they were impacted by violence, and what they felt to be contributing factors to violence, identified a role for nursing management in preventing violence, and described strategies to mitigate and prevent violence in the NICU. The findings of this qualitative study contribute to an understanding of the experiences of violence for NICU nurses and highlight the need for deliberate action to prevent and address the phenomenon. The following discussion will offer an interpretation of these findings.

Novel Concepts

Four novel concepts arose from this study that offer a new perspective on violence in nursing and contribute to a greater understanding of the experience of violence amongst neonatal nurses. The first two concepts, health care strain and relationships refer to barriers to reporting violence. Concern for co-existing families is a

concept that arose from the impacts of VV, and a sense of responsibility is a concept that surfaced from the impacts of VV and HV. All four concepts demonstrate the compassion and selflessness of the participants.

Health Care Strain

One participant discussed feeling unable to report the HV projected onto her out of concern for patient care. She identified that her perpetrators were clinically competent and skilled and feared that should she seek retribution for the violence she was subjected to it could have negative repercussions for their career, such as termination, which would then impact the patient population they serve. Concern for the patients and families as a deciding factor in reporting HV reflects the participants' understanding of the existing healthcare strain and her altruistic commitment to providing excellence in care.

Relationships

Another novel concept is that of relationships which was two-fold. Some participants who experienced VV were cautious in reporting the experience because they did not want to negatively impact the parent-infant dyad. It is well understood that infants have better health outcomes with parental presence in the NICU. If, as a result of reporting, a parent was removed from the NICU the fear was that it could have detrimental effects on the infant. Similar to the concept of healthcare strain, these participants put the patients' needs above their own and chose to withstand the violence to optimize patient outcomes. This concern was in complete contrast to other participants who felt that a reasonable consequence for VV was removal from the NICU. Another participant chose to bear VV so as not to disrupt the existing relationship she had with

the mother of a NICU patient, despite her being violent. Again, this demonstrates a willingness to prioritize the needs of others before oneself as a nurse.

Concern for Co-Existing Families in the NICU

Three participants spoke about the impacts of VV on other families present in the NICU when the violence occurred. They spoke of families feeling they wanted to help the nurses and that their care suffered due to the time lost spent navigating the violence. This concept reveals a unique impact of violence in the NICU that was not discussed in the literature but would be worth further exploration. Additionally, despite their experiences of VV, these participants continued to demonstrate a very tender concern for neighbouring NICU families.

Sense of Responsibility

Four of the participants, three who experienced HV and one who experienced VV, spoke about how their experiences ignited a sense of responsibility to counter violence by way of mentorship and modelling best behaviour. The three nurses who suffered HV became preceptors and mentors to other nurses to intentionally offer support and create a warm and safe learning environment. One of the nurses who experienced VV shared this same motivation. After being a victim of physical abuse, she reflected on gaps in care for that particular family and utilized those learnings to better her nursing practice. She spoke about modelling the appropriate behaviour when caring for families to subtly influence others' nursing practice. This sense of responsibility is not a concept that was discussed in the literature.

Implications of Violence

Within this study, six of the eight nurses experienced VV from parents of infants in the NICU in the form of verbal, psychological, and physical assault. Three of the eight nurses experienced HV from within the nursing profession. The effect the violence had on the nurses was different based on the type of violence experienced. The nurses in the study who experienced VV were subtly changed professionally but were seemingly less personally affected long-term than those who experienced HV. In the immediate experiences of VV, the nurses were scared, intimidated, and felt vulnerable and unsafe. These same emotions as a consequence of VV were described in studies of psychiatric and emergency nurses (Alsharari et al., 2022; Hierbert et al., 2022; Yildiz & Yildiz, 2022). However, besides feeling more cynical and mistrusting of families, the nurses were ostensibly able to move on from the experience. Of those who experienced HV two of the nurses were impacted on a very personal level. They were targeted by senior nurses for a prolonged period. They carried their experiences with them and continued to be influenced by the violence even after they moved on from that job. The experiences affected their personal and professional confidence, caused them to worry about how others view them and impacted their ability to interpret feedback and confrontation. The violence they experienced felt very personal as the perpetrators targeted them specifically. The personal nature of the targeted HV was one of the most notable differences between those who experienced VV and HV and could be what contributed to the differences in impacts on the nurses. Being personally targeted had an isolating effect on the nurses and left them without peer support. In contrast, except for one nurse's experience, the families who exhibited VV toward nurses rarely used a targeted

approach and treated most nurses in the same way. This led to a shared experience among the nurses in their unit who could then offer each other peer support. This feeling of exclusion secondary to HV was also noted by Bry and Wigert (2022) in their study of nurses who were bullied in the NICU. Similar to the study participants, the literature demonstrates that nurses who have been victims of workplace violence report psychological harm including anxiety, depression, a lack of confidence, fear, sadness, vulnerability, somatic symptoms, social dysfunction, and poorer quality of life (Angland et al., 2014; Atan et al., 2013; Brophy et al., 2017; Campana & Hammoud, 2015; RNAO, 2008; Vidal-Alves et al., 2021). The experience of HV for these two nurses changed their lives, one could even say it changed who they were.

Another notable difference between the victims of VV and HV was their ability to accept and permit violence. Many nurses were able to rationalize and even justify the VV they experienced based on contributing factors such as parental stress, psychosocial influences, trauma, and the NICU environment. The literature reflects the ability of nurses to not only accept violence as part of their job but to empathize with the offenders (Hiebert et al., 2022). The nurses in this study demonstrated great empathy and understanding of the contributing factors to VV and thus the parents. This ability to empathize essentially helped them cope with the violence. The nurses who experienced HV did not display this same empathy toward their perpetrators. They recognized that what was happening to them was wrong. Their values, sense of self, and love for their work as a neonatal nurse fueled them onward in an environment that was not supportive of their personal or professional growth.

