ORGANIZATIONAL LEADERSHIP AND THE FRONTLINE NURSE; STRATEGIES TO PROVIDE QUALITY, RESPECTFUL CARE TO VERBALLY ABUSIVE CLIENTS

By

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LEADERSHIP

We accept this thesis as conforming

to the required standard

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ABSTRACT

Verbal abuse against nurses is a wide spread problem in Canada and around the world. Unfortunately, an increased awareness of the problem has done little to bring forth effective solutions. This action research project engaged Carewest managers and frontline nurses in a discussion about organizational and individual empowerment around the issue of verbally abusive clients. This research project utilized appreciative inquiry methodology, a blended focus group/learning circle inquiry process and an extensive literature review to obtain data. The data indicated that emotional intelligence, trust, and relationships, the ability to collaborate with leaders and colleagues, and the availability of education were important in empowering staff to provide care to verbally abusive clients. The recommendations from these findings include, but are not limited to, the creation of opportunities to dialogue such as a world café, the development of a community of practice, and the availability of educational opportunities for staff.

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If you have built castles in the air, your work need not be lost;
that is where they should be.
Now put foundations under them.
(Henry David Thoreau, as cited in BrainyQuote, 2009, ¶ 1)

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CHAPTER ONE: FOCUS AND FRAMING

Introduction

This research project's focus is to build organizational and nursing competencies and resilience around the issue of verbal abuse in a healthcare workplace. Enhancing an organization's ability to navigate safely through verbal abuse will impact their workplace culture in a positive way. Investing time and energy into the creation of a positive work environment impacts the quality of care provided to clients. It also impacts employee satisfaction, staff retention, and saves thousands of dollars in overtime and staff turnover costs. In order for any organization within the healthcare industry to seriously address its workplace culture, verbal abuse against nurses must be addressed.

Zero tolerance to abuse is a commonly used strategy by healthcare facilities. The framework of zero tolerance to abuse is inherently negative and often outlines potentially negative consequences for clients who engage in inappropriate behaviours and language. Sanctions against verbally abusive clientele of healthcare are often not enforceable by leadership for a variety of reasons, which include medical, ethical, systems, or political consequences (Curwin & Mendler, 1999; McEvilly, 2007).

An area of interest this research project explored is the potential consequences for perpetrators of verbal abuse. It is very difficult to sanction clients who are verbally abusive. Nurses are bound by their ethical code and standards to provide care that is in the best interest of their clients. This situation often forces them to walk into the line of fire when it comes to verbal abuse. Davies (2006) wrote, "Zero tolerance for abuse does not mean that health-care providers have the right to refuse to provide care" (p. 8).

I have been interested in positive leadership and successful management of verbal abuse and its impact on organizational culture for many years. My experiences within the healthcare system early in my career drove me away from the industry. I found the workplace culture to be negative, stressful, and saturated with verbally abusive and unhappy people. My career expanded into the areas of providing care to youth with severe behavioural and emotional issues and interacting with individuals that had severe mental illness. As a result of my experiences in these areas I was trained and mentored on how to deal in a positive way in these highly charged emotional interactions. As a result of the accumulation of these experiences, I recognized the need and relevance of examining the issue of providing care to verbally abusive clients within a healthcare setting through a positive framework.

My research question was: What strategies do the leadership of healthcare organizations and frontline nurses need to empower themselves when confronted with verbally abusive clients? Subquestions include:

1. How do Carewest Leadership and other healthcare organizations empower themselves and their nurses to provide quality, respectful care to verbally abusive clients?
2. What philosophies, beliefs, attitudes, and societal trends empower (or could empower) Carewest, other healthcare organizations, and nurses to provide quality care to verbally abusive clients?
3. What empowers frontline nurses to be resilient and at peace when providing care to verbally abusive client

The Opportunity and its Significance

A critical issue in the healthcare arena that is often overlooked is the deliberate and intentional creation of a positive healthcare culture. Healthcare is a stress-filled, unpredictable, and complex industry. The stress and fear brought on by acute illness, unexpected injury, and trauma of dealing with the pain and frustration of chronic illness seldom brings out the best in clients or their families. Chronic financial and human resource deficits in the healthcare industry are exhausting frontline nurses as they struggle to provide quality care, while simultaneously being squeezed by a dysfunctional and failing healthcare system. Decisions that directly impact frontline services are being made in rooms far removed from the reality of the care unit. Nurses are the most visible and frequent point of contact with clients and families trying to access and receive services. Healthcare providers and clients often feel they have little control over the services they provide and receive respectively (Dion, 2006; Glouberman & Zimmerman, 2002; Robson, 2001).

Healthcare also has a diverse multicultural workforce and client base to navigate, each with their own set of beliefs, assumptions, values, customs, and cultures. There are many issues that are outside the direct control of organizational chief executive officers, leaders, and staff. This project contributes to the creation of a positive workplace culture for nurses through the examination of competencies in dealing with verbal abuse and emotional supports that will enhance a nurse's resilience.

This project focused on a very important leverage point: verbal abuse. By focusing on building competency and resilience around the very serious issue of verbal abuse, the findings of this project can significantly impact a nurse's workplace culture in

a positive way. Ideas, beliefs, and values are real forces or fields of energy. It is within this field-rich space between individuals that connections are made, ideas are generated, solutions to problems are found, and quality programs are created. This research project explored nurses' understandings of and experiences with Carewest's values and beliefs about verbal abuse against nurses. It allowed managers and nurses the opportunity to share their successful experiences in coping with and managing verbal abuse in a healthcare setting.

The last 25 years have taken me through a wealth of learning opportunities in dealing with volatile and emotionally charged interpersonal situations that include verbal abuse. I have always wanted an opportunity to share this knowledge and enter into structured dialogue with other nurses in the healthcare industry. In 1999, I created a well-received workshop entitled Bedside Manners 101: Because the Life You Save Could be Your Own. It includes very simple, concrete strategies to verbally de-escalate clients when they are becoming agitated, annoyed, or angry. These strategies are concrete, simple, teachable, and relevant for frontline workers, frontline managers, directors, and chief executive officers. These skills can be utilized in any verbal interaction from the most benign to the most volatile.

The reality and severity of the healthcare shortage in Alberta and across Canada cannot be understated. There is a direct link between verbal abuse and nurses' intent to leave the profession (Sofield & Salmond, 2003, p. 276). There are daily headlines about healthcare concerns due to staff shortages. Sankey (2008) stated, "With a global shortage of nurses, the Registered Nurse graduate is in urgent demand" (¶ 2). My employer,

Carewest, is feeling the impact of this reality and is engaged in a number of corporate strategies to try and address the issue.

Carewest has proven itself to be a diverse, innovative, financially responsible, and nimble healthcare company. It is full of attractive career options, challenges, and learning opportunities for seasoned as well as new healthcare staff. The ability to recruit and retain high-quality skilled staff now and over the coming years has become a primary Carewest focus. Carewest has set up workforce planning committees at a corporate level and at every Carewest site, which include the Director of Human Resources and frontline staff. These committees address and discuss recruitment and retention issues. Carewest has identified nursing shortages as a serious corporate threat and is looking for solutions. At Carewest's Employee and Management Advisory Committee, nurses have recently identified the management of acts of aggression, and training to deal with it, to be a primary concern for their discipline. A clearly defined framework and strategy for addressing the issue of verbal abuse may positively impact nurses' workplace culture.

Nurses' satisfaction with their workplace is seriously impacted by the recorded incidence of verbal abuse and violence. Many organizations have implemented zero tolerance to violence and abuse campaigns, but the problem remains wide spread. According to Whitehorn and Nowlan (1997) "between 65% and 82% of nursing staff have experienced verbal abuse" (p. 28). Shields and Wilkins (2006) put forward, "Emotional abuse at work is widespread with nursing staff experiencing this form of ill treatment most often from patients (44%), followed by visitors (16%), nurse co-workers (12%), and Physicians (8%)" (p. 38). There is a significant amount of literature indicating the need for policies and frameworks to be implemented around the issues of violence

and verbal abuse in healthcare (Clements, DeRanieri, Clark, Manno, & Kuhn, 2005; Oztunc, 2006). This research advances academic knowledge and dialogue in the area of effectively managing verbally abusive clients in a healthcare setting and may enhance nurses' resilience in dealing with verbal abuse. This knowledge can then be implemented in the development of new policies, frameworks, and initiatives.

This project will solidify Carewest's commitment to the creation of a positive organizational culture by examining what competencies and organizational supports empower nurses' resilience in dealing with verbal abuse and impact nurses' workplace culture in a positive way. The positive and optimistic nature of the appreciative inquiry process fit in very nicely with Carewest's philosophy about how to act and interact with one another. As an example of this, instead of "Zero Tolerance to Abuse" posters, Carewest has "Respect" posters. Corporate policies include a safe and respectful workplace as opposed to a policy on verbal abuse.

Carewest (2008) has also created a communication handbook called *Positive Talk* for frontline staff, which outlines specific positive responses to common concerns and issues that clients have. Appreciative inquiry methodology has been woven through the entire research project from participant recruitment, question formulation, structured dialogue, to lessons learned. This project can help Carewest move towards the positive culture it desires and achieve a competitive advantage in staff recruitment and retention.

This research project provided a forum for discussion and transparency to a serious issue that continues to erode healthcare and the nurses who work within it. Nurses are highly trained to stabilize medical conditions of their clients, but they are often ill equipped to deal with a client or family member who is angry, uses profane language,

and is rude. It should come as no surprise that according to St-Pierre and Holmes (2008) "workplace violence can contribute to stress, depression and workplace injuries, which may lead to absenteeism" (p. 353). This project focused on finding concrete solutions and strategies around the issue of verbal abuse against nurses in the workplace. If the opportunity presented by this research project is not pursued, Carewest would not be acknowledging an important stressor in a nurse's day. Nurses will continue to experience the negative impact of verbal abuse and its resulting impact on costs, workplace culture, and quality of care.

Systems Analysis of the Opportunity

A perfect storm is the metaphor I have chosen to explain and examine the healthcare system. The perfect storm, as defined by the *Merriam-Webster Online Dictionary,* is a critical or disastrous situation created by a powerful concurrence of factors ("Perfect Storm," 2009, ¶ 1). Healthcare industry workers and leaders are already beginning to feel the tensions of an impending storm. For the Canadian healthcare system, the concurrent factors are: an economically unsustainable healthcare delivery system, an aging baby boomer population, a workforce labour shortage, and underpinned with an increasingly uncivil society (Dion, 2006; Robson, 2001; Sankey, 2008). These factors have already begun to converge and create the perfect storm for healthcare workers attempting to deliver quality frontline care. The largest segment of healthcare workers is nurses.

A perfect storm can be averted by changing any one of the factors contributing to it. Given the factors represented, we must prepare now to weather this storm. We know it is coming. The fact is: In the Calgary Health Region, it has already arrived. After a brief

analysis of the larger systemic factors, this project focused on the needs of the ones steering the ship: the frontline managers and, most importantly, the crew on the deck (i.e., frontline nurses), getting tossed around by the waves of staff shortages, intense emotions, over reactions, and their client's or family's high expectations. How can healthcare organizations, Carewest specifically, cushion the blow and minimize the damage? How might emotional support, inter-personal skills, and self-protection strategies assist nurses to weather the storm and serve as a recruitment and retention strategy?

A systems analysis takes a bird's eye view of any problem or issue that needs to be solved. It sets out to help us understand that we are all interconnected, and a shift in any one area of a system creates a change for better or for worse in another. Senge et al. (as cited in Harrigan, 2000) described systems thinking as:

> Systems thinking is a way of thinking about, and a language for describing and understanding, the forces and interrelationships that shape the behavior of systems. This discipline helps us see how to change systems more effectively, and to act more in tune with the larger processes of the natural and economic world. (p. 51)

The systems under examination, as they pertain to healthcare, are: economic considerations, population trends, labour, and societal norms.

There is currently a heated scholarly debate as to whether or not Canada's healthcare system truly is unsustainable. Glouberman and Zimmerman (2002) noted, "A renewed sense that the healthcare system is out of control buttressed by terrifying economic projections in a period of recession has once again led to questions of economic sustainability" (p. 5). In its *Myth Busters* series, December 2007, the Canadian Health Services Research Foundation asserted that the assumption that "Canada's system of healthcare financing is unsustainable" (¶ 1) is a myth. They further stated, "An

analysis of estimated expenditures over time can be misleading when the figures are not adjusted for population growth, inflation and aging" (¶ 6). Frank, McIntyre, and O'Sullivan (2003) wrote, "Canadian healthcare costs could accelerate from 56 billion in 2000 to over 100 billion by the year 2010 and will be unsustainable without significant increases in transfer payments from the federal government" (p. 34). The belief that healthcare in its current form is unsustainable has resulted in dramatic changes to healthcare delivery infrastructures. This causes frustration and confusion, not only for individuals working within the healthcare industry, but also for the general public trying to access it. Client anger about a systems issue is often directed at the person with the most contact with the client: the nurse. Nurses need to find ways to empower themselves and become increasingly nimble and resilient now and in the future.

The concerns regarding Alberta's healthcare costs and sustainability resulted in cutbacks and hospital implosions under the former leadership of Premier Ralph Klein. Working in a climate of upheaval and change is not new to nurses and leaders working the frontline. They have been feeling the effects of healthcare reform for the past 10 years. Mr. Klein has been replaced by Ed Stelmach, but healthcare is very much in the news and on everyone's mind. Change and uncertainty are part of a nurse's day-to-day reality; from all indications, this is not likely to change anytime soon. In response to grave economic predictions, many provinces, including Alberta, engaged in numerous restructuring initiatives and financial cutbacks. In an effort to stabilize healthcare, it has become more unstable. Smith (2008) put forward, "Regardless of what the critics say, Liepert [Alberta's Minister of Health], is talking the right talk. Business as usual has not

worked. All that has resulted is escalating budgets, lengthening waiting lists, acute staff shortages and misallocation of resources" (p. A10).

The same or very similar strategies used by Klein are being resurrected today as potential solutions. Under Minister of Health Ron Liepert, the province is once again engaging in a massive organizational restructuring. The Regional Health Authorities are being dismantled and amalgamated into what is being referred to as one large super board. There is a high probability that this initiative will create more instability for healthcare organizations and frontline nurses. According to Glouberman and Zimmerman (2002), "The press to increased efficiency of the system resulted only in economies that were passed from one sector to another—savings in hospitals shifted the burden of cost or care to other providers and consumers of healthcare" (p. 6). Underlying causes of the difficulties in healthcare are difficult to define and even more complex to resolve. This stark reality is that a frontline nurse's workload and stress level is not likely to ease up or become more tenable in the foreseeable future.

In today's healthcare climate, nurses need a high level of interpersonal competencies in dealing with stressed people, as well as emotional support from their workplace. Hospitals are already feeling the pressure of too many people and not enough hospital beds to care for them. In Calgary hospitals on any given day, nurses are looking after clients in the hallways and single rooms need to be doubled up. Jack Davis (2008), past chief executive officer (CEO) of the Calgary Health Region, began addressing issues of capacity over 2 years ago at a public board meeting. In that meeting he stated, "When we talk about the costs of healthcare and the pressure in the system, it's not that things

are being mismanaged or they're not efficient but that there is extraordinary growth and demand for health services" (¶ 7).

According to the College and Association of Registered Nurses of Alberta (2003) *Nursing Practice Standards*, a nurse must provide quality patient care at all times. They must access information for areas in which they are lacking knowledge and engage in sound decision-making. If a nurse does not have the skills required to deal with a verbally abusive or aggressive client, they must seek advice and training from the clinical nurse educator or the unit manager. Unfortunately, healthcare managers and educators are often ill equipped to deal with verbally abusive and aggressive clients or family members. Although sympathetic, they lack concrete strategies to minimize the incidence of verbal abuse towards their nurses or prevent it from occurring in the first place.

Just by analyzing the numbers alone, one can calculate that healthcare has a major problem on its hands. Over the past two decades, Canada's percentage of Gross Domestic Product has trended consistently upward in healthcare dollar utilization (Frank et al., 2003). Provincial health spending in many provinces, including Alberta, has also trended upward. The cost of an individual's healthcare jumps dramatically as they age. According to statistics gathered in the year 2000, 65-year-old males utilized an average of $5,000 worth of healthcare per year. By age 85, this amount jumps to $15,000 (Robson, 2001). As we do our mathematical calculations and add in the demographics of the baby boomers, those individuals born between the years 1946 and 1964, there appears to be the potential for healthcare's economic collapse. The first of the baby boomers are set to reach age 65 in the year 2011. "Along with the labour market, the aging boomer population will have an impact on the country's health-care system, retirement homes

and pension plans, said Statistics Canada" ("Baby Boomers," 2007, ¶ 13). Overcrowding in hospitals and care centres results in disgruntled clients/family and staff. For an organization to maintain a positive culture and a nurse to maintain positive interactional exchanges in this workplace environment will require training, skill, effort, and emotional support.

Patients get angry and frustrated when their care needs are not met in as timely a fashion as they would like. There are days in which units do not have their normal nurse-to-patient staff ratio. Human resource shortages can be found across the healthcare sector. Scott-Findlay, Estabrooks, Cohn, and Pollock (2002) wrote,

> Healthcare organizations in most of the western world are struggling with a shortage of nurses. An aging population with greater healthcare needs, a graying profession, declining nursing school enrolments, and more career choices for women all contribute to the shortage. The extent of the Canadian registered nursing shortage is predicted to reach between 60,000 and 112,000 by 2011. (p. 348)

In newspapers across Canada, you will find articles about the severity and impact of nursing shortages across the country. In the *StarPhoenix* of January 5, 2007, Pamela Cowan noted, "A leaked memo revealed that a large number of nursing vacancies in the Regina Qu'Appelle Health Region raised the prospect of temporarily closing the Pasqua Hospital's emergency room" (¶ 2). Aggressive recruitment campaigns have pitted province against province in their bid to lure nurses. In a *Calgary Herald* article of January 21, 2007, Sarah McGinnis wrote, "A Calgary Health Region ad campaign to recruit nurses has drawn fire across the country from provinces who say Alberta is 'poaching' their nurses" (p. 1). The same article described British Columbia offering large signing bonuses, and a spokesperson for Nova Scotia indicated they could not afford to lose even one nurse (p. 1). The situation is very serious, and there will be no

easy or quick answers to the nursing shortage. Nurses have to do more with less. This is the current workplace reality. Already high stress levels may, in the future, become untenable and cause a mass exodus of nurses out of the healthcare industry. This project gathered information to create ways to emotionally support nurses and find ways to improve their ability to cope.