An interesting concept that emerged from this study is that of secondary violence whereby participants were personally impacted by some exposure to violence that did not directly involve them. Alshehry et al. (2019) discussed the concept of secondary trauma within the context of the professional quality of life and nurses who experienced HV. They described it as negative feelings resulting from fear and workplace trauma (Alshehry et al., 2019). One of the study participants who experienced HV described this phenomenon. The nurse described feeling unable to address the bullying she was experiencing which she then felt perpetuated HV toward other nurses in the NICU. In her witnessing of violence toward others, the nurse felt a tremendous burden and felt personally responsible for the continued violence. She felt the weight of the violence despite it not being directed at her. Two additional participants described the sensation of secondary violence but within the context of VV. They both either actively witnessed violence or heard about violence within families from the NICU. The participants described this type of exposure to violence as traumatizing. The experiences of secondary violence further compounded the emotional impact of violence on these nurses who were already victims of HV and VV.

Contributing Factors

Participants who experienced HV identified three main contributing factors to the violence including burnout, nurse anxiety, and learned behaviour. The participants mirrored the findings of Bry and Wigert (2022) in their articulation of the role of burnout in HV. Both the author and the participants discussed the burden of high staff turnover and the ongoing need for support and preceptorship of new staff as contributing factors to

HV. The perceived increase in workload secondary to precepting contributes to feelings of burnout. Similarly, one of the participants identified anxiety associated with having to trust and rely on new staff as a contributing factor to HV. Bry and Wigert (2022) echo this in saying that experienced staff report feeling pressured to constantly train new staff and report feeling distrustful toward them. The mistrust leads to incivility and bullying (Bry & Wigert, 2022). The literature did not explicitly discuss HV as a learned behaviour, however, Roberts (2015) explained HV within nursing as a by-product of oppression within a medically dominated and hierarchical healthcare system. Nurses turn inward with denigration as a result of feeling powerless and undervalued. This theory could explain the learned behaviour the participant spoke of.

In addition to the three main themes participants identified as contributing factors, they also noted that the expectations experienced staff held of new staff did not align with the new staff's actual knowledge and competency. This same misalignment of expectations was discussed by McKenzie et al. (2021) who conducted a study on new graduate nurses transitioning into the NICU. The nurses in the McKenzie et al. (2021) study verbalized feeling unprepared to work in the NICU and described feeling victimized due to their knowledge deficits. Two participants in the study at hand stated they felt there was a gap in their level of knowledge and experience as new nurses and the expectations of existing nurses in the NICU which led to their ill-treatment. This leads to the concept of a senior-to-junior nurse hierarchy dynamic. Senior nurses were described by participants as holding power due to their experience and knowledge. This power imbalance between senior and junior nurses was thought to contribute to HV. For

one participant, the senior nurse who acted as her preceptor failed her on her preceptorship which could have had a tremendous impact on her career at that point. That is the ultimate power to have as a senior nurse. Interestingly, despite the nursing leadership knowing the participant was wrongly failed due to HV, they failed to address the violence which brings to question the insidious power senior nurses may hold over an entire unit. The notion of senior nurses not supporting junior nurses and an existing power imbalance was present in the work of Bambi, Guazzini, De Felippis, et al. (2017), Chatziioannidis et al. (2018), and McKenzie et al., (2021). This information could be utilized to better support nurses transitioning into the NICU workplace and experienced staff being asked to mentor. Preceptors provided with expectations of what to expect of new staff's knowledge and competency may be better able to support them in their new learning environment thus contributing to a less hostile environment and diminishing the power imbalance. Understanding this power imbalance and hierarchy can also help to address HV in the NICU.

The factors that contribute to VV identified by participants in the present study were very much in line with that of the literature. Nurses described psychosocial factors, inconsistencies in care, fear, and the NICU environment as precipitating factors to VV. Many of these same factors were described as contributors to violence in the studies conducted by Brophy et al. (2017) and Pich et al., (2017). Understanding contributors to violence in the NICU is an important part of supporting nurses as victims. Of particular interest is the NICU environment as a triggering factor to violence. Some participants spoke about the stress of being admitted to the NICU environment eliciting violence from parents, while two participants spoke about the geography of the NICU as a risk

factor for VV. The comment was made regarding the open-bay style NICU. One participant felt that being in an open bay NICU exposed her to an increased amount of violence as there was no means to separate herself from the perpetrators. Another participant felt violence lessened when families could be together in a parent room. She felt the open bay style NICU contributed to their stress and subsequent violence. None of the participants who work in a single-room care NICU identified the private room as a risk factor for violence. This concept of the actual environment stimulating violence and placing nurses at risk was raised by the RNAO (2008) who stated that the geography of a unit can place nurses in vulnerable positions without access to safe spaces. Similarly, in a study performed by Angland et al. (2014), ED nurses felt the design of the ED, specifically the lack of space, caused patients and families to become violent. While many NICUs are evolving, single-room care NICUs remain relatively new as care environments. As nurses transition from working in open-bay to single-room care the differences in experiences of violence may become more evident.

The Role of Nursing Management

Participants consistently spoke about the importance of managers and healthcare leadership in mitigating and responding to violence in the NICU. Some participants felt very supported by their managers after they experienced either HV or VV, while others felt violence was essentially exacerbated by managers who refused to acknowledge the impact on nursing.

Managers are in a unique position to set the tone for the culture and expectations of a nursing unit. Communication between direct care providers and managers is necessary to establish the mutual expectations of each role when it comes to violence.

One could speculate that the hierarchy between managers and nurses could contribute to barriers to communication between the two. This could ultimately lead to managers being unaware of the needs of nurses when it comes to violence. In a study conducted by Jankelova and Joniakova (2021), it was demonstrated that effective manager communication skills such as clarity, openness, listening, feedback, empathy, non-verbal communication, and appropriateness were associated with nurse job satisfaction. Supporting managers to create an environment of open communication and develop effective communication skills could be an effective strategy for supporting nurses who experience violence.

Based on the findings here it could be of benefit to explore the perception of nursing managers' skill, ability, and obligation to navigate violence in the NICU toward nurses. A scoping review conducted by Gonzalez-Garcia et al., (2021) defined 22 core competencies of a nursing manager. Some of these competencies included communication, conflict management and resolution, change management, strategic thinking, and team building (Gonzalez-Garcia et al., 2021). However, it remains unclear as to how managers build these competencies. Inspire Nurse Leaders, a nursing consultation and coaching firm based out of the United States surveyed nurse managers in America and found that only 12% of organizations have leadership development programs, only 34% of nurse leaders received orientation, and of those, only 26% felt prepared to lead after the orientation (Inspire Nurse Leaders, 2023). A search of Canadian resources to support nursing managers points the reader to master's programs and certifications available. There is no formally recognized process describing the ongoing support of managers to maintain and build skills to support and manage staff in

the literature. One could surmise that organizational investment in developing the managerial skills necessary to mitigate and respond to violence of any type could decrease experiences of violence and enhance perceptions of nurse support.

Strategies to Mitigate and Respond to Violence

The participants in this study verbalized very specific strategies to lessen and counter both HV and VV in the NICU. This is significant in that the strategies are proposed by nurses with lived experience of violence in the NICU. Working with nurses at the point of care who are faced with HV and VV to strategize against violence in the NICU would offer a grassroots approach to responding to the phenomenon and ensure the development of strategies that are meaningful to NICU nurses.

It is noteworthy that Chaiwuth et al. (2020) found that nurses from healthcare organizations without formalized processes to report violence were four times more likely to experience violence. It would be advantageous for health centres to have articulated processes in place to address violence. The findings of this study could be used in the development of evidence-based policies to support the prevention and response to VV and HV in the NICU. This would provide role clarity in addressing violence, eliminate any uncertainty regarding how to proceed as a victim of violence, set the precedence for a zero-tolerance culture, and in turn enhance nurses' sense of being valued.

Implications of Research

Opportunities for Future Research

While conducting the literature review for this study it was evident that there is a paucity of research on the experience of violence amongst neonatal nurses. Of the 34 articles reviewed, only three were specific to the experiences of neonatal nurses. There is an opportunity for further exploration of the experiences of neonatal nurses and violence beyond this study including the overall prevalence of violence and any differences between Canada and other countries. Additionally, one could investigate the differences in violent experiences among nurses who work in an open bay NICU and nurses working in a single-room care NICU. Lastly, to further support those who experience violence, it would be beneficial to explore the perceptions of management and their role in mitigating and addressing violence in the NICU. Such a study could reveal gaps in the larger system regarding managing violence and lead to strategies to address the same.

Nursing Education

It is well established in the literature that VV and HV are a reality for all nurses. Organizations need to first acknowledge and offer transparency of the occurrence and then provide education and resources to support nurses. The nurses in this study identified that they would benefit from capacity-building efforts to help them both recognize situations that could escalate to violence and curb violence when it occurs. Nurses should be offered this education as regularly as they are provided clinical education. Providing nurses with the skills necessary to recognize and respond to violence needs to be prioritized in healthcare to support the health and well-being of the neonatal nursing community.

Limitations

It is important to acknowledge the limitations of this study. There is an absence of demographic data capturing participants' ethnicity or if they identify as a minority. In the literature nurses who identify as a minority were more likely to experience violence (Alshehry et al., 2019; Boateng & Brown, 2021; Brophy et al., 2017; Cukier & Vogel, 2021; Honarvar et al., 2019). Having this information would have added to the quality of the findings. In future research, it would be important to consider that nurses from racialized groups may experience violence differently.

The sample size of this study is eight participants. While the smaller sample size is representative of a larger group, the findings are not generalizable to all NICU nurses. Information power, whereby multiple relevant stories were generated from participants, (Malterud et al., 2016 as cited in Doyle et al., 2020) was given precedence over data saturation, thus further limiting the generalizability of the findings. Additionally, participants were recruited via a flyer that was shared via social media sites, known neonatal contacts around the country, and professional nursing networks such as the Canadian Association of Neonatal Nurses, and the International Council of Nurses. While participants represented different areas of the country, it is not possible to know how many neonatal nurses were made aware of the study and if those who participated were most impacted by the experience of violence. Further research on the experience of violence in neonatal nursing would enrich the literature and enhance the overall understanding of the phenomenon.

Lastly, another limitation of the study is that of recall bias. The length of time between an event and a recall can weaken a participant's accurate portrayal of an event

(Althubaiti, 2016). Participants of this study were required to work or have worked in the NICU within the last five years before they participated in the research. While all participants fit these criteria, some recalled stories up to 10 years ago therefore making recall bias a potential limitation of the study.

Chapter 7. Conclusion

Violence in nursing is pervasive. The literature exploring this topic has focused mainly on adult nursing more specifically in care areas such as the emergency department, and psychiatric and long-term care. Governing bodies such as the RNAO, Standing Committee on Health, CFNU, the Canadian Nurses Association and the World Health Organization have all raised the alarm on the prevalence and severity of violence in healthcare and nursing specifically and call upon those in leadership positions to address the phenomenon.

Using qualitative description, this study was designed to explore the experiences of violence amongst neonatal nurses. Findings could be grouped into experiences of HV and VV. The participants' stories were thematically organized into general concepts including the occurrences of violence, contributing factors, addressing violence, and job satisfaction. Within these themes was great detail and insight into the experiences of violence for neonatal nurses.

Nurses are suffering secondary to violence and there is no consistent manner by which to address either the violence or the suffering. Participants clearly articulated their ideas to mitigate violence in the NICU based on their firsthand experiences. The information generated from this study can be used in many ways to support nurses. Study findings can help inform processes to mitigate, report, and respond to violence in the workplace. Furthermore, this research can serve as a launching point for further studies to provide a greater understanding of the violence experienced by neonatal nurses. Nurses are in an ideal position to work with healthcare leaders toward addressing violence and in turn alleviating the associated ramifications for nurses.