As the analysis of the various systems that directly impact the work environment of nurses in Canada and North America reveal, the storm is upon us. The pending mass of educated baby boomers reaching retirement by the year 2011 increases the number of individuals who will become ill and frail. In reviewing how many people are working in the area and their ages, you can see what is in the training pipeline. Simultaneously, a large portion of the nursing workforce will retire. The already scarce nursing resources required to look after an aging population will significantly decrease. At a public board meeting April 29, 2008, Jack Davis, the Calgary Health Region CEO, further reinforced the seriousness of this issue. He stated,

> So, in conclusion, to me it's clear. There is huge volume increases coming into the system, partly related to population growth, partly aging, partly new treatments and technologies. We have major workforce issues, major capacity issues, major financial issues, but within all of that context, the efficiency of the system in terms of dealing with people expeditiously, dealing with higher acuity cases, maintaining our safety and quality, is actually quite outstanding. Can we carry on like this? Absolutely not. (¶ 85)

Society has become increasingly intolerant, demanding, and down right rude. Remington and Darden (as cited in Dion, 2006) polled 2,013 people in America. Of those polled, 78% indicated that a lack of respect and courtesy is a serious problem, and 61% believed it has gotten worse in recent years (p. 3). People are engaging in these behaviours when they are in a state of wellness. It would make sense then when they

experience a significant health event their behaviour would deteriorate. Pain and fear bring out the worst in people. Given this current societal trend, the results of resent research will come as no surprise. Referring to statistics released by a joint initiative of the Canadian Institute of Health Information, Statistics Canada, and Health Canada, Kondro (2007) stated,

> Some 29% of the 18,348 Canadian nurses surveyed, indicated that they'd been physically assaulted by a patient in the year 2005, while 44% said they'd been subjected to emotional abuse by patients or families of patients, 25% suffered from chronic back problems, and 9% suffered from depression. (p. 437)

Uncivil behaviour negatively impacts a nurse's emotional and physical well-being and their ability to provide quality care. This project gathered information that enhances organizational supports and nurses' resilience in dealing with uncivil behaviour.

Research has indicated that society is more rude today than it was yesterday (Dion, 2006). That trend is likely to continue. Nursing is a hazardous profession, both emotionally and physically. How can we impact the nursing environment in a positive way? Optimistic news about systems analysis is that new science reveals that you do not have to do things on a grand scale and in a big way to make a significant difference. You simply need to find a leverage point. Nolan (as cited in Harrigan, 2000) stated,

> Not all aspects of a structure need to be changed to obtain significant improvement. Well focused, intelligent changes can sometimes produce substantial, enduring results. Systems theorists refer to these sensitive elements of structure of a system as leverage points or triggers. (p. 54)

The individual nurse or leader working on a healthcare unit is expected to cope with many stressors outside of their direct control. They cannot control the aging population. They have no control over the number of positions, vacancies, or staff shortages. They have no control over clients' and families' high, and at times unrealistic,

expectations. They may, however, learn to gain some control over their clients' or families' frustration, anger, and resultant abusive language or behaviour by changing their own behaviour and responses to it. Nurses and nurse leaders have control over how they respond and react to verbally abusive clients. Nurses gain control over their work environment by taking control of their responses to abusive language and behaviours. They do this by utilizing new skills and psychological self-protection strategies. Through a journey of collaborative discovery, nurses take control, weather the storm, and overcome forces threatening to make them jump ship.

Right relationships between all stakeholders in healthcare are critical when it comes to creating a positive work environment. According to an article in *The Canadian Press* ("Union Says," 2006), Alberta has the lowest number of full-time positions for nurses: "Many nurses opt to work less than full time because they can't stand the work environment and they can't take the workload" (¶ 6). If we are sincere in our quest to positively impact healthcare culture, we cannot overlook the very serious issues of interpersonal engagement and verbal abuse. Tension is tangible. Individuals who are working within environments that are wrought with emotional tension do not want to be there. Healthcare leaders must constantly be tending to relationships between individuals, disciplines, and other stakeholders. Wheatley (2006) noted,

> Let us remember that space is never empty … when we pretend that it doesn't matter whether there is harmony … we lose far more than our personal integrity. We lose the partnership of a field-rich space that can help bring order to our lives. (p. 57)

Organizational Context

Carewest is an innovative healthcare organization and a wholly owned subsidiary of the Calgary Health Region. Carewest is a nonprofit organization and is encompassed under the umbrella of the Calgary Health Region. In the Carewest (2005) *Administrative Manual*, Policy AM-01-01-02, it states,

> Carewest is a non-profit public sector company incorporated under Part 9 of the Companies Act R.S. A. 1980 Chapter C-20, as amended, as a wholly owned subsidiary health corporation of the Calgary Region Health. The Carewest Board, with ratification through the Calgary Health Region Board, approves general bylaws for Carewest that govern the organization, management and operation of Carewest. (p. 1)

Therefore, Carewest has the ability to not only gain new knowledge through this project, but also Carewest's size and autonomy allow it to roll out new information or initiatives across the entire organization should the executive leadership choose to do so.

The relationship between Carewest and the Calgary Health Region is often confusing to Carewest staff and the general public. Carewest is owned by the Calgary Health Region and, as such, is contracted to provide programs and services that are required to serve the health needs of individuals living within this region. Carewest's core funding comes from federal and provincial taxation and paid healthcare premiums, which are filtered through the Calgary Health Region. It is important to note that Carewest and the Calgary Health Region are separate legal entities. Carewest has its own Board of Directors and operates various departments (i.e., human resources, education, health and safety, and so on). Carewest has control over its own budget allocations within contract guidelines, as well as its own policies and procedures (Cygman, 2007, p. 9). In the spring of 2008, Ron Liepert, the Minister of Health, announced the dismantling of the provincial health boards in favour of one provincial super board (Peggy, 2008). Provincial

restructuring has already begun with the secondment of various regional healthcare leaders into new positions, roles, and responsibilities. This has left Carewest and all healthcare regions in the province in a state of flux and uncertainty.

Carewest, which up until 1986 was known as Calgary Auxiliary Hospital and Nursing Home District No. 7, opened its doors in 1961. Carewest is Calgary's largest healthcare provider of its kind. It operates nine sites and several community services aimed at helping people live more active, independent lives. Carewest currently provides 1120 healthcare beds, has 2,166 staff members and over 900 volunteers contributing 40,000 hours per year (M. MacKenzie, personal Communication, June 14, 2009).

Carewest has proven itself to be an innovative healthcare company. Since its inception, Carewest has successfully changed its primary focus from traditional long-term care to transitional care and support, chronic complex care for adults, and specialized assessment and treatment service for seniors. Leadership and staff have had to navigate organization-wide change in both structure and programs.

Carewest is an organization that values its employees and clients and wants to maintain a positive and collegial environment in which they can work and live respectively. Carewest's (2006) current *Frame of Reference* refers to how they conduct themselves. At their website, they stated that its vision is to lead the way in specialized continuing care (¶ 1). Under the heading of "Our Ethical Foundation," it states, "Carewest aims to develop and maintain a reputation of trust, credibility and public accountability with our clients, staff and community" (¶ 1). Carewest goes on to say, "We uphold individual rights and responsibilities; help clients and families deal with difficult

health choices; operate with honesty, fairness and integrity; and adhere to a high standard of clinical and business ethics" (How We Conduct Ourselves section, ¶ 2–5).

Carewest has several policies and procedures that reflect its compassion and value for its clients and staff. Carewest is a nonrestraint organization. This means that there are safeguards in place within their corporate literature to ensure that individuals are not restrained either physically or chemically. In the Carewest *Care and Service Manual*, there are two critical policies that pertain to restraint. The first, Section: Behaviours of Daily Living, subsection: Safety, CS-03-01-01 (Carewest, 1993), clearly acknowledges that "Carewest will ensure safe and appropriate interventions that support resident safety while maintaining the resident's dignity, comfort, and autonomy" (p. 1). It goes on to explain that "Carewest does not support the use of mechanical or environmental restraints" (p. 2). In the same section of the *Care and Service Manual*, Policy CS-03-01-02 (Carewest, 2004) states, "Carewest does not condone the inappropriate use of psychopharmacological drugs on any client" (p. 1). Carewest policies on behaviour management, as they pertain to clients, make clear that all individuals will be treated with compassion and respect and physical or chemical restraints are not in keeping with best practice nor will they be used as a part of a nurse's daily practice. In dealing with behavioural difficulties, staff and leaders must be very thoughtful when planning care and interventions, to ensure staff and clients are safe while care is provided. In this environment, it becomes even more important that nurses are trained in verbal de-escalation techniques and how to positively influence behavioural changes in their clients.

Carewest has also done an excellent job of clearly articulating the way in which they expect staff to engage in interpersonal dialogue and address concerns of verbal abuse, as reflected in the Carewest (2005) *Administrative Manual*, Section Resident Services and Resources, subsection legal/ethics, AM-02-04-01. This policy states,

> Carewest is committed to: fostering a healthy, safe and caring environment for clients, service providers and visitors, cultivating an atmosphere of trust, respect and dignity in all our relationships, protecting against disrespectful behavior, abuse, violence, discrimination, and harassment, ensuring there is compliance with the relevant policies and legislation. (p. 1)

This document was created in April 2005. It has excellent information and is an excellent resource for not only providing guidelines, but also spells out strategies for resolving issues and concerns. This policy and its contents have not yet been rolled out across the organization.

Carewest is an ideal organization in which to conduct action research. It has already proven its commitment to the creation of a positive work environment by: (a) the generation of strong policies, (b) the references and initiatives that have been done to date through the cultivation of positive work cultures as a part of the corporate business plan, and (c) the CEO is reinforcing his commitment by writing articles showcasing his thoughts on the importance of a positive corporate culture (Forbes, 2009)

Healthcare leaders and nurses now, more than ever, need to have strong ethical underpinning. The same forces that threaten to make nurses' and nurse leaders' work environment untenable are the same forces that may make them engage in unethical behaviour or make unethical decisions. According to Dolan (2004), "In the area of ethics, healthcare leadership has never been more challenged in this country [United States] than it is today" (p. 6). In its framework of support, Carewest (2006) includes a foundation of

ethics that outlines specific behavioural expectations and principles. Behaviours of participants in this research project must align with these expectations. Further to this, nurses are bound by the Canadian Nurses Association's (2008) Code of Ethics, which states, "The Code of Ethics for Registered Nurses serves as a foundation for nurses' ethical practice. It provides guidance for ethical relationships, responsibilities, behaviours and decision-making" (Purpose of the Code section, ¶ 1). Leaders in healthcare are the moral compass of their organization. Staff look to them and model their own behaviours and decisions after them. In an action research project, it was very important to set up ethical guidelines at the beginning of the project. Dual roles may cause confusion. The relationship between sponsor and researcher, director and manager roles may become blurred causing tensions or misunderstandings. Research participants could have had difficulty adjusting to one of their peers as research lead and participant. Opportunities for raising and resolving ethical concerns were built into the structure of the action research project.

Carewest leadership has already identified the need to create and maintain a positive work culture as its number one priority in staff retention and recruitment. The current Carewest CEO has identified respect as a core value at Carewest. Forbes (2008) stated, "How we treat each other, including co-workers, residents, clients, volunteers and visitors, determines the heart and soul of Carewest" (p. 2). Carewest policies and procedures outline rules of engagement and behavioural expectations of its employees. Communication and education around these policies has not yet been formally rolled out by Carewest educators or Health and Safety.

CHAPTER TWO: LITERATURE REVIEW

The purpose of this research project was to answer the research question: What strategies do the leadership of healthcare organizations and frontline nurses need to empower themselves when confronted with verbally abusive clients? Four topics important to this research project are explored in this literature review.

The first topic reviewed looks at resilience, its definition, core components, and current theoretical understanding. Resilient frontline nurses can face adversity again and again without a negative personal consequence and, in fact, often grow beyond the experience. The frontline nurses in this research project are likely to reveal resilient attributes.

The second topic is the concept of empowerment, its definition and core components, as well as its relationship with organizations, the caring nurse, transformational leadership, emotional intelligence, individual beliefs, cognition, and choice. Empowerment is a phrase that means to enable ("Empowerment," 2009, ¶ 2). How can we enable our frontline nurses to provide quality care to verbally abusive clients.

The third topic explored in the literature review is the concept of verbal abuse as it pertains to nurses in their place of work. This section includes the definition of verbal abuse, an analysis of the incidence of verbal abuse, and its theoretical underpinning. The third topic also explores organizational responses, zero tolerance initiatives, and organizational culture, along with organizational and individual strategies for dealing with verbal abuse. The internal experience of the nurse being abused and how individual

belief systems may impact an individual's ability to effectively interact with verbally abusive clients are also explored.

The fourth topic discusses organizational culture and the importance of cultivating a positive and healthy culture within a healthcare organization. It discusses how some organizations keep culture as their central theme. It also discusses polarity management and recognizing the difference between a pole to be managed and a problem to be solved.

Resilience

An understanding of the phenomenon of resilience is required to provide depth to this action research project. Today's nurses face frequent adversity and workplace challenges. Organizational restructuring and uncertainty, untenable workloads, increasing health complexities of the clients they care for, and acts of verbal abuse and aggression are part of their workplace reality. Many nurses burn out, become cynical, and leave the profession. There are, however, exceptions: nurses who not only survive in the face of such adversity, but also appear to grow and thrive (Caza, 2007; Edward, 2005; Jackson, Firtko, & Edenborough, 2007). This literature review will explore the concept of resilience: its definition, core components, and current theoretical understanding.

Definition and Core Components

The academic literature revealed more confusion than clarity about the phenomenon of resilience. Jackson et al. (2007) wrote, "Resilience has attracted the attention of scholars for years: yet, a common definition has proved elusive" (p. 3). The *Merriam-Webster Online Dictionary* ("Resilience," 2009) defined resilience as "an ability to recover from or adjust easily to change or misfortune" (¶ 2). The online *YourDictionary* ("Resilience," 2008) defined resilience as "the ability to bounce or spring

back into shape, position, etc. [or] the ability to recover strength, spirits, good humour, etc. quickly; buoyancy" (¶ 1–2). These definitions suggest that there is some type of adversity or perceived negative event that must be overcome. Numerous scholars have agreed that, in order for resilience to be measured or examined, a negative or perceived adversarial event or trigger (the antecedent) must occur (Earvolino-Ramirez, 2007; Edward, 2005; Fredrickson, 2001; Jackson et al., 2007; Polk, 1997).

The literature examined also discussed an aspect of resilience beyond bouncing back. Masten and Coatsworth (as cited in DiRago & Vaillant, 2007) outlined two markers used to identify resilient individuals. First, the individual must have been exposed to a threat either in the form of high-risk status or as exposure to severe trauma. Second, the individual must show positive adaptation (p. 61). In referring to clinicians working in a very stressful and demanding environment, Edward (2005) put forward, "These clinicians have the ability to move beyond the stressors of the moment time and time again" (p. 143). Several scholars have agreed that positive adaptation is a core component of resilience. Not only can resilient individuals bounce back or recover to their previous level of functioning, but they can learn and grow beyond it.

Current Theoretical Understanding

There has also been debate in the literature about whether resilience is a result of inherent personality traits, skills that can be learned, or a process of identity development. Caza (2007) surveyed 228 certified nurse midwives in her dissertation examining adversity at work and an identity-based theory of resilience. She referred to resilience at work as "an individual's capacity to emerge from experiences of adversity displaying competence, professional growth, and the ability to handle future challenges in the

workplace" (p. 174). She described resilience as a process rather than a trait. Much of the focus of her research was on the positive aspects of adversity. Positivism was a strong theme throughout the literature. Patterson (as cited in Vestal, 1997) defined positivism as the ability to attribute positive meaning to challenging events and situations in our lives in order to deal with them adaptively (p. 31).

Polk (1997) engaged in a process of concept analysis around the theory of resilience in nursing because in nursing science the theory was "unclear, outmoded or unhelpful" (p. 2). She analyzed 26 articles on resilience and examined them for evidence of defining attributes and themes. Polk defined the concept of resilience as "the ability to transform disaster into a growth experience and move forward" (p. 1). From her examination of the studies, four patterns emerged: dispositional, relational, situational, and philosophical (see Table 1). Polk's middle range theory of resilience will be utilized to capture and theme data from my research project.

Another area touched on in the literature, but requires further review, is whether or not an individual had to display competence in a specific area of expertise in order to exhibit resilience when adverse events occur. The discussion was inconclusive. Jackson et al. (2007), in a review of 70 articles pertaining to resilience and workplace adversity, referred to resilience as a skill that can be learned, but does not provide a clear indication of the competencies to be learned. Jackson et al. did, however, identify strategies in which nurses are to be encouraged to engage, such as "mentoring relationships, achieving life balance and spirituality, positive emotions and personal growth and reflection" (p. 7). They believed these protective factors are an important component of the resilience puzzle.

Table 1. *Summary of Polk's (1997) Middle Range Theory of Resilience*

Pattern	Description
Dispositional	Refers to physical and ego-related psychosocial attributes. These factors include intelligence, health, and temperament. Resilient individuals are characteristically more intelligent, in good health, have a good physical appearance, are athletic and exhibit a caring attitude towards others.
Relational	Includes both intrinsic and extrinsic aspects defined as the placement of value on close confiding relationships as well as a broader social network. This includes turning to another person to make sense of an experience or derive comfort, identifying and relating to positive role models, willing to seek out a confidant and a deep commitment to the development of personal intimacy. The relational pattern also reflects extrinsic social skills such as multiple interests and hobbies, commitment to job, education and strong social network of friends within the community.
Situational	Is manifested as cognitive appraisal skills, problem solving ability, and attributes that indicate a capacity for action in facing a situation. It includes the ability to make a realistic assessment of skills and analyze one's own capacity to act and foresee the potential consequences of one's actions. It includes the ability to reflect, be flexible, persevere and be resourceful. This pattern includes curiosity, creativity, novelty seeking and exploring nature.
Philosophical	Is manifested by personal beliefs such as, self-knowledge is valuable, reflection about oneself and events, life has purpose and the belief in finding positive meaning in experiences. There is a realization that life has a purpose that each person's life path is unique and one must maintain a balanced perspective.

Note: Compiled from Polk (1997, pp. 3–4).

A nurse's ability to be resilient when confronted with verbally abusive clients may be a core factor to the enjoyment of their work and the maintenance of a positive workplace, which directly impacts recruitment and retention. The results of this action

research project will expand knowledge in this important area. Resilience may be a skill that can be learned.

Empowerment

Empowerment is relevant to building resilience and improving a nurse's ability to deal with verbally abusive clients. The literature review of the concept of empowerment revealed a plethora of research and articles that explained the phenomenon of empowerment in a variety of different contexts. I could find no articles on empowerment that were specific to frontline nurses dealing with verbal abuse. There were, however, numerous articles that related to empowerment and the field of nursing (Gibson, 1991; Kuokkanen & Katajisto, 2003; Nedd, 2006; Rodwell, 1996). It was clear from the literature that, in order for empowerment to occur, infrastructures in the form of information, support, resources, and opportunity must not only be offered by the organization, they must also be taken advantage of by the individual nurse (Labonte, as cited in Rodwell, 1996; Kanter; as cited in Spence-Laschinger & Sebastian, 2000). The creation of an empowered workplace culture depends on an interdependent relationship between frontline nurses and the healthcare organization.

Definition and Core Components

The idea of empowerment is rooted in the social action ideology of the 1960s and the self-help perspectives of the 1970s. In a broad sense, empowerment is a process by which people, organizations, and communities gain mastery over their own lives (Rappaport, as cited in Gibson, 1991, p. 355). The early literature on empowerment informed much of the research available on nurse empowerment. In the *Merriam Webster Online Dictionary* ("Empowerment," 2009), empowerment is identified as a transitive

verb, which means to "enable" (¶ 2). Enable (2009) is defined as "to provide the means or opportunity, to make possible, practical or easy" (¶ 1). Wallerstien and Bernstein (as cited in Gibson, 1991) pointed out that part of the problem in defining empowerment is that it "takes on a different form in different people and within different contexts" (p. 355). Rappaport (as cited in Gibson, 1991) concluded that the form empowerment takes, the strategies for empowerment, and the results will be variable. Thus, empowerment cannot be defined in a single way; it needs to be defined by the people concerned (p. 355). Empowerment involves reciprocal relationships between a variety of players. These relationships are a complex interplay between healthcare organizations, nurses, patients, and society as a whole.

Current and Historic Theoretical Constructs

Mason, Backer, and Georges (1991) reflected on three key areas that require attention in order for nurse empowerment to occur at a societal level: raise the consciousness, develop positive self-esteem, and political skills. Mason et al. wrote, "Inequality in the class structure of the healthcare system mirrors the more general contradictions of social class in society at large" (p. 73). Frier (as cited in Mason et al, 1991) noted that oppressed groups are characterized by a self-depreciation that arises from an internalization of their oppressor's view of them. Roberts (1996) described nurses as an oppressed group (p. 209). The occurrence and acceptance of verbal abuse and aggression within the healthcare setting, and nurses specifically, is simply a reflection of greater societal inequalities. According to the literature, there is a need for nurses to gain power within themselves, their organization, and society as a whole.

Organizations

Much of the research done within the context of nursing is based on Kanter's theory of empowerment (as cited in Spence-Laschinger & Sebastian, 2000). According to Kanter's theory, structure and infrastructure are described as the primary ingredient for empowerment, and empowering organizations are those that have infrastructures that allow access to information, support, resources, and opportunity (Spence-Laschinger & Sebastian, 2000; Spence-Laschinger & Wong, 1999; Spence-Laschinger, Sebastian, & Kutszcher, 1997). These infrastructures improve an employee's organizational commitment, self-esteem, organizational engagement, and sense of control, and results in more effective and efficient work behaviours (Spence-Laschinger, Finegan, & Shamian, 2001; Spence-Laschinger, Finegan, Shamian, & Wilk, 2004; Nedd, 2006).

Kanter (as cited in Spence-Laschinger & Sebastian, 2000) proposed that empowerment is based on the concept of power as enabling, rather than dominating: "power shared is power accumulated" (Kanter's Theory section, ¶ 1). Power can be derived by both formal systems, which can include job definition that is flexible, visible, and central to core business, and informal systems, which can include connections within organization, with sponsors, peers subordinates, external stakeholders (Spence-Laschinger et al., 2001). Organizations can assist nurses to develop a positive group identity by focusing on strengths, diversity, and the contribution of their expertise.

The Caring Nurse

Empowerment is a concept that needs to be applied to both the caregiver and the care receiver. In the social and psychological context of empowerment, Conger and Kanungo (1988) proposed "that empowerment be viewed as a motivational construct—

meaning to enable rather than simply to delegate" (p. 474). They defined empowerment as "a process of enhancing feelings of self-efficacy among organizational members through the identification of conditions that foster powerlessness and through their removal by both formal organizational practices and informal techniques of providing efficacy information" (p. 474). Strong negative emotional responses, such as stress, fear, anger, or depression, decrease an individual's feelings of competence. Providing a supportive and trusting environment can be effective in strengthening self-efficacy beliefs (Conger & Kanungo, 1988). This applies not only to nurses, but also to the clients receiving care.

The embedded belief by nurses and society, that nursing is a caring profession may be inadvertently disempowering patients and causing a lack of accountability and responsibility for their own behaviours while receiving care in a healthcare setting. Maeline and Teasdale (as cited in Rodwell, 1996) made an important point in differentiating between caring and empowerment. They suggested that caring involves doing things for patients, protecting them, and engaging in a paternalistic relational pattern; whereas, empowerment redistributes power in favour of the patient, with emphasis on their independence and accepting of responsibility of decisions made. Manthey (as cited in Rodwell, 1996) argued that acceptance of responsibility is what opens the door to authority and power. If groups or individuals are to be empowered, they must accept responsibility for their actions (p. 309).

Transformational Leadership

Transformational leadership is positively related to empowerment and job satisfaction (Morrison, 1997). Bass (as cited in Morrison, 1997) described

transformational leadership as including four primary components: idealized influence, inspiration, intellectual stimulation, and individualized consideration (p. 2). From a leadership perspective, Morrison stated, “Empowerment is perhaps the most widely discussed influence transformational leaders have on followers” (p. 3).

Thomas and Velthouse (1990) indicated that transformational leadership should influence the competence, meaningfulness, and impact dimensions of empowerment. According to Yukl (2006), “Transformational leadership is likely to be more important in a dynamic, unstable environment that increases the need for change, and such leadership is more likely when leaders are encouraged and empowered to be flexible and innovative” (p. 138). Healthcare is an unstable and uncertain industry in constant flux (Davis, 2008; Dion, 2006).

Transformational leaders articulate a clear vision. This vision guides the actions and decisions of each member of the organization. People must be given autonomy and discretion in their work (Yukl, 2006, p. 147). Articulation of a shared mission or vision provides the most critical information for empowerment. The discussion of benefits of a transformational leadership style cannot be understated when trying to impact a problem as pervasive as verbally abusive clients. Jones (as cited in Morrison, 1997) found that employees on patient care units with high levels of patient satisfaction described the nurse managers of the units as having significantly higher transformational leadership behaviours than did employees on units that had lower patient satisfaction (p. 3). The leadership style of a manager not only impacts the employees directly, it also impacts the patients directly. A transformational leadership style creates a positive cycle of empowerment between the patient, the individual staff, their leaders, and the organization

as a whole. Satisfied patients are less likely to be verbally abusive, resulting in a healthier workplace culture.

Emotional Intelligence

In order to create a supportive and trusting environment in which staff can feel empowered, one needs to look at the concept of emotional intelligence in both leaders and frontline nurses. According to Goleman, Boyatzis, and McKee (2002), "The glue that holds people together in a team, and that commits people to an organization, is the emotions they feel" (p. 20). It takes a leader and frontline staff with high levels of emotional intelligence to guide and direct the emotional feeling or tone of a unit or an organization (p. 11).

Goleman et al. (2002) indicated that leaders with a high level of emotional intelligence are passionate and project high levels of enthusiasm and energy. They can also become very serious, empathic with the feelings of the group, and express those feelings on their behalf. This leaves staff feeling understood and cared for. During times of crisis, an emotional bond is formed that helps them stay on course amid profound change and uncertainty. Goleman et al. also pointed out that connecting with colleagues at an emotional level makes work more meaningful (pp. 20–21).

Frontline nurses that possess high levels of interpersonal and social analytical skills are considered to be emotionally intelligent. Morse (as cited in McQueen, 2003) indicated that emotionally intelligent people

> form connecting relationships with others easily, read other people's feelings and responses accurately, lead and organize other people and handle disputes successfully. It seems appropriate, therefore to foster interpersonal intelligence in nursing, where it is advantageous to form good rapport and connected relationships with patients. (p. 102)

Interpersonal skills and emotional self-control become extremely important when patients require intense emotional engagement. The study of one's emotions and emotional self-regulation becomes paramount. Incorporating emotional intelligence training into organizations and nursing curricula should improve understanding of oneself and others and lead to improved skills when dealing with psychosocial issues (McQueen, 2003, pp. 106–107).

Individual Beliefs

The literature also revealed that empowerment is a process influenced by the qualities and values of the individual nurse (Kuokkanen & Leino-Kilpi, 2001). Kuokkanen and Katajisto (2003) believed, "The exercise of power must be comprehended at the individual level … empowerment is seen as a process of personal growth and development" (p. 210). Wood and Bandura (as cited in Kuokkanen & Leino-Kilpi, 2001) wrote that the process of empowerment requires critical introspection and changing patterns of activity accordingly (p. 274). According to Kuokkanen and Leino-Kilpi, "Belief systems, worldview and self - concept create the foundation and guide human behaviour, thus directly influencing the empowerment process" (p. 274). They concluded that there are both hard and soft aspects of personality involved in individual empowerment. The hard aspects are courage, fearlessness in the face of criticism, carrying on against objection, and caring for one's self and one's progress. The soft aspects are social ability and positive regard for others (p. 278). Nurses must become introspective and reflective. They need to continually evaluate the underlying beliefs or assumptions that may be impacting their emotional and behavioural responses to verbally abusive clients.

Cognition

More recent literature has begun to explore the cognitive aspects of empowerment. Thomas and Velthouse (1990) developed a cognitive model that consists of an ongoing cycle of environmental events, task assessments, and behaviour. They wrote about the four components of intrinsic motivation, or task assessments, as the basis for worker empowerment: impact, competence, meaningfulness, and choice. Impact refers to what difference an individual is making in their environment. Competence refers to completing tasks skilfully. Meaningfulness refers to the degree at which the task aligns with an individuals values and standards. Choice refers to the ability for an individual to accept responsibility for their actions; the individual believes their behaviour is self-determined (p. 673).

Spreitzer (as cited in Spreitzer, Kizilos, & Nason, 1997) built on the cognitive model of empowerment developed by Thomas and Velthouse (1990). They described the psychological aspects of empowerment as "what individuals need to experience or feel in order for such interventions to be effective rather than specific management practices intended to 'empower' employees" (p. 681). The task assessment model aims primarily to provide choice to subordinates (Thomas & Velthouse, 1990).

Labonte (as cited in Rodwell, 1996) reminded us that the Latin root of power, *potere*, also means the ability to choose. Therefore, groups and individuals must not only have access to the structural systems described within Kanter's theory, but must also have the internal motivation to take advantage of them in order for empowerment to occur (p. 308). If perceived choice is paramount to staff empowerment and behavioural change, then it should follow that perceived choice could also assist a verbally abusive client to

make behavioural changes. In the staff–organization relationship, the organization is responsible to create choices for their staff within the organizational policies, procedures, and training infrastructures. In the nurse–client relationship, the nurse would be responsible to structure choice for the client within the environmental context. This fulfills the purpose of their task and diffuses an emotionally tense situation.

In conclusion, the concept of empowerment is a complex interplay between leaders, staff, and patients. It consists of not only the act of giving over of power, but also the acceptance of that power. It is my intention to utilize Kanter's theory (as cited in Spence-Laschinger & Sebastian, 2000; Spence-Laschinger, & Wong, 1999; Spence-Laschinger et al., 1997; Spence-Laschinger et al., 2001) to theme research data as it pertains to organizational structure and infrastructure.

Verbal Abuse as it Pertains to Nurses in their Place of Work

An examination of the literature about verbal abuse as it pertains to nurses in their place of work is very important in the context of this research project. In this topic area, I will define verbal abuse and discuss its prevalence against nurses in the healthcare industry, which includes literature about "zero tolerance to abuse" (Holmes, 2006, p. 212) policies and why they should not be considered as a solution to verbal abuse in the healthcare industry. Specific theories about verbal abuse in relation to theories about violence, and strategies for individual and organizational management will be presented. The physiological aspects of verbal abuse and how underlying beliefs and meaning assigned to it may impact frontlines nurse's ability to provide respectful quality care will also be examined.

Definition and Analysis of Incidence of Verbal Abuse against Nurses

Around the world, the high incidence of verbal abuse is well documented throughout nursing literature (Oztunc, 2006; Rowe & Sherlock, 2005; Sofield & Salmond, 2003). Wondrak (1999) defined verbal abuse as any "expressed aggression or hostile verbal attack directed against any other individual" (p. 80). Anderson and Clarke (1996) stated, "Verbal abuse is communication through words, tone or manner that disparages, humiliates, intimidates, patronizes, threatens, accuses or is disrespectful toward another" (p. 95).

One of the first comprehensive and detailed analyses of verbal abuse against nurses took place in West Texas and was carried out by H. C. Cox in 1987. From a random survey mailed to 1,000 registered nurses and 100 directors of nursing, with a response rate of 57%, Cox concluded that verbal abuse is so prevalent that "it is surprising any of us stay in nursing!" (p. 49). Cox also indicated that 82% of nurses had experienced verbal abuse. Medical staff members were the primary perpetrators, followed closely by patient's relatives, then by patients themselves. She also concluded that agencies could "safely consider that at least 18% of its turnover rate is related to verbal abuse" (p. 49).

In a survey done by Sofield and Salmond (2003), 463 staff nurses were asked about the prevalence of verbal abuse over the past month. Only 9% indicated no experience of verbal abuse, 67% reported one to five incidents, and the remaining 24% found verbal abuse more prevalent (p. 278). Their research indicated clients are not the primary perpetrators of verbal abuse, but came in a close second behind physicians, followed by patient families, peers, supervisors, and subordinates (p. 278).

The incidence of violence is not only holding steady, but also appears to be increasing. In a 2008 *Nurse Management* survey of 1,400 nurses from around the globe, representing every region of the United States and countries from as far away as Saudi Arabia, the results were clear: "Alarmingly, nearly 80% of nurse leaders have experienced some form of violence within the work setting" (Hader, 2008, p. 13). This survey also indicated that verbal rather than physical violence is much more common in healthcare. It showed that 71% of nurses responded that they were subject to severe criticism from supervisors, physicians, colleagues, and patients (p. 17). The literature was conclusive: Nurses frequently deal with verbal abuse from all stakeholders within the healthcare system, including their colleagues.

Theoretical Underpinning of Verbal Abuse against Nurses

My research into verbal abuse against nurses began by examining the lens in which current researchers view the issue and the meaning they assign to it. Many researchers have put forth various theories as to why verbal abuse against nurses exists and persists. They all perceived nurses to be done upon by forces outside of their control. The pervasive belief that nurses are oppressed could, in fact, be keeping them in that state. Roberts (1996) stated, "The 'marginal' status (of nurses) leads to feelings of low self-esteem and self-hatred" (p. 210). Bent (as cited in Roberts, 1996) indicated that nurses could be liberated through a shared sense of injustice, which would lead to unity and empowerment in nursing (p. 213).

Reakes (as cited in Wondrak, 1999) believed there is implicit support for a patriarchal system that emphasizes nursing in a sexist way. She made the comparison of a nurse to an abused child. The nurse creates an image of a vulnerable child who could

increase anger in the abuser. Gordon and Green (as cited in Wondrak, 1999) suggested that the solution to verbal abuse against nurses is to break down sexual barriers by reinforcing new models of behaviours that are not traditional female conforming behaviours (pp. 81–82). Public perception is that nursing jobs require feminine traits such as nurturing, caring, and empathy; perceptions the public does not believe men are suited to. Rather than being an obstacle to in their career however, these assumptions facilitate men's entry into better paying, higher status positions (Wingfield, 2009).

Cox (1991) looked beyond these sociological issues and looked to a model called "oppressed group behaviour" (p. 32). She put forth this framework as a valid one for the study of nursing practice and pertinent to the study of verbal abuse (p. 32). Cox (as cited in Sofield & Salmond, 2003) suggested that nurses become verbally abusive themselves as a coping mechanism, because the nurses direct their frustration inwardly, towards each other, towards themselves, and towards perceived subordinates (p. 277). Roberts (1996) stated,

> The oppressed group behaviour model suggest that persons who are in groups that subordinate to more powerful groups in their society learn certain behavioural patterns that although necessary for their survival, lead to a cycle of further oppression. Nurses have been considered an oppressed group. (p. 209)

Sofield and Salmond (2003) suggested researchers used Robert's framework of the oppressed group to better understand verbal abuse against nurses and find out where the healthcare system needs to focus their education (p. 277). Sofield and Salmond discovered that the majority of nurses (56%) indicated a poor or fair response to handling verbal abuse, and 44% were more comfortable with their ability (p. 279).