This work makes a valuable contribution to qualitative research exploring the experience of violence amongst neonatal nurses as there appears to be a gap in this knowledge. Future areas of research could expand on this study to further examine experiences. Of particular interest would be the prevalence of violence amongst neonatal nurses, international comparisons of violence in the NICU, and differences in experiences in single-room or open-bay NICU and whether ethnicity played a role in the experience of violence. Another area of study could attempt to understand the perceptions of neonatal nursing managers and their role in violence.

It is of utmost importance that nurses be heard regarding their experiences. Work conducted to address violence should be done in collaboration with nurses who can eloquently speak to the experiences and the impacts of violence. Violence towards nurses needs to be addressed not just to support the profession and improve healthcare, but because nurses are human beings that deserve compassion and intentional response to their suffering.

References

Al-Qadi, M. M. (2021). Workplace violence in nursing: A concept analysis. *Journal of Occupational Health, 63*(1). https://doi.org/10.1002/1348-9585.12226

Al-Shamlan, N. A., Jayaseeli, N., Al-Shawi, M. M., & Al-Joudi, A. S. (2017). Are nurses verbally abused? A cross-sectional study of nurses at a university hospital. *Journal of Family and Community Medicine, 24*, 173-180. https://doi.org/10.4103/jfcm.JFCM_45_17

Alsharari, A. F., Abu-Snieneh. H. M., Abuadas, F. H., Elsabagh, N. E., Althobaity, A., Alshammari. F. F., Alshmemri, M. S., Aroury, A. M., Alkhadam, A. Q., & Alatawi, S. S. (2022). Workplace violence towards emergency nurses: A cross-sectional multicentre study. *Australasian Emergency Care, 25*(1), 48-54. https://doi.org/10.1016/j.auec.2021.01.004

Alshehry, S. A., Alquwez, N., Almazan, J., Namis, I. M., Morenco-Localle, R. C., & Cruz, J. P. (2019). Workplace incivility and its influence on professional quality of life among nurses from a multicultural background: A cross-sectional study. *Journal of Clinical Nursing, 28*, 2553-2564. https://doi.org/10.1111/jocn.14840

Althubaiti, A. (2016). Information bias in health research: Definition, pitfalls, and adjustment methods. *Journal of Multidisciplinary Healthcare, 4*(9), 211-217. https://doi.org/10.2147/JMDH.S104807

Angland, S., Dowling, M., & Casey, D. (2014). Nurses’ perceptions of the factors which cause violence and aggression in the emergency department: A qualitative study. *International Emergency Nursing, 22*, 134-139. https://doi.org/10.1016/j.ienj.2013.09.005

Atan, S. U., Arabaci, L. B., Sirin, A., Sirin, A., Isler, A., Donmez, S., Guler, M. U., Oflaz, U., Oflaz, U., Ozedemmir, G. Y., & Tasbast, F. Y. (2013). Violence experienced by nurses at six university hospitals in Turkey. *Journal of Psychiatric and Mental Health Nursing, 20,* 882-889. https://doi.org/10.1111/jpm.12027

Bambi, S., Guazzini, A., De Felippis, C., Lucchini, A., & Rasero, L. (2017). Preventing workplace incivility, lateral violence and bullying between nurses. A narrative literature review. *Acta Biomed for Health Professions, 88*(5), 39-47. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6357576/

Bambi, S., Guazzini, A., Piredda, M., Lucchini, A., De Marinis, M. G., & Rasero, L. (2019). Negative interactions among nurses: An explorative study on lateral violence and bullying in nursing work settings. *Journal of Nursing Management, 27*, 749-757. https://doi.org/10.1111/jonm.12738

Bernardes, M. L. G., Karino, M. E., Martins, J. T., Okubo, C. V. C., Galdino, M. J. Q., & Moreira, A. A. O. (2020). Workplace violence among nursing professionals. *Revista Brasileira de Medicina do Trabalho, 18*(3), 250-257. https://doi.org/10.47626/1679-4435-2020-531

Boateng, G. O. (2022). “Go back to your country”: Exploring nurses’ experiences of workplace conflict involving patients and patients’ family members in two Canadian cities. *Nursing Inquiry, 29*(1). https://doi.org/10.1111/nin.12444

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research, 4*, 1-8. http://doi.org/10.1177/2333393617742282

Braun, V. & Clarke. V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Brophy, J. T., Keith, M. M., & Hurley, M. (2017). Assaulted and unheard: Violence against healthcare staff. *New Solutions: A Journal of Environmental and Occupational Health Policy,* 1-26. https://doi.org/10.1177/1048291117732301

Bry, A., & Wigert, H. (2022). Organizational climate and interpersonal interactions among registered nurses in a neonatal intensive care unit: A qualitative study. *Journal of Nursing Management, 30*, 2031-2038. https://doi.org/10.1111/jonm.13650

Campana, K. L., & Hammoud, S. (2015). Incivility from patients and their families: Can organizational justice protect from burnout? *Journal of Nursing Management, 23*, 716-725. https://doi.org/10.1111/jonm.12201

Canadian Nurses Association. (2022, July 7). CNA urges Canada's premiers to take immediate action to avoid collapse of the health-care system. https://www.cna-aiic.ca/en/blogs/cn-content/2022/07/07/cna-urges-canadas-premiers-to-take-immediate-action

Casey, D., (2017). When visitors become violent: What is the ethical response? *MedSurg Nursing, 26*(2), 148-150.

Chafe, R. (2017). The value of qualitative description in health services and policy research. *Healthcare Policy, 12*(3), 12-18.

Chaiwuth, S., Chansprasit, C., Kaewthummanukul, T., Chareosanti, J., Srisuphan, W., & Stone, T. E. (2020). Prevalence and risk factors of workplace violence among

registered nurses in tertiary hospitals. *Pacific Rim International Journal of Nursing Research, 24*(4), 538-552.