Organizational Responses to Verbal Abuse against Nurses

Given the overwhelming evidence that nurses deal with verbal abuse on a consistent basis in their day-to-day work life, it is disconcerting to discover that the literature revealed little information about organizational strategies and interventions required to provide care to clients who are verbally abusive or to deal with verbal abuse in general within the workplace. The literature also revealed little information about individual skills, knowledge, or competencies required to successfully navigate verbal abuse. The literature that was found revealed the same concern for the lack of concrete strategies and information about dealing with verbal abuse at both the individual and organizational level (Kidd & Stark, 1995; Richter, 2006; Rowe & Sherlock, 2005; Turnbull & Paterson, 1999).

Moreover I could find no positive conceptual frameworks within the literature about providing respectful, quality, and inclusionary care to verbally abusive clients. I did find in the literature some positive and proactive organizational and individual strategies that could help protect and maintain the psychological, physical safety of frontline nurses and positively impact workplace culture. I did not, however, find these under any specific identifiable umbrella or comprehensive intervention model. The only organizational response found in the literature, as it pertained to verbal abuse against nurses, was “Zero Tolerance to Abuse” (Curwin & Mendler, 1999; Davies, 2006; Dunbar & Villarruel, 2004; Holmes, 2006). I believe that a zero tolerance to abuse initiative cannot, for reasons beyond the depth of this work, be considered a positive framework for dealing with verbal abuse. However, given its prevalence within the literature and its continued lobby

by many loyalists as the solution to verbal abuse in many healthcare environments around the world, zero tolerance is discussed.

Zero Tolerance

Zero tolerance initiatives have become a trend in numerous social and health service industries as a way of dealing with social problems over the past three decades (Brockman, 2002; Holmes, 2006; Sughrue, 2003; Whittington, 2002). A zero tolerance policy entails that a specified behaviour will not be tolerated under any circumstances and that there will be a nonnegotiable sanction imposed whenever that behaviour occurs (Holmes, 2006, p. 212). Zero tolerance was introduced in the 1980s and is now the catch phrase for a broad array of public policy directives and exclusionary practices (Sughrue, 2003, p. 240). It has become a world-wide phenomenon in many healthcare settings, although there have been no critical reviews of its effectiveness in the nursing literature (Holmes, 2006, p. 222).

Holmes (2006), after an extensive examination of the literature and policy reviews of zero tolerance initiatives in the United States and the United Kingdom, concluded that zero tolerance "is an ineffective response to violence in healthcare settings and its adoption … should be rejected" (p. 212). He further stated,

> That by declaring 'zero tolerance' as opposed to addressing the cause of violence, governments have done little more than stomping their metaphorical feet and declare they simply 'will not tolerate it'. This is quite pointless, of course, because the potential for violence is profoundly human and can not be eliminated by dictate. (p. 222)

Holmes's conclusion was the exact opposite of the conclusions of the United Kingdom's comptroller and auditor general, which he had reviewed. In 2003, the comptroller and auditor general declared zero tolerance as the cornerstone of safe working in health

services. He went on to suggest that health trusts develop a local policy on withholding treatment from violent and abusive patients (p. 215) According to Holmes, a critical problem with this very serious declaration is there is only one review by C. Wiskow, completed in 2003, that voiced strong approval of the concept. Wiskow cited no third party research evidence to back up his assertion. Holmes went on to discuss that Wiskow's report is not cited (as of June 1, 2005) by any credible publication databases he reviewed and was only found through Goggle Scholar. He stated, "[It is] remarkable that such an obscure publication should serve as the platform for an important national policy" (p. 215).

Other literature revealed that not only is zero tolerance ineffective, it creates a negative and toxic organization. Duxbury and Whittington (2005) put forward, "Zero tolerance policies have actually compounded the problems (of aggression and violence) by creating a workplace culture of client blame and encouraging intolerance by healthcare workers" (p. 471). According to Holmes (2006), nurses agree they feel that "not only is zero tolerance to abuse not effective, it actually increases the incidence and level of intensity" (p. 220).

In other areas of society, such as the young offenders system and the education system, where zero tolerance initiatives are well entrenched in organizational infrastructure, there is now considerable literature regarding legal and organizational lobbies against its use. Zero tolerance has created discrimination based on a variety of factors including ethnicity, colour, and age. Studies have also consistently shown that people from impoverished and disadvantaged backgrounds are more likely than other

people to find themselves punished by zero tolerance policies (Dunbar & Villarruel, 2004; Giroux, 2003; Hill, 2001).

In the spring of 2009 in Calgary, Alberta, Canada, a local newspaper columnist's wife was in excruciating pain due to a bowel obstruction and had to visit a Calgary emergency department. In commenting on zero tolerance to abuse he put forward,

> The staff talk a lot about abuse; one fellow we met was accused of it when he made a joke. They're very sensitive about abuse. Signs everywhere warn that it won't be tolerated. And the staff shouldn't be abused—it isn't their fault. But what about patient abuse? If my wife isn't being abused at this moment, after 10 hours in public without a glass of water or a sedative or an offer of any kind of comfort, lying flat on her back before a roomful of strangers, I'm not sure what qualifies. (Braid, 2009, 6:30 p.m. section, ¶ 2)

Care receivers are not the only ones contemplating the ethical underpinning of zero tolerance. Of those healthcare organizations that have implemented zero tolerance to abuse initiatives, many nurses become ethically conflicted. Holmes (2006) stated that nurses, according to their ethical standards, must "treat the sick regardless of their personal attitudes toward them" (p. 221). His opinion was that zero tolerance to abuse "cuts across the rights of patients and the public, and ultimately undermines their (nurses) professional rights and responsibilities" (p. 223).

Some nurses feel the "signs are nice, but it is just lip service" (Hader, 2008, p. 18) and there are no negative consequences to the perpetrators, not so if you end up in one of several hospitals in London, England. Under the umbrella of zero tolerance, frontline staff, often nurses, have applied concrete sanctions against a plethora of offences, such as excessive noise, threatening or abusive language, derogatory racial or sexual remarks, and so forth. Staff members carry yellow warning cards and red total-expulsion cards in

their pocket, which they can hand out at their discretion (Holmes, 2006, p. 214). This raises many practical and ethical concerns at both an individual and a societal level.

A nurse must maintain a therapeutic relationship of mutual trust while negotiating a policing role. Given the imbalance of power, this would be very difficult. Whittington (2002) surveyed 37 nurses regarding their attitude toward patient aggression and their tolerance of it. He concluded that there was a mismatch between zero tolerance policies and procedures and the variable tolerance nurses had to caring for a client using therapeutic modalities (p. 824).

From a societal perspective, patients can and do become blacklisted and may be denied treatment at conventional surgeries and hospital. According to the British Broadcasting Corporation News (as cited in Holmes, 2006), in the Midlands of England, "blacklisted patients can only receive care at police stations where a 'clinic' set up for blacklisted patients is situated" (p. 221). Holmes wrote,

> Zero tolerance is potentially an effective way of creating a large underclass of poor, desperate, and hard to manage people and denying them appropriate healthcare … they open a door to neglect and denial which they may never be able to close. (p. 215)

Canada has a strong national identity aligned with universal healthcare for all. It should not be surprising that healthcare organizations that have tried to embrace zero tolerance have frontline nurses accusing them of empty posturing due to the lack of any real negative consequences (Hader, 2008).

In spite of the lack of evidence to the efficacy of zero tolerance and its overwhelming shortcomings, many authors of current articles examining issues of verbal abuse or violence against nurses, many parties continue to lobby for the development and enforcement of zero tolerance to abuse initiatives within healthcare (Oztunc, 2006;

Sofield & Salmond, 2003). It is important to note that there are some good strategies that have been borne out of zero tolerance initiatives, but these strategies can be applied under an umbrella that's name, philosophical tenants, and application are not exclusionary or contentious (Holmes, 2006).

Organizational Strategies for Respectfully Dealing with Verbal Abuse

Much of the literature as it pertains to recommendations for organizational responses to verbal abuse in the workplace remain fairly consistent. A primary focus is the need for the development of strict policies to both prevent and respond to verbal abuse at an organizational level. Often, but not always, recommendations include the implementation of zero tolerance to abuse policies, which was discussed in depth earlier, has little evidence to its efficacy and may in fact increase violence (Sughrue, 2003). The literature has also suggested user-friendly reporting systems, quick managerial response, individual support systems, ongoing education and training about how to communicate with verbally abusive individuals, post-incident staff debriefing, suggestions about building staff morale among nurses, and the need for individual self-esteem enhancement of nurses (Rowe & Sherlock, 2005). Mentoring systems and trend tracking have also been identified as important in highlighting risk areas for management and providing strength and support for staff (Oztunc, 2006; Sofield & Salmond, 2003).

DelBel (2003) made further suggestions for organizational responses: (a) be proactive and implement family and community education regarding realistic expectations of services, (b) have a patient relations representative to get involved when patients or families make threats, (c) implement restricted visitation to disruptive family members when appropriate, (d) discuss patient/family member problems at monthly

unit/staff meetings, (e) offer opportunities to express feelings and give each other support, and (f) organize team meetings, especially when a difficult patient/family is present on unit (p. 33). DelBel also suggested individuals refer to the Crisis Prevention Institute for more ideas.

Bowie (1999) went into detailed depth about the potential effects of abuse on staff and had many useful suggestions on how to minimize or mitigate any long-term effects of the incident. Pity, blaming or patronizing is damaging; instead provide, empathy and understanding. Support also needs to be provided in a way that is sensitive to the victim. (p. 168).

The individual does not always need or want individual support. They may, however, benefit from a group discussion after the event. Mitchell and Everly (as cited in Bowie, 1999, pp. 169–172) created a model called Critical Incident Stress Debriefing (CISD), and suggested the potential implementation of it as part of an organization-wide strategy. CISD is designed with two purposes in mind: the first is to mitigate the impact of the negative event, and the second is designed to accelerate normal recovery for healthy individuals needing to recover from an abnormal event. CISD has several steps: introduction, fact phase, thought phase, reaction phase, symptom phase, teaching phase, and re-entry phase. It allows for quick intervention for the sharing and development of competencies and strategies to deal with these issues, without downplaying the psychological trauma involved. In a situation where greater therapeutic support is required, an external employee assistance program may be appropriate.

Given the evidence that abuse and violence targeted to healthcare staff can be correlated to staff–patient ratios, increasing frustration and anger due to increasing wait

times and misdirected anger about the status of the healthcare system, it is important that healthcare organizations continue to think creatively for solutions to difficult problems. Holmes (2006) stated, “Attention needs to extend beyond individuals to the health system itself and ultimately to the polity and its relationship to its constituency” (p. 222). Solutions facing the healthcare system are complex. Healthcare organizations must find time to dialogue and reflect on critical issues. They need to not only educate and lobby governments about the current trends and issues. Their leadership needs to put forth effective and innovative solutions for consideration.

Individual Strategies for Respectfully Dealing with Verbally Abusive Clients

An in-depth search of the nursing literature revealed very little information about verbal de-escalation theories, models or strategies that could be utilized by individuals within the healthcare industry (Kidd & Stark, 1995; Richter, 2006; Turnbull & Paterson, 1999). The literature consistently recommended that organizations educate and train their staff about how to report and deal with verbal abuse, but the recommendations about exactly what to teach individual staff was fairly general.

Maunder (1997) suggested that the transactional analysis model introduced by Berne in 1964 is a good model to utilize for adult-to-adult de-escalation. Within the context of that model, she identified three critical areas: tone of voice, gestures and postures, and words. She suggested tone of voice should be calm, confident, and relaxed, sit straight, keep level eye contact, be open, and use words associated with adult communication, such as when, what, problem-solve, and understand (p. 109). She also outlined some general principles to follow when a client is escalating their behaviour and becoming abusive: call for help, move other people away, stay calm, keep your voice low

and clear, do not argue or shout, listen, apologize, be aware of body posture, and try to slow things down (p. 109). Maunder made two additional important points. First, she advised nurses to never put themselves at risk, and second, that in some scenarios, it is not what is said so much as the way it is said (p. 109).

Sofield and Salmond (2003) suggested strategies very similar to those of Maunder (1997), with the following additions: acknowledge the person by name and their viewpoints, set limits, think logically not emotionally, promote a positive problem-solving atmosphere, follow up on any agreements, and look critically at your own behaviour (p. 281).

Richter (2006) noted, "Nonphysical techniques are only rarely taught and actively trained" (p. 125). Given the lack of information about verbal de-escalation techniques within the healthcare industry, he looked to other industries, such as hostage negotiation, care of out-of-control adolescents, and rules to guide staff in their attempts to de-escalate agitated clients. Regarding his comprehensive set of rules and suggestions, he placed the following caveat: "Don't stick too tightly to the rules … and … de-escalation does not work without in depth training" (p. 132). Richter outlined 10 rules or guiding principles in the application of de-escalation strategies:

> [1] Attitude check, attitude towards the patient and their aggression should be empathy, concern, respect, sincerity and fairness… [2] Assess the risks associated with each available option. Are the expectations realistic? … [3] Control the situation not the patient … [4] Share risk assessment, decision making, responsibilities and actions with colleagues if possible … [5] De-escalation is more successful as an early intervention … [6] Gain time, this is one of the main sub goals of verbal de-escalation … [7] Spatial considerations are important and distance keeping between staff and patient has several advantages … [8] Apply de-escalation techniques with apparent self-confidence without being provocative … [9] Power plays between staff and patients have to be avoided … [10] Staff should be aware of general safety issues. (pp. 132–134)

As you can see from the sample of guiding principles from different researchers, over the past decade, the interventions suggested remain consistent, and are repeated throughout the literature.

Some researchers believed that progress is being made in the area of verbal de-escalation, but much more in-depth study is required. Wondrak (1999) suggested five strategies be learned in advance and utilized, as one tool among many in a skill set, to deal with verbal abuse (see Table 2).

Table 2. *Five Strategies to De-Escalate Verbal Abuse*

Strategy	Description
Side-Stepping	Simply implies to the practitioner when confronted, move to one side as if avoiding confrontation. It is a psychological technique in which the practitioner responds totally nondefensively. The underlying premise is for the practitioner to acknowledge the content has been heard without getting "hooked'.
Self-disclosure	Requires that the practitioner not hold too firmly to the professional authoritarian image but humanize themselves. Disclosing how one feels either about the abuse itself or can relate to others in a genuine and honest manner through a common experience can be very effective.
Partial Agreement	Respond to criticism less defensively by listening to part of what is being said and agreeing to the bits that may be easier to accept.
Gentle Confrontation	Once a client is calming down, gentle confrontation helps to encourage criticism in an attempt to focus not on the anger but the real reasons behind the anger. It is a technique that constructively attempts to redirect the criticism.
Being Specific	Decide what it is you want to say, and say it as clearly as possible without unnecessary padding. Keep it simple and brief. This is one of the most difficult techniques but with practice becomes easier.

Note: Compiled from Wondrak (1999, pp. 88–92).

Table 3. *Paterson and Leadbetter's (1999) Strategies for Dealing with Verbal Abuse*

Strategy	Example
Personalise	Use names and previous relationships
Paraphrase and summarise	Repeat statements, checking for understanding
Reflect Feelings	Comment o feelings and identify them: I appreciate that you are angry.
Reassure	Praise the client for expressing emotions: It is okay to be angry
Relaxation	Encourage client to use relation strategy (i.e., take deep breaths)
Involve or Divert	Redirect the client into available activities
Planned ignoring	Use this only as a part of a formal strategy
Use nonverbal skills	Convey interest and empathy by adopting an open attentive posture
If the client continues to escalate they suggest:	
Encourage dialogue	Keep the person talking
Use silence	
Use arousal	Raise your tone of voice to match theirs briefly then return to normal
Use distraction	Seek detailed information, give choices, change the focus.
Use limits	For example, "Once you stop shouting I will listen to you."
Negotiate	Avoid unnecessary confrontation. Try to gain small concessions first.
Give direction	Stop now
Use disclosure	Remind aggressor that you are a person with a family etc. and not a faceless representative of the "system"
Consequences	Inform the client of the consequences of the behaviour. Great care must be taken so that it is not perceived as a threat
Use the audience	Decide whether or not the audience is beneficial or counterproductive and act accordingly
Use humour	Apply this with caution and only if you can be reasonably sure that what you say will be perceived as funny by the client.

Note: Compiled from Paterson and Leadbetter (1999, pp. 112–114).

Verbal de-escalation is an inexact science. There are a multitude of variables at work, both internally and externally. Careful attention to practice can reduce the likelihood of violence, but it will not eliminate it. Critical analysis of incidents must occur within a nonblaming culture. The goal of an incident review is to promote learning, not assign blame (Paterson & Leadbetter, 1999). They have suggested 19 strategies for dealing with verbal abuse (see Table 3).

The Internal Experience of the Abused Nurse

There is scarce literature examining what individual nurses involved in an emotionally charged verbal interaction with a client are thinking. What are their beliefs, what meaning are they giving to the words and the nonverbal gestures? What meaning do they attach to verbal abuse? Why is a client being verbally abusive? What if anything does it have to do with the receiver of that abuse? According to Harris and Morrison (1995), “With few exceptions, very little research has been conducted in psychiatry and/or nursing to provide a greater understanding of the interactional nature of violence” (p. 204).