Chakraborty, S., Mashreky, S. R., & Dalal, K. (2022). Violence against physicians and nurses: A systematic literature review. *Journal of Public Health, 30*(8), 1837 1855. https://doi.org/10.1007/s10389-021-01689-6

Chatziioannidis, I., Bascialla, F. G., Chatzivalsama, P., Vouzas, F., & Mitsiakos, G. (2018). Prevalence, causes, and mental health impact of workplace bullying in the neonatal intensive care unit environment. *British Medical Journal Open, 8.* https://doi.org/10.1136/bmjopen-2017-018766

Chesire, D. J., McIntosh, A., Hendrickson, S., Jones, P., & McIntosh, M. (2021). Dimensions of hospital workplace violence: Patient violence towards the healthcare team. *Journal of Clinical Nursing, 31*(11-12), 1662-1668. https://doi.org/10.1111/jocn.16021

Colorafi, K. J., & Evans, B. (2016). Qualitative descriptive methods in health science research. *Health Environments Research and Design Journal, 9*(4), 16-25. https://doi.org/10.1177/1937586715614171

Creswell, J., & Poth, C. (2018). *Qualitative inquiry & research design: Choosing among five approaches.* (4th ed.). Los Angeles: Sage Publications.

Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020). An overview of the qualitative descriptive design within nursing research. *Journal of Research in Nursing, 25*(5), 443-455. https://doi.org/10.1177/1744987119880234

Eakin, J. (2018). *Qualitative analysis and interpretation I: Theoretical background and introduction* [YouTube]. https://www.youtube.com/watch?v=hHQhzdV1UxE

Edward, K., Stephenson, J., Lui, S., Warelow, P., Giandinoto, J., Ousey, K. (2016). A systematic review and meta-analysis of factors that relate to aggression perpetrated against nurses by patients/relatives or staff. *Journal of Clinical Nursing, 25*(3-4), 289-299.

Gonzalez-Garcia, A., Pinto-Carral, A., Perez-Gonzalez, S., Marquez-Sanchez, P. (2021). Nurse managers' competencies: A scoping review. *Journal of Nursing Management, 29*(6), 1-4. https://doi.org/10.1111/jonm.13380

Goldstein, L.S. (2000). Ethical dilemmas in designing collaborative research: Lessons learned the hard way. *International Journal of Qualitative Studies in Education, 13*(5), 517-530. https://doi.org/10.1080/09518390050156431

Government of Canada. (2022, June 10). Requirements for employers to prevent harassment and violence in federally regulated workplaces. https://www.canada.ca/en/employment-social-development/programs/workplace-health-safety/harassment-violence-prevention.html

Grossoehme, D. H. (2014). Overview of qualitative research. *Journal of Health Care Chaplaincy*, *20*(3), 109–122. https://doi.org/10.1080/08854726.2014.925660

Hahn, S., Muller, M., Hantikainen, V., Kok, G., Dassen, T., & Halfens, R. J. G. (2013). Risk factors associated with patient and visitor violence in general hospitals: Results of a multiple regression analysis. *International Journal of Nursing Studies, 50*(3), 374-385. https://doi.org/10.1016/j.ijnurstu.2012.09.018

Hamblin, L. E., Essenmacher, L., Ager, J. Upfal, M., Luborsky, M., Russell, J., &

Arnetz, J. (2016). Worker-to-worker violence in hospitals: Perpetrator characteristics and common dyads. *Workplace Health and Safety, 64*(2), 51-56. http://doi.org/10.1177/2165079915608856

Havaei, F., & MacPhee, M. (2019). The impact of heavy nurse workload and patient/family complaints on workplace violence: An application of human factors framework. *Nursing Open, 7*, 731-741. https://doi.org/10.1002/nop2.444

Havaei, F., Astiva, O. L. O., & MacPhee, M. (2020). The impact of workplace violence on medical-surgical nurses' health outcome: A moderated mediation model of work environment conditions and burnout using secondary data. *International Journal of Nursing Studies, 109*. http://doi.org/10.1016/j.ijnurstu.2020.103666

Havaei, F., MacPhee, M., & Ma, A. (2020). Workplace violence among British Columbia nurses across different roles and contexts. *Healthcare, 8*(2), 98. https://doi.org/10.3390/healthcare8020098

Hiebert, B. J., Care, W. D., Udod, S. A., Waddell, C.M. (2022). Psychiatric nurses' lived experiences of workplace violence in acute care psychiatric units in Western Canada. *Issues in Mental Health Nursing, 43*, 146-153. https://doi.org/10.1080/01612840.2021.1956656

Honarvar, B., Ghazanfari, N., Shahraki, H. R., Rostami, S., & Lankarani, K. B. (2019). Violence against nurses: A neglected and health-threatening epidemic in the university affiliated public hospitals in Shiraz, Iran. *The International Journal of Occupational and Environmental Medicine, 10*. https://doi.org/10.15171/ijoem.2019.1556

Hsu, M. C., Chou, M. H., & Ouyang, W. C. (2022). Dilemmas and repercussions of

workplace violence against emergency nurses: A qualitative study. *International Journal of Environmental Research and Public Health, 19*(5), 2661. https://doi.org/10.3390/ijerph19052661

Inspire Nurse Leaders. (2023, December 31). *Call to action: Ineffective leader training and development revealed. https://inspirenurseleaders.com/wp-content/uploads/2023/12/Survey-Infographic-11.27-v2.pdf*

Jankelova, N., & Joniakova, Z. (2021). Communication skills and transformational leadership style of first-line nurse managers in relation to job satisfaction and moderators of this relationship. *Healthcare, 9*(3). https://doi.org/10.3390/healthcare9030346

Kahsay, W. G., Negarandeh, R., Nayeri, N. D., & Hasanpour, M. (2020). Sexual harassment against female nurses: A systematic review. *BioMed Central Nursing, 19*(58). https://doi.org/10.1186/s12912-020-00450-w

Kim, Y., Lee, E., & Lee, H. (2019). Association between workplace bullying and burnout, professional quality of life, and turnover intention among clinical nurses. *Public Library of Science, 14*(2). https://doi.org/10.1371/journal.pone.0226506

Kim, H., Sefcik, J. S., & Bradway, C. (2017). Characteristics of qualitative descriptive studies: A systematic review. *Research in Nursing and Health, 40*(1), 23-42. https://doi.org/10.1002/nur.21768

Lambert, V. A., & Lambert, C. E. (2012). Qualitative descriptive research: An acceptable design. *Pacific Rim International Journal of Nursing Research, 16*(4), 255-256.