Anderson and Clarke (1996) identified verbal aggression as a manifestation of the fight response. An individual perceives that they are being threatened in some way. This arouses the autonomic nervous system and all physiological responses that go with it, such as anxiety, tension, and increased heart rate and blood pressure. They stated that verbally aggressive acts “release tension as an individual tries to defuse and cope with intense feelings” (p. 98). It also “is often a direct by-product of an individual’s fear” (p. 10). They pointed out, “When clients yell at healthcare providers or criticize their care, they are relieving frustration and intense feelings. Critical combative statements are

not necessarily intended as a personal attack, although it is sometimes difficult to remain cognizant of this" (p. 105). Self and Viau (as cited in Wondrak, 1999) advised that the practitioner must know and examine themselves carefully. They advised the need to know your triggers and analyze your own ways of dealing with anger and embarrassment. Even the most seasoned practitioner can be rendered speechless and defensive if the content of the verbal abuse touches on a sensitive area. Defensiveness can only lead to retaliation and further escalation of the situation (pp. 86–87).

Anderson and Clarke (1996) suggested intervention strategies very similar to other researchers. They went beyond the other literature when they suggested that, during the de-briefing and recovery period, the healthcare provider involved needs to become self-reflective about their own feelings and behaviours during the interaction. Their opinion was, "Self-examination of attitudes and feelings enhances healthcare providers' ability to apply preplanned defusing techniques and maintain self-control … when healthcare providers lose objectivity, their ability to intervene is compromised" (p. 106).

From the literature, one could conclude that the primary skill required for frontline nurses to respectfully communicate with verbally aggressive clients is the ability to short circuit their fight–or-flight response. This, of course, is a very tall order as the response is automatic and does not require any conscious permission to engage, since a sense of being threatened and the presence of fear starts this response. The frontline staff must not feel fearful or threatened. This information was reiterated throughout the literature as primary strategies for de-escalating verbally abusive clients: remain calm and confident, keep an even tone of voice, and be diplomatic (Oztunc, 2006; Rowe & Sherlock, 2005).

Belief Systems and their Impact on Interacting with Verbally Abusive Clients

Wondrak (1999) suggested, "The expression of verbal directness is a feature of the level of intimacy that exists between people. We tend to shout and express our real feelings to individuals around us whom we trust" (p. 85). He went on to suggest that patients may choose individual practitioners with whom they feel safe to express their frustrations and feelings. One of his staff identified that having a psychodynamic understanding allowed her to be objective and not personalize the attack.

Brammer (as cited in Wondrak, 1999) suggested the following six important characteristics to cope with verbal abuse: (a) an awareness of self-values, (b) the ability to analyse one's own feelings, (c) the ability to influence and act as a model to others, (d) altruism, (e) a strong sense of ethics, and (f) responsibility (p. 87). What we see around us and how we perceive events depend on our core beliefs about ourselves, the world, and our place in it. Perhaps one answer as to why so many frontline nurses appear to be inherently comfortable dealing with verbally abusive clients is that they enter into a transient psychological state that Quinn (2004) has called a fundamental state of leadership. He noted, "What we see around us depends on our own state of being. When we make deep change … we see a different world. We also behave differently. The world then reacts differently" (p. 23).

Quinn (2004) suggested that personal transformations would give rise to a more positive and productive organization. He stated, "It is possible for anyone, no matter how high or low their position, to enter an extraordinary state which I call the fundamental state of leadership" (p. ix). This state differs from a normal state in which the ego

maintains primary control. In the normal state, an individual is self-focused, internally closed, comfort centred, and externally directed. Quinn noted,

> A fundamental state of leadership is a temporary psychological condition. When we are in this state, we become more purpose driven, other-focused, and externally open.… We stop asking, What do I want? Since what we want is to be comfortable, this question keeps us in the reactive state. Instead we ask, What result do I want to create? (p. 21)

When we engage in this creative process, we get our self or ego out of the way. There is now room for the heart of who we are as individuals and as an organization to reveal itself. Our values and behaviour are more congruent. Our relationships increase in meaning, trust, and caring (pp. 22–23).

Organizational Culture

Organizational culture is defined by intangible variables such organizational identity and a collective sense of shared purpose. According to Wheatley (2006), "There is an essential role for organizational intent and identity … no person or organization can be an effective co-creator with its environment without clarity about who it is intending to become" (p. 39). Literature indicates vision, core beliefs, values, and shared purpose must be co-created with the thousands of care receivers and care providers who have a vested interest in the organization (Wesorick, 2002a). Researchers have also suggested a yearly review to make sure these important declarations remain known, current, relevant, and embedded in the culture of the organization (Wesorick, 2002a; Wheatley, 2006).

Healthcare organizations with a goal of providing quality care to the clients they serve must consciously develop a work culture that values, respects, and has the ability to retain highly skilled nurses (Aiken, Clarke, Sloane, & Sochalski, 2001; Sofield & Salmond, 2003). An interesting process framework developed by the Clinical Practice

Model Resource Centre (as cited in Wesorick, 2002a) represents the importance of culture in every initiative and aspect of organizational life. The framework for bringing new ideas or initiatives to life is entitled the "Healthy Culture Molecule" (p. 26, Figure 3) and is reproduced in Figure 1. Utilizing the Healthy Culture Molecule as a framework for service development keeps organizational culture front and centre in any change or quality improvement initiative.

H-Humanized P-Shared Purpose D-Principles of Dialogue R-Relationships I-Infrastructures S-Scope of Practice/Service C-Competency G-Integrated Competency N-Networking Councils T-Clinical Tools/Resources	The Healthy Cultural Molecule P – S – C – G | D – H – R | I / \ N T

Figure 1. Healthy culture molecule[1].

Another area of interest, as it applies to organizational culture, is the concept of polarity management. According to Wesorick (2002a), "Polarities are two values that look very different and appear to be opposites, but in fact are interdependent or connected. Each value is a pole" (p. 22). She further stated that many issues in healthcare "are not problems to be solved but a consistent dynamic that exists in our cultures" (p. 21), which suggests that the reason healthcare initiatives often fail and demoralize staff is because we are coming from a problem-solving framework of one right answer. This leads to black-or-white, right-or-wrong mindsets.

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[1] From "The Institute of Medicine Report: A Cause for Celebrations," by B. Wesorick, 2002, *CPMRC Connections, 4*, p. 1. Copyright 2001 by B. Wesorick. Adapted with permission.

Polarity management is an essential skill for successful cultural transformation. Another important consideration is: “To be successful, leaders must know how to differentiate between problems to be solved and polarities to be managed. Both are important. Both skills need to be strong” (Wesorick, 2002a, p. 24). For instance, if an employee is stealing from the company, that is a problem to be solved. There is a right solution, and that solution is likely to be: fire the individual. To take a look at polarity management, we will use teamwork versus individual work as an example. If your organization is moving towards teamwork, they might focus so much on team work they forget the individual. You may end up with group think in your team and individuals who feel isolated within the teams. The result will be less effective teams and less effective individuals. For a polarity to be managed successfully, the focus must move back and forth between the two poles—in this case, the team and the individual not losing sight of either (Johnson, 1993).

Quinn (2004) reiterated the importance of polarity management by identifying eight concepts effective leaders must be aware of: responsible freedom, tough love, reflective action, authentic engagement, appreciative inquiry, grounded vision, adaptive confidence, and detached interdependence (p. 89). Polarity management uses tension that normally exits between poles as a springboard to co-create a higher purpose. Within this concept, verbally abusive clients are not a problem to be solved, but rather a chronic dilemma; the patient is one value of a polarity to be managed, with frontline nurses being the other value. According to Wesorick (2002a), “You need the positive outcomes of both to have a healthy healing culture” (p. 23). She went on to state, “A culture that

creates the best for both those who give and those who receive care is clear about what matters most" (p. 26).

Summary

In this literature review, I explored four topics important to this research project: resilience, empowerment, verbal abuse, and organizational culture as it pertains to nurses in their place of work. Masten and Coatsworth (as cited in DiRago & Vaillant, 2007) outlined two markers used to identify resilient individuals. First, the individual must have been exposed to a threat, either in the form of high-risk status or as exposure to severe trauma. Second, the individual must show positive adaptation (p. 61). There is evidence in the literature that clinicians do show positive adaptation after stressful events time after time (Edward, 2005, p. 143), and resilience may be a skill that can be learned (Jackson et al., 2007, p. 7). In order for empowerment to occur, infrastructures in the form of information, support, resources, and opportunity must not only be offered by the organization, they must also be taken advantage of by the individual nurse (Labonte, as cited in Rodwell, 1996; Kanter, as cited in Spence-Laschinger & Sebastian, 2000).

Verbal abuse is prevalent within the nursing industry (Cox, 1987; Hader, 2008; Sofield & Salmon, 2003). I reviewed the literature as it pertained to zero tolerance to abuse policies and discussed even though there remains a continued lobby to implement this initiative (Oztunc, 2006; Sofield & Salmond, 2003) there is an equally vocal lobby of those against it (Curwin & Mendler, 1999; Holmes, 2006; Sughrue, 2003). I reviewed individual and organizational suggestions and strategies to deal with verbal abuse, as well as the internal experiences of a nurse who experiences verbal abuse and how underlying

beliefs and meaning assigned to it may impact frontlines nurse's ability to provide respectful quality care (Quinn, 2004; Wondrak, 1999).

Healthcare organizations with a goal of providing quality care to the clients they serve must consciously develop a work culture that values, respects, and has the ability to retain highly skilled nurses (Aiken et al., 2001; Sofield & Salmond, 2003). The healthy culture molecule framework (see Figure 1) can assist an organization to keep the components of a healthy organization at the forefront of their planning. An organization with a healthy culture ensures positive outcomes not only to those receiving care, but also to those giving the care (Wesorick, 2002a, p. 26). Polarity management skills are necessary to successfully address many issues within healthcare. Frontline nurses providing care to verbally abusive clients is not a problem to be solved, but two values of a polarity to be managed. All humans can and will be disrespectful or abusive at times. A respectful way of life and work needs system infrastructure and support to maintain healthy relationships between caregivers and care receivers (Wesorick, 2002a, p. 28).

CHAPTER THREE: CONDUCT OF RESEARCH

Research Approach

The research question guiding my research was: What strategies do the leadership of healthcare organizations and frontline nurses need to empower themselves when confronted with verbally abusive clients?

This project was undertaken upon the foundations of qualitative action research. Coghlan and Brannick (2005) stated, "[The] desired outcomes of the action research approach are not just solutions to the immediate problems but are important learnings from outcomes both intended and unintended, and a contribution to scientific knowledge and theory" (p. 4). This project consisted of two focus groups: one with managers and one with frontline nurses, which allowed the researcher to engage in introspective activities of inquiry and reflection with these unique viewpoints.

"Dictionaries define research as a careful and diligent search" (Glesne, 2006, p. 3). Stringer (2007) stated, "Fundamentally, action research is grounded in a qualitative research paradigm whose purpose is to gain greater clarity and understanding of a question, problem, or issue" (p. 19). "Qualitative researchers seek to understand and interpret how the various participants in a social setting construct the world around them" (Glesne, 2006, p. 4). At first glance, action research resonated deeply with me. At its core, qualitative action research consists of developing relationships with others. Palys and Atchison (2008) wrote,

> Qualitative researchers believe that understanding people's perceptions requires getting close to "research participants"…. You must spend time with them, get to know them, feel close to them, be able to empathize with their concerns, perhaps even be one of them, if you hope to truly understand. This approach directly

> contradicts the quantitative view that "objective" understanding requires aloof detachment, lest the researcher "lose perspective." (p. 10)

Another very attractive characteristic of action research is that an expert is not coming in to solve a problem or share their expertise about a particular issue. The participants are the experts about the problem or issue, and it is the responsibility of the researcher to skilfully draw out the participant stories and knowledge that currently lays latent; but, is waiting to be discovered. A defining trait of action research is that the researcher is an equal participant in the process. Reason and Bradbury (as cited in Coghlan & Brannick, 2005) stated, "Action research is a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview" (p. 3). In action research, the researcher acts as a facilitator, catalyst, and participant in the process.

Action research is a catalyst for positive social and cultural change. Any time an individual or group of individuals place attention on a particular issue, the process of change has already begun. Change is not something that needs to be rolled out in a large and grand scale. Change is emergent and can begin with conversations among small groups of people. Action research provides a forum for these conversations. Wheatley (2006), when contemplating personal and organizational change, noted, "Life demands that we participate with things as they unfold, to expect to be surprised, to honour the mystery of it, and to see what emerges" (p. 78). Action research is an emergent process of discovery. It is an iterative process of three fundamental steps, which include observation, reflection, and action (Glesne, 2006; Stringer, 2007). According to Coghlan and Brannick (2005), "Action research is about real time change; it's the story of what takes place" (p. 29). During this research process, organizational leaders and frontline

nurses had the opportunity to tell their stories about experiences and situations that involved verbally abusive clients and discussed strategies to manage verbal abuse in a healthcare setting. Reason and Torbert (as cited in Coghlan & Brannick, 2005) noted, "The purpose of academic research and discourse is not just to describe, understand and explain the world but also to change it" (p. 7).

Project Participants

Action Research Team

My advisory team consisted of 14 individuals. These individuals included: the Director of Service Development; my organizational sponsor; the Nursing Practice Leader; the Manager of Education; two Neurological Rehabilitation unit team leaders, and a recreation therapy student; an editor; a transcriptionist; my project supervisor; and three Royal Roads University colleagues who reside in British Columbia. My advisory team assisted me in research planning, organization, and the implementation of my research.

I drew on the organizational expertise of Carewest staff to help me navigate through the corporate process required for doing research. My organizational sponsor, Mark Ewan, met with me frequently to discuss issues or share progress. My project supervisor provided the advice and guidance about the academic requirements of the project and advise with respect to themes identified in my data. The unit team leaders were to act as scribes during the focus groups, but there was an emergency on the unit. At the last minute, they were replaced by a Recreation Therapist with an interest in research and her student. My Royal Roads University colleagues helped with data collection and interpretation and gave me a variety of viewpoints on various topics that enriched and

enhanced my learning experience. My colleagues also helped to me identify researcher bias and move me away from thought processes that inhibited the action research process. I hired a transcriptionist to transfer the data from the audio recorder to typed text.

Project Participants

For this particular research project, I engaged in what qualitative researchers call purposeful sampling (Glesne, 2006). According to Patton (as cited in Glesne, 2006),

> The logic and power of purposeful sampling … leads to selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research. (p. 34)

This research project recruited organizational leaders and frontline nurses interested in exploring the issue of verbal abuse against nurses. It targeted managers who have ideas and opinions about verbal abuse, at an organizational and individual level, and would like to share their knowledge. The secretary for the client service managers sent out letters of invitation to all Carewest managers and frontline nurses (see Appendices A and B). She also sent out the consent form for individuals to review (see Appendix C). She emailed posters to all managers at Carewest so they could be posted on their units for individuals who did not have internet access or that did not access their email in a timely way (see Appendix D). Interested individuals were instructed to contact the secretary if they were interested in participating and to contact myself if they had questions regarding the research. Individuals were made aware that there were only 10 spaces, and participants would be selected on a first-come/first-served basis. The secretary gave me the list of confirmed participants three days prior to the focus group.

The manager's group consisted of 7 individuals. Four of these individuals hold a management position on a care unit. Their unit management experience varied from a few months to more than 10 years. The managers were between the ages of 35 to 50. There was one male in the group. The remaining three individuals work within the business enabling portfolio at Carewest. Two individuals had greater than 10 years of experience in their field and with Carewest. One individual had less experience in her field, and she has been with Carewest less than 2 years. In order to maintain their privacy, I will not disclose their positions.

The research also targeted frontline nurses who interact in a positive and effective manner with individuals who are verbally abusive. They were either noted by others or declared by themselves to provide respectful care to verbally abusive clients time after time. The frontline nurses' focus group consisted of 9 frontline nurses with varying degrees of experience as nurses. Their ages ranged between 30 to 50 years of age. Experience as a nurse ranged from 10 to 30 years.

Research Methods and Tools

This research project utilized focus groups as its method of data collection. Stringer (2007) wrote about focus groups:

> The most successful and productive action research occurs where individual participants have the opportunity to talk extensively about their experiences and perceptions. Interview processes enable people not only to reveal the issues and agendas but also to reflect on the nature of events that concern them. (p. 87)

I held two one-hour focus groups. I chose the focus group to allow participants to build on each other's knowledge and experience through a facilitated, dynamic, conversational process. Prior to the commencement of the focus group, participants read and signed a consent form (see Appendix C). The contents of this form were discussed,

and any questions participants had were answered before the start of the focus group. Within the focus group, I used a talking stick to maintain structure and to allow individuals to speak without being interrupted. I explain the talking stick later in this section. Focus groups have advantages over other research methodology when combined with a purposeful sample of participants. Palys and Atchison (2008) stated,

> Focus groups may provide provocative and/or insightful information to the exploratory researcher who is … interested in determining issues of importance to those in a research setting or in acquiring new insights about the phenomenon from those who have experienced it. (p. 159)

The focus group questions were carefully designed around the appreciative interview and inquiry methodology, which shifts the focus around to what is working well (see Appendices E and F). Through the process of appreciative inquiry, I drew out their stories, knowledge, and experiences. By sharing these stories with their colleagues and collecting this information through the process of action research, we were able to add to the scientific body of knowledge in providing quality care to verbally abusive clients. Coghlan and Brannick (2005) wrote, “Attending to experience is the first step to learning. The second step is to stand back from these experiences and inquire into them” (p. 34). Through probing questions and structured conversation during the focus groups, patterns and themes emerged.

Faure (2006) noted, “Without the energy and optimism created through inquiry into each individual’s most successful experiences, you do not have an AI [appreciative inquiry] process. It is, therefore, important to design the interviews with care” (p. 28). Prior to the focus groups, I gave careful consideration to the development of questions, from general inquires about the topic being researched to probing questions. I developed

a draft of the research questions and then piloted them with my research advisory team. Eight of these individuals provided feedback on the questions. I looked for general themes or concerns from the feedback about the questions and made modifications as necessary.

My role in the focus group was that of facilitator. I clearly articulated the ground rules of the focus group. I indicated to participants that each person was expected to participate in the dialogue. I also indicated that participants should be respectful and nonjudgmental of each other. I advised them they could leave at anytime and return if they desired. I referred to a written poster on the wall about appreciative inquiry, and we reviewed the need to focus on strengths at both the individual and organizational level. All participants signed a consent form (see Appendix C) prior to participating that included consent to audio record the session.

In order to capture the focus group conversation accurately, I had two tape recorders running and included the use of a talking stick (shoehorn/backscratcher) to prevent individuals from talking over top of one another. Fujioka (1998) noted, "The talking stick was a method used by native Americans, to let everyone speak their mind during a council meeting, a type of tribal meeting" (The Talking Stick is based on Native American Tradition section, ¶ 1). The talking stick created a blending of the learning circle and a focus group format. McKenzie (2003) noted, "A learning Circle format provides a forum for inclusion, deep listening, and honouring our diversities a safe haven for true dialogue" (¶ 1). She further wrote, "The goal is for everyone to have equal value in the workplace, for every voice to be respectfully heard, and, for people to share a common intention or purpose" (¶ 2). The utilization of a talking stick in the focus group

allowed individuals to respectfully listen to others and honour their colleagues' stories by not interrupting or speaking over them. The individual with the talking stick was the only one allowed to speak. Individuals who wanted to follow up, comment, or introduce a new topic raised their hand to receive the talking stick. This allowed ideas to flow, but in a more controlled manner. I also gave all participants an evaluation form that asked for feedback about my facilitation style (see Appendix G). The evaluation form also included space to further expand on a concept or strategy they introduced during the session and wanted to elaborate on but time ran out.

During facilitation of the discussion, I ensured all individuals had the opportunity to participate. I observed the group dynamics closely and intervened when I saw individuals who were not as confident in raising their hand, but appeared to have something to say. I would then reclaim the talking stick and pass it to that participant so they could speak. I also directed the dialogue by asking probing questions when required, but allowed the data to emerge as the dialogue unfolded.

I had scribes at each focus group whose responsibility was to capture ideas and themes on a flip chart. This served to capture data and allow participants to have a visual record of what they had been discussing. I also had the definition of resilience, empowerment, and verbal abuse on posters hung on the wall to further inform the discussion (see Appendix H).

Data Analysis

Data analysis consisted of reading and rereading transcripts, identifying themes and patterns, and categorizing them into an informational format. According to Glesne (2006),

> Data analysis involves organizing what you have seen heard, and read so that you can make sense of what you have learned. Working with data, you describe, create explanations, pose hypothesis, develop theories, and link your story to other stories. To do so you must categorize, synthesize, search for patterns, and interpret the data you have collected. (p. 147)

I began to analyze, theme, and codify data collected from the focus group immediately upon receiving the raw data. Wolcott (as cited in Glesne, 2006) discussed "*description, analysis* and *interpretation* as three means of data transformation or of moving from organization to meaning" (p. 164). The analysis of this data was done by finding general themes or threads that move between participants as they describe their experiences and tell their stories. Once these themes were identified, comparisons were made to the information and knowledge revealed during the literature review. Contrasts and comparatives were done to either validate the data or formulate further questions or hypothesis.

Another important aspect of data collection and analysis was my researcher log. Through my researcher log, I was able to reflect on the research process as it unfolded. Glaser and Strauss (as cited in Glesne, 2006) referred to these logs as memos. They stated that "by writing memos to yourself or keeping a reflective field log, you develop your thoughts; by getting your thoughts down as they occur, no matter how preliminary or in what form, you begin the analysis process" (p. 148). It was important that my thoughts and insights about the process or implications of the data collected were captured, so I carried a digital tape recorder. I listened to the ideas I had taped prior to and during the analysis of the data. For quick reference and reminders, I typed highlights and quotes from the information I recorded about my thoughts on the literature and the conversations that occurred during the focus groups. These thoughts and reflections were an important

part of the data analysis process, as I grappled with making sense of all the notes and information I had collected from the focus group.

Ethics

Ethical considerations must stay front and centre in the mind of the researcher during all stages of a research project. According to Palys and Atchison (2008), "'Research ethics' refers to principles that guide the way we interact with research participants and the commitment to safeguard their rights and interests" (p. 69). Walker and Haslette (as cited in Coghlan & Brannick, 2005) grounded the issues of ethics in the action research cycle of planning, action, and reflection (p. 76).

This project makes recommendations about organizational frameworks for building competencies and providing emotional support for nurses around the issue of verbal abuse. A large area for ethical consideration involved the nature of relationships with research participants. "Ethics must be considered in everyday interactions with research participants and in your data" (Glesne, 2006, p. 129). Participants' emotional well-being was safeguarded through the entire research process.

A very important component of action research is the relationships that exist between all the participants, including the researcher. According to Coghlan and Brannick (2005), "The researcher looks at the possible effects of the inquiry on the participants, the self of the researcher and on the potential future of the relationship between the researcher and participants" (p. 77).

It is very difficult to guarantee anonymity in the acquisition and development of new knowledge. Action research is a dynamic and fluid process. While some areas of confidentiality of information gathering may be very clear cut, other information needs to

be open and shared. Clear identification of information that was going to be considered confidential, and information which was not, was clearly communicated through the letters of invitation (see Appendices A and B), consent form (see Appendix C), and discussion with participants prior to the beginning of the focus group. My research advisory team signed a letter of agreement (see Appendix I).

The letter of agreement included a corporate confidentiality and nondisclosure clause. The research advisory had no no access to confidential information in this research project. This research project required an ethics review; therefore, I, as the researcher, abided by the ethical procedures and processes set out by the Tri-Council Policy Statement (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada [Tri-Council], 1998) and the Royal Roads University (2007) *Research Ethics Policy*. These policies refer to eight guiding ethical principles: respect for human dignity, respect for free and informed consent, respect for vulnerable persons, respect for privacy and confidentiality, respect for justice and inclusiveness, balancing harms and benefits, minimizing harm, and maximizing benefit (as cited in Royal Roads University, 2007, Section D, ¶ 2). I was aware of the concerns and issues underlying these guiding principles and weaved strategies and processes into the research design to address them. Action research is an emergent and inquiring process that often finds its own path of discovery. Although careful thought and examination of the guiding principles helped to minimize, mitigate, or prevent any harm that could have potentially occurred, I will briefly touch on the eight principles and outline specific strategies I implemented during my research project to safeguard participant rights and interests.

Respect for Human Dignity

Maintaining the human dignity of participants is a researcher's number one priority. According to Cheshire (2002), human dignity is "the exalted moral status which every being of human origin uniquely possesses. Human dignity is a given reality, intrinsic to the human substance, and not contingent upon any functional capacities which vary in degree" (¶ 19). Human dignity must be maintained throughout the project.

In order to maintain human dignity, I modeled behaviours and demonstrated that I valued and respected all participants by listening carefully to all ideas and viewpoints. I was empathic and validated participants' emotional responses to incidents of verbal abuse. I embraced, was curious, and inquired further into points of view that were different than my own. I showed appreciation to my participants through praise and by saying thank you. By utilizing the appreciative inquiry methodology, I empowered the participants and showed respect for their stories. Respect for human dignity is a concept that envelops all other ethical principles.

Respect for Free and Informed Consent

In this action research project, informed consent of participants was obtained prior to the start of the focus groups. I provided research information to participants in a clear, honest, and forthright manner. This information was given orally and in written form (see Appendix C). I developed a brief overview of the project, its purpose, goals, and expected duration. This information was given to each potential participant, and it was also reviewed with the chosen participants at the focus group. A written consent form was developed, and each participant signed it prior to participation in the research (see

Appendix C). The written consent was supplemented with an oral explanation of consent at the onset of the focus groups.

All persons invited to participate in the research project were fully informed, to the best of the researcher's ability, about the nature of the project, the potential difficulties they may encounter, as well as the potential benefits from the project. Diener and Crandall (as cited in Glesne, 2006) identified three points that must be included when considering informed consent "1) that participation is voluntary, 2) of any aspects of the research that might affect their well-being, and 3) that they may freely choose to stop participation at any point in the study" (p. 132).

Action research is emergent in nature; therefore, informed consent is a principle that was addressed prior to the project start and then revisited as required throughout the research process. Participants were advised that they could withdraw from the research project at any point in the process without prejudice. Up until the point that the data were themed, their comments and contributions may have been extracted. Beyond that point, it was not possible.

Respect for Vulnerable Persons

A vulnerable person is an individual with decreased decision making capabilities (Tri-Council, 1998, p. i.5). The participants of my research project were registered nurses, licensed practical nurses, registered psychiatric nurses, and human resource professionals. They are highly skilled and competent individuals. There was no involvement of vulnerable participants in this research project.

Respect for Privacy and Confidentiality

Privacy and confidentiality are primary ethical considerations for this project. This research project explored and enhanced competencies and emotional resilience around the issue of verbal abuse, which is a highly sensitive topic. I made efforts to ensure participants felt secure that the confidences they shared would be safeguarded by the researcher. No names were used in the focus group, and all data collected were kept in my home in a locked office and destroyed within 6 months after the research was completed.

In the focus group, all participants' confidentiality was protected by specific ground rules and expectations prior to the beginning of the conversations. During the focus group, participants were assigned a letter of the alphabet. Participants introduced themselves by using their assigned letter. I used this letter to ask follow-up questions or direct comments to a specific individual. This allowed for anonymity of information in the tape recorded data. Participants were asked to identify their stories, each other, and individuals contained within their stories by generic identifiers, such as: young man, middle-aged woman, and so forth. Participants in the group were asked to mention no one by name or by position within the organization.

Discussion of the process and the learning during the process was encouraged outside of the group, but participants were asked to agree that any specific identifiers or specific opinions remain confidential. My initial intention was to hold a post-project meeting and all information revealed in the final document was to be disclosed to the group. Due to a change in my personal circumstance, I emailed chapter 4 (Analysis of the Data) to all participants of the focus groups. I indicated they could read the chapter and

phone me with any concerns or if they wanted to meet with me in person I would arrange for that. There were no concerns raised by any of the participants regarding privacy, confidentiality or the contents of chapter 4 (Analysis of the Data).

In order to maintain confidentiality, I was always aware of what context and role I was in when individuals shared information with me. I have multiple roles (i.e., manager, peer, and principle researcher). Palys and Atchison (2008) wrote,

> The best way to inspire confidence in research participants is to show them how vigilant you are in safeguarding the information others give you; it tells them that you will show the same vigilance with their information and that they really can trust you. (p. 77)

As I am the manager of a large healthcare unit, there are frontline nurses who were appropriate for this study, but I did not want my position to influence their decision to participate or for others to think I was picking favourites. I put up posters (see Appendix D) informing nurses of the upcoming research and allowed them to self-select by forwarding their name to the Fanning Client Service Manager's secretary. The Fanning secretary emailed out research project details to potential participants and send them an invitation (see Appendices A and B). The invitation indicated that I was not aware of who received an invitation, and participant names would not be disclosed until the participant had received confirmation of their acceptance. Therefore, there was no concern of negative repercussions for not participating. There were only spots for 10 participants, and they were assigned on a first-come/first-served basis. We did not fill all 10 seats, but upon my direction, the Fanning secretary passed the list of participants to me for follow up.

As previously mentioned, the privacy and confidentiality of data gathered through the focus groups was maintained by the use of assigned letters of the alphabet to each of

the participants. I kept the master list of names and their assigned alphabet letter locked in my home office. This enabled me to clarify information if necessary, while at the same time maintaining their privacy and confidentiality to the best of my ability. Any summaries or publication of the data collected does not include identifying information.

Justice and Inclusiveness

Justice speaks to the fact that no individual or group should unfairly be harmed in the pursuit of knowledge. Alleged perpetrators of verbal abuse could potentially be harmed if their identity did not remain anonymous and well-disguised during the research process. Guidelines were discussed to ensure that alleged perpetrators of verbal abuse were disguised by location, personality identifiers, behavioural identifiers, diagnosis, and gender.

Inclusiveness refers to the concept that we should not exclude individuals who could benefit from the knowledge or experience. Nurses are not the only individuals who find themselves at the receiving end of verbal abuse. Physicians, security, unit clerks, housekeepers, and foodservices, as well as other departments, can be adversely affected by verbal abuse. Given my inexperience at doing research and the potential size through including all these departments, I chose to maintain my focus on the discipline of nursing. Seeking to understand how other departments within the healthcare industry deal with verbal abuse is very important information to gather in future research projects. I believe the results revealed in this research project may be generalized to other groups within Carewest and the healthcare industry as a whole.

Balancing Harms and Benefits, Minimizing Harm, and Maximizing Benefit

In order to balance harms and benefits during this action research project, I created a safe environment in which the topic of verbal abuse against nurses could be openly and candidly shared while protecting nonparticipants' anonymity (Tri-Council, 1998, p. i.6). Action research often unfolds directly in front of you. It can be unpredictable and take you down a road you were not expecting and confront you with harms, benefits, or both that you had not foreseen. To the best of my knowledge, this did not happen during this research process.

Effective relationships are critical in minimizing harm and maximizing benefits of an action research project. Action research is built on participation of the individuals within the organization being studied and the relationships that are built during the process. Rowan (as cited in Stringer, 2007) believed that, in action research, "ethics involves authentic relationships between individuals, groups, organizations and communities" (p. 77). Strengthening and maintaining right relationships between numerous players within the organization was crucial to the success of this research project and adherence to this very important principle.

In this particular project, the discussion of past incidences of verbal abuse could have evoked strong emotional reactions. In order to minimize harm during the research project, I facilitated the creation of a safe environment for the disclosure of sensitive information. I attended to the physical environment by having everyone seated around a rectangular table: positioning themselves so that they could see everyone and everyone could see them. I asked them to look at the person with the talking stick who is speaking and not at me. I verbalized my expectation that everyone would contribute to the

conversation. I was transparent regarding how I directed and redirected the conversation to balance those individuals who were comfortable speaking in a group setting and those who required more time to verbalize their thoughts. As a facilitator, I allowed space for individuals to check in at the beginning of the process and periodically throughout. I advised them that they could leave the room any time they become uncomfortable and return at anytime they would like.

I role modelled openness and flexibility by sharing my own story and why I am interested in this research topic. I provided empathy as required and asked gentle questions regarding emotional impacts of events to help surface feelings this discussion might evoke. I indicated that I valued everyone's contributions by saying "thank you" after they spoke. Williams (2004) put forward, "Accepting and valuing everyone's contributions leads to the entire group feeling included and respected" (p. 95). When I asked clarifying questions, I was cautious that it was phrased appropriately so that it did not come across as a criticism. I openly and honestly answered questions that were asked of me.

Stringer (2007) suggested the researcher remain mindful of "the possible effects of the inquiry on the participants, the self of the researcher and on the potential future of the relationship between the researcher and participants" (p. 77). All participants honoured each other's experiences and how any and all experiences have impacted them by remaining engaged in the process. I quickly attended to any emotional content or relationships that appeared to be strained and deliberately focused on bringing harmony back into the environment. I utilized a talking stick during the focus group to enable individuals to speak without being interrupted.

If I believed ground rules were being breeched or the emotional tone between individuals was becoming strained, I took the talking stick and used my skills as a facilitator to mediate. I did a post-process check with each participant immediately after the focus groups. Participants were made aware that, if they had unresolved emotion or feelings about the process or any of its content, they could access one-to-one de-briefing time with me or my project sponsor, Mark Ewan. Right relationships and a safe psychological research environment will help to maximize the benefits of this project.

Verbal abuse is prevalent in the healthcare industry and is often directed at nurses. It is an area that causes much discomfort and distress in a nurse's day-to-day work and negatively impacts an organization's workplace culture. It increases absenteeism and causes increased staff turnover (Rowe & Sherlock, 2005; Sofield & Salmond, 2003). This research project allowed participants to discuss skills and strategies they use to address the issue of caring for themselves and clients who are verbally abusive. The information retrieved from these discussions around the issue of verbal abuse provided untapped knowledge and expertise in this very important area. Assimilation and distribution of this knowledge to Carewest leadership and other healthcare organizations will further the discussion of this issue. The next chapter will provide the findings and conclusions brought forward as a result of this research.

CHAPTER FOUR: RESEARCH RESULTS AND CONCLUSIONS

Introduction

The purpose of this research project was to answer the research question: What strategies do the leadership of healthcare organizations and frontline nurses need to empower themselves when confronted with verbally abusive clients? Sub questions include:

1. How do Carewest Leadership and other healthcare organizations empower themselves and their nurses to provide quality, respectful care to verbally abusive clients?
2. What philosophies, beliefs, attitudes, and societal trends empower (or could empower) Carewest, other healthcare organizations, and nurses to provide quality care to verbally abusive clients?
3. What empowers frontline nurses to be resilient and at peace when providing care to verbally abusive clients?

This project was undertaken upon the foundations of qualitative action research utilizing appreciative inquiry methodology. I engaged in a process called purposeful sampling for participant selection. According to Stringer (2007), purposeful sampling "consciously selects people on the basis of a particular set of attributes … that major attribute is the extent to which a group or individual is affected by or has an effect on the problem or issue of interest" (p. 43). The major attribute of participants selected for this research project was their interest in and effect on providing respectful care to verbally abusive clients within the healthcare industry. In order to maintain anonymity, I will cite

all participant quotations from the nurses' focus group as Nurse Focus Group and all quotations from the managers' focus group as Manager Focus Group.

Study Findings

In this chapter, I discuss the themes from the frontline nurses' focus group and the managers' focus group separately. These themes (or findings) are supported by my research data. In the study conclusions, I compared responses from both focus groups with references to the literature to validate the research findings. The scope and limitations of the research are also discussed.