Latifnejad Roudsari, R. (2019). Qualitative description: A less sophisticated approach for junior qualitative researchers. *Journal of Midwifery and Reproductive Health, 7*(4), 1856-1857. https://doi.org/10.22038/jmrh.2019.13927

Liu, J., Gan, Y., Jiang, H., Li, L., Dwyer, R., Lu, K., Yan, S., Sampson, O., Xu, H., Wang, C., Zhu, Y., Chang, Y., Yang, Y., Yang, T., Chen, Y., Song, F., & Lu, Z. (2019). Prevalence of workplace violence against healthcare workers: A systematic review and meta-analysis. *Occupational and Environmental Medicine, 76*(12), 927-937. https://doi.org/10.1136/oemed-2019-105849

Lanctot, N., & Guay, S. (2014). The aftermath of workplace violence among healthcare workers: A systematic literature review of the consequences. *Aggression and Violent Behavior, 19*(5), 492-501. https://doi.org/10.1016/j.avb.2014.07.010

Magilvy, J. K., & Thomas, E. (2009). A first qualitative project: Qualitative description Design for novice researchers. *Journal for Specialists in Pediatric Nursing, 14*(4), 298-300. https://doi.org/10.1111/j.1744-6155.2009.00212.x

McKenzie, R., Miller, S., Cope, V., & Brand, G. (2021). Transition experiences of newly qualified registered graduate nurses employed in a Neonatal Intensive Care Unit. *Intensive & Critical Care Nursing, 67*. https://doi.org/10.1016/j.iccn.2021.103112

Mento, C., Silvestri, M. C., Bruno, A., Muscatello, M. R. A., Cedro, C., Pandolfo, G., & Zoccali, R. A. (2020). Workplace violence against healthcare professionals: A systematic review. *Aggression and Violent Behavior, 51*. https://doi.org/10.1016/j.avb.2020.101381

Milne, J., & Oberle, K. (2005). Enhancing rigor in qualitative description. *Journal of Wound Ostomy and Continence Nursing, 32*(6), 413 -420.

https://doi.org/10.1097/00152192-200511000-00014

Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description – The poor cousin of health research? *BioMed Central Medical Research Methodology, 9*(52). https://doi.org/10.1186/1471-2288-9-52

Nowrouzi-Kai, B., Isidro, R., Chai, E., Usuba, K., & Chen, A. (2019). Antecedent factors in different types of workplace violence against nurses: A systematic review. *Aggression and Violent Behavior, 44*, 1-7. https://doi.org/10.1016/j.avb.2018.11.002

Orb, A., Eisenhauer, L., & Wynaden, D. (2001). Ethics in qualitative research. *Journal of Nursing Scholarship, 33*(1), 93-96. https://doi.org/10.1111/j.1547-5069.2001.00093.x

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research, 42*(5), 533-344. https://doi.org/10.1007/s10488-013-0528-y

Pich, J., Kable, A., & Hazelton, M. (2017). Antecedents and precipitants of patient-related violence in the emergency department: Results from the Australian VENT study (violence in emergency nursing and triage). *Australasian Emergency Nursing Journal*. https://doi.org/10.1016/j.aenj.2017.05.005

Pich, J., & Roche, M. (2020). Violence on the Job: The experiences of nurses and midwives with violence from patients and their friends and relatives. *Healthcare, 8*. https://doi.org/10.3390/healthcare8040522

Registered Nurses' Association of Ontario. (2008, September 1). Violence against nurses: Zero tolerance for violence against nurses and nursing students. https://rnao.ca/policy/position-statements/violence-against-nurses

Reichert, C. (2017, June). Enough is enough: Putting a stop to violence in the healthcare sector. The Canadian Federation of Nurses Unions (CFNU). https://nursesunions.ca/wp-content/uploads/2017/05/CFNU_Enough-is-Enough_June1_FINALlow.pdf

Roberts, S. J., (2015). Lateral violence in nursing: A review of the past three decades. *Nursing Science Quarterly, 28*(1), 36-41. https://doi.org/10.1177/0894318414558614

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health, 23*, 334-340. http://doi.org/10.1002/1098-240x(200008)23:4<334::aid-nur9>3.0.co;2-g

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health, 33*, 77-84. https://doi.org/10.1002/nur.20362

Sanjari, M., Bahramnezhad, F., Fomani, F. K., Shoghi, M., & Cheraghi, A. (2014). Ethical challenges of researchers in qualitative studies: The necessity to develop specific guidelines. *Journal of Medical Ethics and History of Medicine, 7*(14).

Standing Committee on Health. (2019). House of Commons. Violence facing health care workers in Canada: Report of the Standing Committee on Health. https://www.ourcommons.ca/Content/Committee/421/HESA/Reports/RP10589455/hesarp29/hesarp29-e.pdf

Sullivan-Bolyai, S. L., & Bova, C. A. (2021). Qualitative description: A "how to" guide. University of Massachusetts Medical School Publications. http://doi.org/10.13028/8vwe-xc61

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences, 15*, 398-405. https://doi.org/10.1111/nhs.12048

Van Den Bos, J., Creten, N., Davenport, S., & Roberts, M. (2017, July 26). Cost of community violence to hospitals and health systems: Report for the American Hospital Association. https://www.aha.org/system/files/2018-01/community-violence-report.pdf

Vidal-Alves, M. J., Pina, D., Puente-Lopez, E., Luna-Maldonado, A., Ruiz-Cabello, A. L., Magalhaes, T., Pina-Lopez, Y. P., Ruiz-Hernandez, J. A., & Jarreta, B. M. (2021). Tough love lessons: Lateral violence among hospital nurses. *International Journal of Environmental Research and Public Health, 18*(17). https://doi.org/10.3390/ijerph18179183

World Health Organization. (2022). Violence and harassment. https://www.who.int/tools/occupational-hazards-in-health-sector/violence-harassment

Yildiz, I. & Yildiz, F. T. (2022). Pediatric emergency nurses' workplace violence experiences: A qualitative study. *International Emergency Nursing, 62*. http://doi.org/10.1016/j.ienj.2022.101160

Appendix A: Recruitment Poster

HAVE YOU EXPERIENCED VIOLENCE AS A NEONATAL NURSE?