Demographics

The frontline nurses' focus group consisted of 9 nurses with varying degrees of experience. Their ages ranged between 30 and 50 years of age. Experience as a nurse ranged from 10 years to 30 years. The manager's focus group consisted of 7 individuals. Three of these individuals hold a management position on a care unit, and three individuals hold positions in business enabling. Their management experience varied from a few months to more than 10 years. The managers were between the ages of 25 to 50.

Frontline Nurses' Focus Group

This research project focused on frontline nurses that perceived themselves, or were perceived by others, as having a high level of knowledge or expertise while caring for verbally abusive clients. They present themselves as being empowered and resilient in this area. The focus group format provided nurses with a forum in which to engage in conversation. They revealed their philosophies, beliefs and attitudes about caring for clients that are verbally abusive. Together they explored why they believed they are

successful caring for verbally abusive clients. They also discussed what organization wide considerations and initiatives could provide support to nurses. The themes found within the data from the frontline nurses' focus group were emotional intelligence, personal style, trust and relationships, organizational strategies, and education and training.

Emotional Intelligence

The data revealed that emotional intelligence is an important component of effectively dealing with verbally abusive clients (see Figure 2). The participants did not use the term emotional intelligence explicitly, but approximately 25 minutes of a one-hour interview discussed philosophies, beliefs, attitudes, and strategies that are strongly correlated with the concept of emotional intelligence. Two participants put forward the importance of knowing their own emotional state. As an example, one participant noted, "My emotional state of mind is very important coming here [to work] in the morning. I get up and pray, I am very religious and this calms me down."

All participants of the frontline nurses' focus group discussed specific strategies they used to manage their own emotional responses. Not to personalize the abuse was the most frequently used strategy. This strategy was mentioned by 6 out of 9 participants.

> Don't personalize it. Realize they're probably coming from frustration and anger about something completely unrelated to you. (Nurse Focus Group)

> I am not going to personalize it, I am going to get what the meaning is, the message. (Nurse Focus Group)

Out of 9 participants, 4 noted that they managed their emotions by recognizing that a client's anger is displaced and has an underlying cause. This belief allows them to detach themselves from the verbal abuse. One participant stated, "The first thing I would

do is to really explore the underlying problem." Another noted, "There is likely an underlying feeling of loss of power and if you can get to the root of that give them some sense of choice and power over what's happening" (Nurse Focus Group). Two participants also mentioned that monitoring internal dialogue was important. When asked what they said to themselves when dealing with a verbally abusive client, one participant stated, "I think it's not about me." Another noted, "They're attacking my role as a nurse, they are not attacking me" (Nurse Focus Group). Two participants indicated self-reflection about their own feelings and behaviours are important:

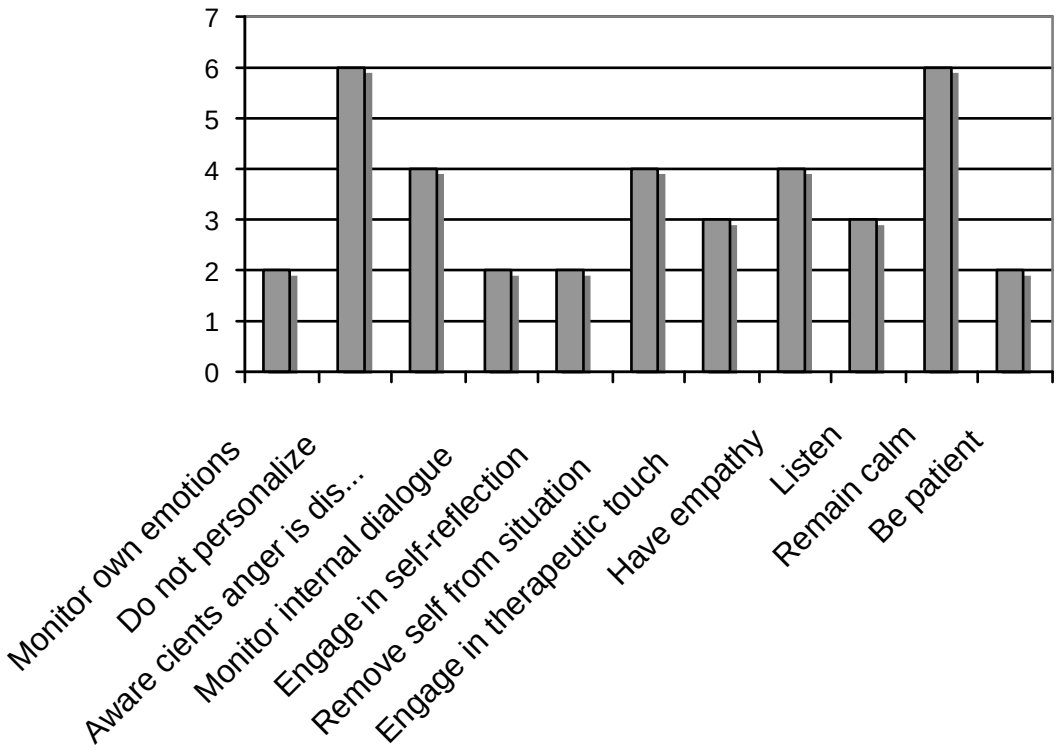

Figure 2. The number of frontline nurse participants that mentioned emotional intelligence indicators (n = 9).

> On my way home I think about how I handled it, how could I have handled the situation better. (Nurse Focus Group)

> Did I get the outcome I was hoping for? How am I feeling about what happened? (Nurse Focus Group)

The data revealed the need to remain calm, have patience, and listen during an interaction with a verbally abusive client. Discussion about these strategies took up approximately 10 minutes of the total 25 minutes spent on the emotional intelligence theme. Remaining calm was mentioned by 6 participants. In response to a client who was having a verbal outburst, one participant stated, “You talk to them, and you’re counteracting with calm.” Another participant recounted a time in which a client was swearing and yelling; she stated, “I remained calm through it.” Two participants put forward that patience is important in emotionally charged situations: “You have to have a lot of patience when dealing with verbally abusive clients” (Nurse Focus Group). Two participants noted that the ability to listen was important when caring for an abusive client.

> First thing I would say, “I’m listening. What is the problem? (Nurse Focus Group)

> When I am confronted with an aggressive or upset patient I just kind of step back, listen to what they are trying to say. (Nurse Focus Group)

Four nurses identified taking time out, or removing themselves from the situation temporarily, often gave the client time to calm down. One participant stated, “Sometimes leaving the situation and returning later takes care of it.” Another noted, “I come back later, give meds out then come back.” Three participants noted the importance of touch: “I think also just a therapeutic touch we need contact we need touch” (Nurse Focus Group). Three participants talked about distraction or diversion as a strategy to use when de-escalating verbally abusive clients: “I changed the subject to something I knew he was interested in” (Nurse Focus Group).

Only 2 participants explicitly mentioned empathy or being empathic was within the data. One participant stated, “I would be empathic, sympathetic, understanding, kind and get to the root of the problem.” Another noted, “I empathized, it must be really difficult to be in this room, to be locked up” (Nurse Focus Group). The need to be empathic could be inferred from statements by 2 other participants:

> Picture yourself in that situation, any day, any moment, we can be in the same situation. (Nurse Focus Group)
>
> I think, what is he feeling? (Nurse Focus Group)

Personal Style

The term personal style was not discussed explicitly, but the data revealed three attributes and five skills that are utilized when interacting with verbally abusive clients. These attributes and skills reflect the participant’s personal style when confronted with an emotionally charged interaction (see Figure 3). This discussion took up 10 minutes of the hour-long focus group.

Confidence was identified as the most important attribute. The need for confidence was mentioned by 6 of the 9 participants. One participant stated, “First and foremost, I bring to the situation, belief in myself and self-confidence.” Another participant stated, “I’m helping, I can handle this, I have the ability, that’s my empowerment.” Yet another participant noted, “I will be able to assess the situation and know what to do, I’m capable.” The need for high self-esteem was referred to by 3 participants. One participant stated, “I think it’s really important to feel good about myself and look after myself.” Another participant noted, “It’s important not to let them [abusive clients] knock down your self esteem.” Two participants put forward the need to optimistic and positive: “I always go in with a positive attitude and give the patient the

benefit of the doubt" (Nurses Focus Group). One participant stated, "You need to have a sense of humour to deal with the situation and if used appropriately it can also help diffuse a tense situation." Another participant thought honesty was important: "You need to be genuine, everybody recognizes openness and honesty." Yet another participant recognized respect as necessary, "No matter what, you always need to remain respectful."

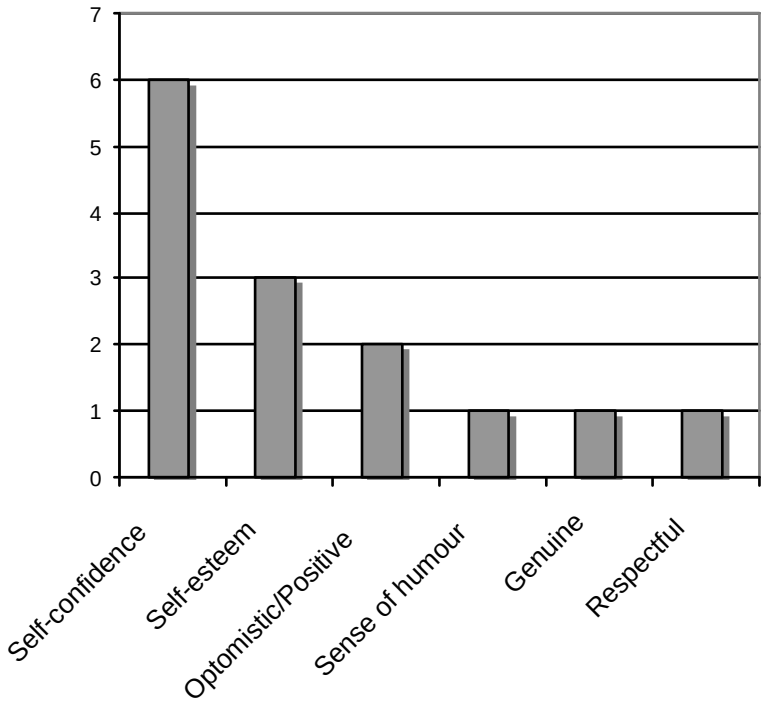

Figure 3. Attributes identified by the frontline nurses' focus group.

The data obtained from the frontline nurses demonstrated six skills that are utilized when de-escalating verbally abusive clients (see Figure 4). Three participants talked about distraction or diversion as a strategy to use when de-escalating verbally abusive clients: "I changed the subject to something I knew he was interested in" (Nurses Focus Group). Three participants spoke about the need for choices: "The way we got him around was to make him realize that he had choices" (Nurses Focus Group). Two

participants noted the importance of setting limits: “We need to set limits, make them aware of their own behaviour” (Nurses Focus Group). One participant stated, “You need to know when to speak and when to remain silent.” Another participant put forward the need to find points on which you could agree: “I agreed with him about the unfairness of the situation.” The same participant also stated, “I felt comfortable to disagree with him when I felt that it was important.”

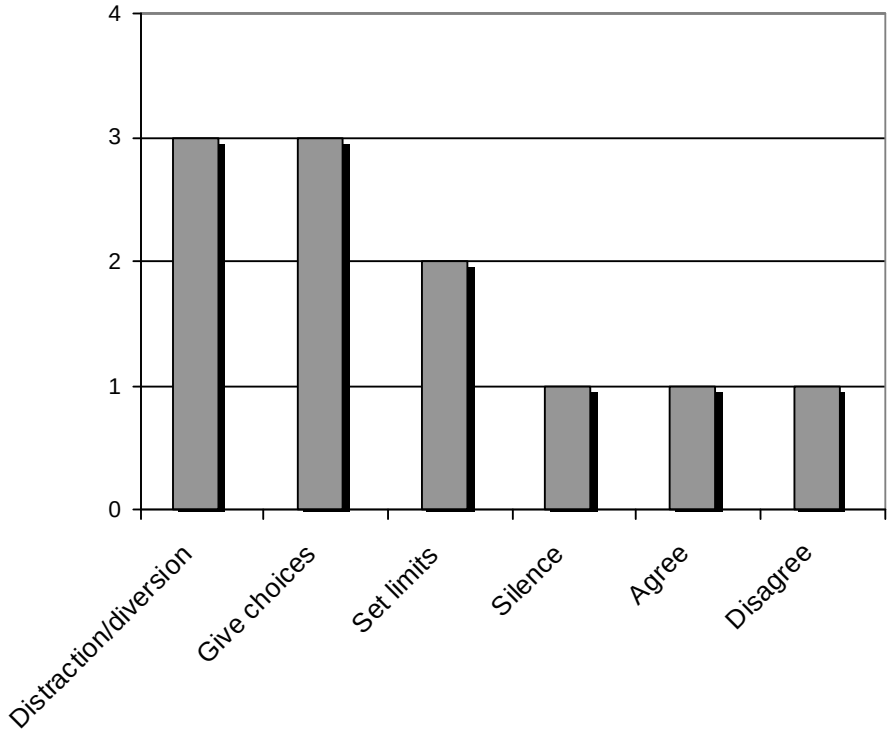

Figure 4. Skills identified by frontline nurses focus group.

Trust and Relationships

Of 9 participants from the frontline nurses’ focus group 3 mentioned the concept of trust and supportive relationships. Five minutes of the group discussion revolved around the importance of the nurse’s relationship with their manager and colleagues. When discussing the importance of a supportive and involved manager, one participant

shared a story about how the support of a manager empowered a nurse to effectively deal with a verbally abusive client. Through the manager's mentoring and coaching the nurse improved her skill set and gained confidence in dealing with the situation:

> The manager talked to the client first of all and then also talked to this nurse who was on the verge of quitting. She convinced her that he wasn't it wasn't personal and that she was bigger than that, and she could rise above it and she did. I see her carrying that strength all the time now. (Nurse Focus Group)

The participants identified the importance of trusting relationships among team members: "When you can act as a team and trust each other as a team, I think that you stand a better chance against verbal abuse" (Nurse Focus Group). The data revealed that the relationship the frontline nurses have with the physicians can also have a positive impact on the ability of the nurse to provide care to abusive clients: "It really was helpful when the doctor providing care thought I was doing a fantastic job. Her being supportive of me really helped" (Nurse Focus Group).

The data also identified that to be effective in de-escalating a verbally abusive client a nurse needs to build a trusting relationships with them. One participant stated, "If I'm confronted with an aggressive or upset patient I just kind of step back, listen to what their trying to say … try to get them to trust me." Another participant noted, "When the client trusts you, they know who they can go to, you help them."

Participants of the frontline nurses' focus group identified that acknowledgement was an important aspect of forming positive relationships with their managers and their colleagues. When discussing managers one participant put forward, "Reward a job well done … good job, you handled that so well, I am proud of you." In speaking about colleagues one participant noted, "Acknowledge them, let them know you're behind them 100%." Another participant went further into the issue and suggested that

"acknowledgement can be given beyond leadership. It can be built into the program in a systemic way … make it part of a culture." This participant also suggested dealing with abuse is an issue that could be brought up at report, "kudos go to 'A', 'B' and 'D' because they have some really difficult families to deal with this week."

Organizational Strategies

When frontline nurses were asked about what Carewest was doing in regards to workplace culture or verbal abuse, they could not articulate any specific initiatives. Zero tolerance to abuse was discussed by 6 of the participants as they knew about this organizational strategy from past work experience. This discussion took of 5 minutes of the hour-long focus group. One participant who worked within a zero tolerance framework perceived their experience as negative: "It sounds fine to say we don't tolerate abuse, but when it does happen, and it happens a lot, there is no support for staff … you lose faith in management." Another participant pointed out, "How can you really say no abuse when their [the clients] behaviour is part of their psychosis … you have to kind of try to diffuse that situation." One participant described their program's decision to opt out:

> In the clinic where I work, we have chosen not to put signs up. As a staff group, we discussed it and have our managers backing. Just our philosophy is a little bit different. We feel that the message is better heard face to face to the people that actually need to hear the message.

Two participants who had not worked under the zero tolerance umbrella thought zero tolerance to abuse signs would be positive: "I think staff feel good knowing that there's a sign, knowing that their supported, whether there is actually follow through or not." When questioned about what impact zero tolerance to abuse has on workplace

culture, one participant put forward, “Well I think that the idea is great but it has no meaning or validity to it when it is not honoured.”

Participants were asked about particular situations in which clients or families received concrete sanctions for inappropriate behaviour under the zero tolerance policy. One participant spoke to two experiences: “If it’s visitors, you can have them removed from the facility. You can tell them you’re calling security and have them removed.” She also mentioned, “Physicians can be very supportive and threaten to discharge patients.”

Education and Training

Education and training was the organization-wide strategy mentioned most often within the data. This strategy was suggested by 7 out of the 9 participants in the nurses’ focus group and took up to 10 minutes of the one-hour focus group. The nurses were asked: What is the best you can imagine from your organization and its leadership as you provide care to verbally abusive clients?

Education specific to the skills required to care for verbally abusive clients was suggested by 5 of the participants in the group. One participant stated, “I think that creating a competency program for interpersonal relationships, conflicts, verbal abuse and verbally abusive clients.” A second participant stated,

> We aren’t the psych unit. We are not expecting these behaviours. The staff aren’t trained. I think in an optimal situation the staff should be trained … I feel that they’re just being left to deal with patients that are totally out of their realm of knowledge. I think that’s really unfair. I think that organizations should help those staff.

Another participant warned others not to assume because a person works in psychiatry that they have skills in de-escalating verbally abusive clients: “To presume that a group like psych nurses have these skills is a false lead … there are great role

models and those with really poor behaviours." Two participants in the group discussed the need for education about specific disease processes:

> Everybody was educated to deal with MS [multiple sclerosis]. All of the sudden we have an influx of brain injury people that are verbally abusive. Are the [nurses] emotionally and psychologically prepared to deal with these people? So that's where education I think is number one. (Nurse Focus Group)

One participant spoke to the extensive education she received in school and the positive impact it had on the ability to intervene with verbally or physically abusive clients:

> Over a three-year program, one afternoon every week we spent with actors which came into our college and we had recorded interactions with these actors or actresses role-playing difficult situations. And then we were up for peer critique afterwards and we'd take the tapes home with us and critique our own performances. So we had lots and lots of role-playing which took the scariness out of all that type of stuff, whether it's somebody whose combative, swinging a chair around or somebody who threatens your life. We were prepared, when we left school, for that type of stuff.