We know nurses are experiencing more and more violence on the job. However, we don't know how neonatal nurses experience violence.

We are looking for nurses who work in a NICU, or who did work in a NICU within the last 5 years to be a part of a research study that explores the experience of violence amongst neonatal nurses.

Are you a neonatal nurse who would be willing to share your story of violence? In doing so you would have the opportunity to contribute to new information that could improve the quality of work life of neonatal nurses.

Gail MacRae Sly is a Master of Nursing student at Athabasca University. If you are interested in participating in this study, contact Gail at gmacraesly1@learn.athabascau.ca or via phone or text at
902-233-5829

Eligible participants will receive a $20 gift card to Tim Horton's

Appendix B: Introductory Script

We are here today because you have consented to participate in a qualitative research study exploring the experience of violence amongst neonatal nurses. I thank you for being here. I would like to provide you with a brief overview of what you can expect throughout this interview.

I will be asking you five quick questions about yourself; this will be followed by six open-ended questions about your violent experience. The entire interview should take no longer than 60 minutes. The interview will be recorded within Microsoft Teams and stored on a password-protected computer.

Being involved in this study allows you to contribute to new information about violence in neonatal nursing. However, sharing stories of violent experiences can be a very vulnerable experience that could lead to emotional turmoil. If you haven't already done so using the support person table provided to you, I would like to encourage you to identify your personal and professional supports whom you could reach out to if you're feeling distressed after the interview. I will also provide you with a list of provincial mental health supports available to you after our interview.

Your participation is entirely voluntary, should you require a break from the interview, or you decide you no longer want to participate, you will be accommodated without penalty. You will be compensated for your time in the form of a $20 Tim Horton's gift card after you review the data and interpretation. The gift card will be sent to you via email.

The process to maintain your confidentiality has been described in the informed consent process, do you have any questions about this before we start? Do you have any questions about the informed consent or the study before we proceed?

The contact information for myself and my supervisors can be found on your copy of the informed consent. You are welcome to contact us at any time with questions or concerns.

Do you consent to the recording of this interview?

Appendix C: Interview Guide

Nurse demographic questions:

- What is your age?
- What region of Canada do you live and work in? Example: Atlantic, Central, Prairies, West Coast, Northern Territories
- Do you identify with a specific gender, if so, with what gender do you identify? (optional)
- How long have you been or were you a neonatal nurse?
- Do you or did you work in an open bay unit or single room care unit?

Interview questions:

- How do you define violence towards nurses?
- Can you share with me a time you experienced violence at work?
- What factors do you think might have contributed to the incidence of violence?
- What did you do after the incident?
- How did this experience impact you as a nurse?
- What do you think should be done to address workplace violence?

Appendix D: Consent Form

Information, Authorization, and Consent Form

Research Title: The experience of violence amongst neonatal nurses

Researchers:

Lead investigator:
Gail MacRae Sly BScN RN, MN student Athabasca University
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Introduction:
You are being invited to participate in a research study exploring the experience of violence amongst neonatal nurses. The study is being conducted by Gail MacRae Sly, an MN student at Athabasca University and a fellow neonatal nurse for the last 19 years.

This form provides information about the study. Before consenting to participate, you must understand the goals of the research and any risks and benefits associated with participation. You are not obligated to participate in this study, taking part is your choice. You may choose to participate in the study, or you may decide not to. If you choose to take part, there are some limitations regarding your ability to withdraw. I will be asking you to review the data I have collected from you. To do this I will provide you with a transcribed version of our conversation. Once you confirm that I have captured what you have said correctly, you will have two weeks from that day to withdraw from the study should you wish. Declining to participate in the study or withdrawing part way through the study will not have any negative impact on you.

Why is this study happening?
Violence in healthcare, especially in nursing, is increasing. Nurses who experience violence at work can experience anxiety, depression, post-traumatic stress disorder, and a desire to leave their work or the profession. There is a lot of information available on this important topic. However, there is not a lot of information about violence towards

neonatal nurses. To adequately support neonatal nurses and to improve the quality of their work life, it is important to understand how they experience violence in the workplace. For this study, neonatal nurses are being asked to share their stories of violence at work.

This study is being conducted as a thesis in partial fulfillment of the requirements for the degree of Master of Nursing at Athabasca University.

How will the study be done?
If you agree to participate in the study, we will mutually agree upon a time to meet to discuss your experience. There are specific questions you will be asked, but you can also add as much detail as you want. We will meet virtually using Microsoft Teams, this meeting will be recorded to ensure the information you share is captured accurately. Microsoft Teams stores information from meetings in "data centres", usually in the location closest to the end users of the application, which in this case in Canada. Alternatively, when a local data centre cannot be used, the data or recording gets stored in the United States data centre. This means that the recording of our interview could be accessible in the United States under the Patriot Act for the time it remains on the Microsoft Teams server. An expiry date will be manually set for 2 weeks after our recorded meeting to ensure it is deleted by Microsoft Teams. Once the expiry date is reached, Microsoft Teams deletes the content within 30 days. Additionally, the Microsoft Teams account to be used is provided by Athabasca University, and accessible to the lead investigator via username and password. The Microsoft Teams account will be accessed through a password-protected computer. The recorded interview will be reviewed and "transcribed" or written out to capture everything you have said. The transcription will also be stored on a password-protected file and computer. The information you share will be used to identify themes in the experience of violence amongst neonatal nurses and to create a narrative describing this concept. You will have a chance to review the themes and the narrative to make sure your story is accurately understood.

What is being asked of you?
If you choose to be a part of this study, you will be asked to sign the consent form, take a picture of your signed consent form, and email it to the lead investigator, Gail MacRae Sly at gmacraesly1@learn.athabascau.ca. This will require up to 20 minutes of your time. To conduct the research, you will be asked to participate in an interview using Microsoft Teams. You will need to have access to Microsoft Teams to participate, you can do this using an app or your web browser. Together, we will agree upon a time to meet. You will be asked a series of questions about your experience of violence as a neonatal nurse. This will take about 60 minutes of your time. As stated, our conversation will be recorded and transcribed and the information you share grouped into themes. You will be asked to review the study findings, this is called member checking, to ensure the information you shared is accurately captured and reflects what you wanted to share. This is projected to take another 60 minutes of your time. Prior to our meeting, you will be asked to identify your existing support systems to lean on in case you need to debrief or reflect after your participation. You will be provided with a document that will assist you in identifying these supports and will be asked to bring that document to your interview. This is

optional and to be completed at your discretion and is expected to take about 20 minutes of your time. Your support systems do not need to be shared with the researcher.

What are the benefits and risks of the study?

Benefits:

If you choose to be included in this study, you will have the opportunity to contribute to new information about violence in neonatal nursing. This information can be used to create positive change for nurses in the neonatal environment such as implementation of psychosocial supports, policy, and guidelines around violence in the workplace. Additionally, you will give a voice to neonatal nurses and contribute to new nursing knowledge.

As a token of appreciation for your participation, you will be provided with a $20 gift card to Tim Hortons once you review the data and data interpretations (member checking).

Risks:

Sharing stories of violence can be a very vulnerable experience and could potentially re-traumatize study participants. It is important that your support systems be identified before participation in the interview, that way you will have a quick reference list of supports to access should you need that. You should identify both professional and personal support systems available to you. You may choose to notify those you have identified as personal supports that you are participating in this study and may need to call on them afterwards. Additionally, you will be provided with a list of provincial mental health supports available to you for your ease of access should you require that support post-interview.

What alternatives to participation do I have?

You may decide not to participate in this study, or you may choose to withdraw from the study after you agree to participate. There will be no negative impacts for you should you choose to decline or withdraw.

Please note, that withdrawal from the study can only be accommodated up to two weeks after you confirm your data transcription.

What happens if I withdraw from the study?

If you choose to withdraw from the study, simply inform the researcher within the described deadline. Your interview data, recordings, and transcriptions will be destroyed. Again, there are no negative outcomes associated with withdrawing from the study.

Will the study cost me anything?

There is no cost to participating in this study.

Are there any conflicts of interest?

The researcher has no conflicts of interest to disclose.

Will I be informed of the study results?

The final thesis can be shared with you once available. Please indicate below following your signature if you wish to have a copy of the thesis.

How is the information I provide being used?
The information you provide during our interview will be used solely for research purposes. Your story will not be used directly to provide feedback or elicit change in your work environment.

How will my privacy be protected?
The recorded interview will be stored on a password-protected computer within a password-protected Microsoft Teams account thereby eliminating others from accessing the recording. The recorded interview will automatically be deleted from Microsoft Teams two weeks after the interview occurs. The transcribed data will be stored on the same password-protected computer within a password-protected file. Your name will not be stored with the data. Participants will be identified by number, for example, Participant 1. Additionally, some of the narrative that is created from the interviews will be reflective of all research participants, information will be grouped together when possible. However, direct quotes from participants will be used. Should any data be printed, it will be printed on a private printer and stored in a locked drawer to which the key is held by the lead investigator of the study. Data will be kept for 5 years after completion of the thesis and security maintained for the duration of that time. After 5 years all data will be destroyed by the principal investigator.

Confidentiality of participants would need to be breached if information was shared with the researcher that indicated the participant was at risk of harm or at risk of harming others.

Who should I contact with any questions?
As a research participant, you can contact the lead investigator, Gail MacRae Sly, or the supervisory committee with questions. Our contact information can be located at the top of this consent form for your convenience.

Participant 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 destroyed.

- You understand that your ability to withdraw from the study is limited to two weeks post-data transcription confirmation.

	YES	NO
I agree to be video recorded	◯	◯
I agree to the use of direct quotations	◯	◯
I allow data collected from me to be archived for 5 years on the password protected computer of the lead investigator	◯	◯
I am willing to be contacted following the interview to verify that my comments are accurately reflected in the transcript.	◯	◯
I wish to have access to the thesis upon completion	◯	◯

Your signature confirms:

- You have read what this research project is about and understood the risks and benefits. You have had time to think about participating in the project and had the opportunity to ask questions and have those questions answered to your satisfaction.
- You understand that participating in the project is entirely voluntary and that you may end your participation at any time without any penalty or negative consequences.
- You have been given a copy of this Informed Consent form for your records; and
- You agree to participate in this research project.

_______________________________ _______________________________

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, and any potential risks and that he or she has freely chosen to participate.

_______________________________ _______________________________

Signature of Principal Investigator Date

This project has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns about your treatment as a participant, the research, or ethical review processes, please contact the Research Ethics Officer by e-mail at rebsec@athabascau.ca or by telephone at 780.213.2033.

Appendix E: Athabasca University Ethical Approval

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.: **25132**

Principal Investigator:
Mrs. Gail MacRae Sly, Graduate Student
Faculty of Health Disciplines\Master of Nursing-Generalist Program

Supervisor/Project Team:
Dr. Lorraine Thirsk (Co-Supervisor)
Prof. Debbie Fraser (Co-Supervisor)

Project Title:
The Experience of Violence Amongst Neonatal Nurses

Effective Date: February 16, 2023 **Expiry Date**: February 15, 2024

Restrictions:

Any modification/amendment to the approved research must be submitted to the AUREB for approval prior to proceeding.

Any adverse event or incidental findings must be reported to the AUREB as soon as possible, for review.

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.

An Ethics 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: February 17, 2023**

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

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Athabasca University Research Ethics Board
University Research Services Office
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E-mail rebsec@athabascau.ca
Telephone: 780.213.2033