The other 8 participants received no formal training about dealing with verbal abuse in the healthcare industry or how to de-escalate a verbally abusive client.

Managers' Focus Group

This research project focused on managers that were interested in discussing how to empower frontline nurses and the organization as they strive to provide quality respectful care to verbally abusive clients. The focus group format allowed managers to have a conversation about what resources and initiatives are currently in place to build individual and organizational resilience. Managers also had the opportunity to share information about what resources or initiatives they would like to see in the future. The research data indicated the managers' focus group themes (findings) as emotional intelligence, managerial support, organizational resources, and education and training.

Emotional Intelligence

Managers were asked the question: What philosophies or beliefs empower us to be resilient and at peace when confronted with verbally abusive clients? Although managers did not use the term emotional intelligence, they made indirect reference to the concept (see Figure 5). Discussion around concepts related to the emotional intelligence theme took up 10 minutes of the one-hour focus group.

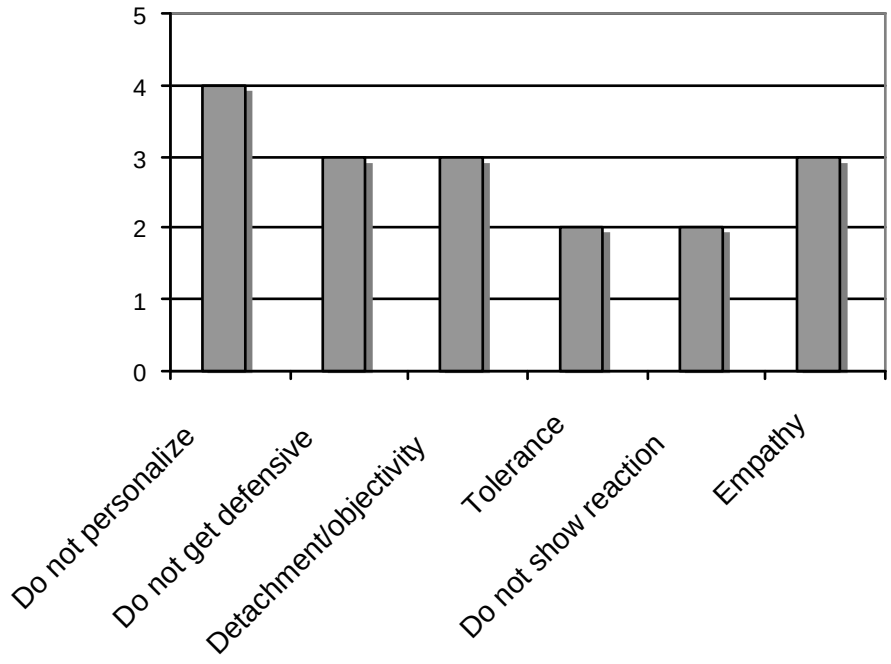

Figure 5. Managers and emotional intelligence: The number of participants that made reference to a specific emotional intelligence trait (*n* = 7).

Of the 7 managers, 4 discussed managing their emotional responses through not personalizing the abuse. Three mentioned not becoming defensive and 3 thought remaining objective was important. One participant stated, “We know that there are people that deal with verbal abuse and they do it time and time again and their skills improve over time. They can bounce back. They don’t personalize it.” Another

participant stated, “I have a life philosophy that I don’t respond to a difficult situation when I feel threatened or angry or defensive.” Three participants in the group referred to strategies that assist them to detach themselves and be more objective. One participant spoke about “rising above it, putting cameras in the sky looking at it that way.” Another stated, “I’m watching the conversation. I’m trying to watch me from their eyes” (Manager Focus Group). Yet another participant noted, “I try to look at it objectively…. You think that it’s sort of an objective action rather than something that’s happening at me.”

Two participants noted that tolerance for verbally abusive clients was important: “Tolerance needs to be encouraged” (Manager Focus Group). Two participants referred to the need not to show a negative reaction through facial expressions: “I put on my nurse’s face, I don’t show a reaction” (Manager Focus Group). Two participants discussed the need to be self-aware. One participant noted, “I need to look back at myself to see how I am contributing to this situation and how could I cause it to have a different outcome.”

According to 3 participants empathy is an important part of de-escalating a verbally abusive client: “I think in the healthcare field understanding the disease process and the issues at play with the patient and their family can greatly help appreciate or have empathy for their emotional state of mind” (Manager Focus Group). One participant was a family member whose child was experiencing life-threatening health problems; she identified that this experience allowed her to “understand the emotion and passion” of clients and family members. She understood the emotional toll and frustration a person would experience in this position; her belief was to appreciate the advocacy. She stated,

"Even if the family or client is being verbally abusive.… You know there are cycles of emotions, and it's not directed to a person."

Managerial Support

The need for a trusting and positive relationship between unit managers and nurses was revealed in the data. This topic took up 5 minutes of the focus group. Four participants noted the need for managerial acknowledgement, feedback, support, and opportunities for discussion. According to one manager,

> It is really important for management to be aware of situations and provide feedback so if a conflict situation ended well, people handled it well, to give that positive reinforcement so that people are growing in those skills. If it went badly or there was difficulty, have those debriefing sessions where you can problem solve and learn skills that you might be able to implement the next time.

One participant put forward that there are "expectations of management to follow up on issues as they become known." Another participant stated, "When somebody makes the decision about how they might respond we need to be able to support their decision.… [If they need further assistance] help provide them with a solution." According to one participant, a manager's response needs to involve all players:

> I think as leaders when we're made aware of an incident of verbal abuse, that we do more than just pat the employee on the back, follow-up with either the staff, the other staff, the client where it's appropriate, and the family member letting them know that behaviour is not acceptable and not appropriate and doesn't help foster a respectful environment.

Two participants referred to the importance of managers setting up situations in which nurses and other members of the team can help each other deal with difficult clients. One manager suggested,

> Provide an opportunity at staff meetings … to voice concerns, to be able to maybe look at doing some brainstorming and strategies on how to deal with difficult situations and problems. I think that's something that's very important to

> empower them so they have ownership and they can depend on one another as a team.

When asked the question: If we all felt empowered, resilient and at peace when caring for our verbally abusive clients, what would the possibilities for our organization's future be? One participant noted, "We would have a high trust organization. A high trust organization would lead to greater positivity … everyone would be listened to and issues would be addressed."

Organizational Resources

The data from the managers' focus group demonstrated that there are a number of communication forums (see Figure 6) and organizational initiatives (see Figure 7) put in place to improve organizational culture and decrease verbal abuse. Discussion about organizational resources took up 25 minutes of the one-hour focus group.

Keeping in Touch sessions occur quarterly with site Directors. It is a forum for the staff to receive information about what is currently happening organizationally and provides an opportunity for staff to raise concerns directly with the site Director. One participant stated, "Keeping in touch sessions with management is a good vehicle for raising concerns." Completion of staff performance appraisals have been integrated into Carewest's balanced scorecard, "I think that [performance appraisals] speaks to a respectful workplace and just keeping everybody in check" (Manager Focus Group). In regards to the workforce planning committee, one participant stated,

> I call them workforce culture committees … as a concept it was a committee of staff and some management advisors around issues at a workplace and these are the kinds of things that can come up and help give staff ownership.

Another participant believed staff surveys are an excellent tool for employees to raise concerns about verbal abuse:

> Through the staff survey, we can collect information from staff, all kinds of comments, and all kinds of issues … that's a vehicle where they can voice those concerns [problems with verbal abuse and the need for education].Two

participants referred to the development and implementation of policies that outline expected standards of conduct:

> There are several policies and procedures in place to address abuse in the workplace … we did respectful workplace. We did abuse against clients, abuse against staff. We looked at standards of conduct. There were four or five policies that initially set the tone for the whole respectful workplace initiative.(Manager Focus Group)

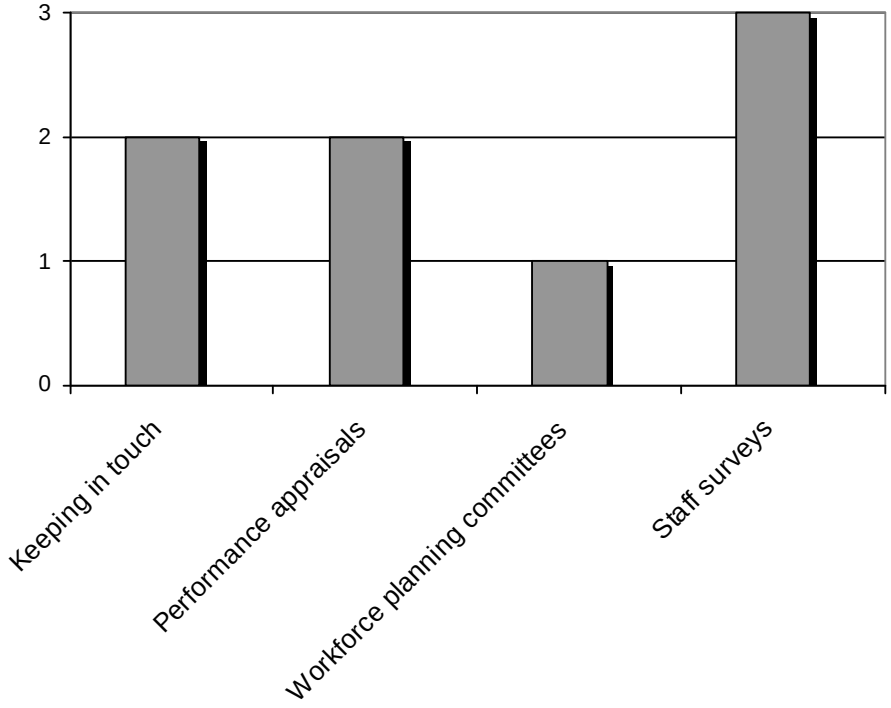

Figure 6. The number of times a word or phrase relating to communication forums was mentioned during the Managers' Focus Group.

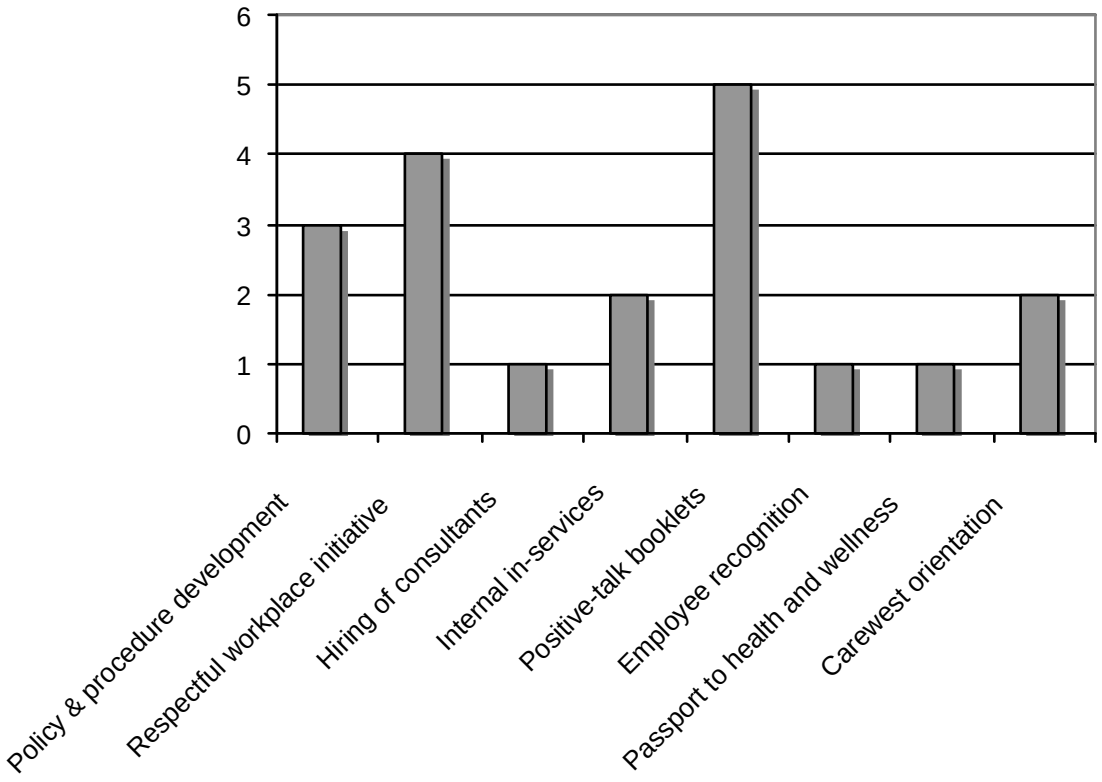

Figure 7. The number of times a word or phrase was mentioned relating to organizational initiatives.

One participant discussed the respectful workplace initiative,

> Primarily you saw it in *Carewrite* [an organizational newsletter] with an executive message on the first two pages … January 2008 throughout the year; every message had to do with a respectful workplace, whether it's bullying, harassment, violence, just communication, being respectful towards each other.

One manager talked about how the positive talk booklets were developed in order to help stakeholders communicate more respectfully with one another:

> We've embarked on the "positive talk" series booklets … how staff can appropriately communicate towards families … with each other. And there's going to be one targeted towards families and clients on how to be a positive and collaborative part of the healthcare team.

One participant also mentioned ongoing employee recognition and the passport to health and wellness initiative as positively impacting workplace culture. She also went

into detail about the information on abuse that all Carewest employees receive on the first day of orientation. She stated, “I feel the need to discuss resident aggression as a hazard” (Manager Focus Group).

One of the managers was trying to improve her unit’s culture. Due to a number of factors it had become negative and toxic. When it became evident to her that the situation was beyond her skill level she put forward, “The organization hired outside consultants to work with the unit on respectful communication and conflict resolution” (Manager Focus Group).

Education and Training

The strategy of education and training was brought up throughout the manager’s focus group. Out of the 7 managers, 4 believe that there is a need for education and training about how to de-escalate verbally abusive clients and about how disease processes may impact a client’s behavioural responses. When asked what formal training Carewest provides on how to deal with verbally abusive clients, one participant revealed there is an internal in-service offered periodically on crisis intervention: “We have sent staff to crisis intervention in services.” The data demonstrated that education needs to begin with school curriculum and be continued by healthcare organizations. Ten minutes of the one-hour focus group was spent discussing the need for education and training. The managers’ group was asked: What is the very best we can imagine from our organization as it strives to empower managers and nurses as they provide care to verbally abusive clients? The managers responded by stating that the need for education about how to deal with verbal abuse needs to be part of the registered nurse, licensed practical nurse, and nursing attendant school experience. For example, “bring this into

schools, like a module about how to handle it, the fact that it happens, the earlier they can start learning this the better" (Manager Focus Group).

One manager stated, "I think in a very perfect world every single staff member would have the knowledge, skills and training." Another participant noted, "We need to supply the education and the supports and the training for them [nurses] to deal with verbally or physically abusive clients." One participant indicated that education also needs to include information about the disease process, "understanding the disease process … can greatly help appreciate or have empathy for their emotional state." Two participants also discussed cultural sensitivity as being important in the educational process: "It is something we don't do enough of … in a very diverse multi-cultural organization, people bring many different orientations to conflict, the ability to raise issues, to feel equal in the workplace" (Manager Focus Group).

Study Conclusions

This research project targeted frontline nurses that identified themselves as having high levels of skill while caring for verbally abusive clients. This research also targeted managers that deal with verbally abusive clients or had an interest in the topic. Both groups increased their levels of awareness by engaging in conversations and reflecting on individual and organizational strategies. When participants were asked: What did you enjoy most about this focus group? In response to this question 8 out of 9 nurses, and 5 out of 7 managers, put forward sharing information with others was the most enjoyable aspect of the focus group. One manager noted, "Interaction with other managers, actively listening to others opinions about this subject." According to one nurse, "Collaborating, sharing ideas and approaches. Excellent means of brainstorming." The study conclusions

will address the main themes of emotional intelligence, trust and relationships, organizational communication, and education and training.

Emotional Intelligence

Components of emotional intelligence were identified in both focus groups. Salovey and Mayer (as cited in Goleman, 2006) described five distinct domains of emotional intelligence: knowing one's emotions, managing emotions, motivating one's self, recognizing emotions in others, and handling relationships (p. 43). Data from the focus groups provided support for these dimensions. For example one nurse stated, "Try to stay relaxed, as was said earlier, you can't be defensive." Another nurse stated, "I need to take my own emotional temperature. Am I in control of my own emotions." Maintaining positive relationships with verbally abusive clients was mentioned. One manager noted, "You need to call a client on their behaviour in a way that keeps your relationship with them intact."

The literature revealed that emotional intelligence impacts the selection of coping techniques in emotionally charged situations (Gerits, Derksen, Verbruggen, & Katzko, 2005, Introduction section, ¶ 1). Participants from both focus groups indicated they manage their emotions during verbal abuse through utilizing a detachment strategy. According to one nurse, "if the remark is quite personal and hits home to a place that does hurt you. It's harder. Then you have to put up that barrier and say I'm strong than this." According to Carmack (as cited in Henderson, 2001),

> Although most nurses eloquently discussed the importance of emotional engagement, a significant minority emphasized the need for detachment and objectivity … the more emotionally demanding the circumstances, either due to intensity, acuity or length of contact time, the more important it is to learn to balance the two and to maintain as well as interrogate boundaries. (p. 133)

The data from the managers and the frontline nurses indicated that displaying empathy, the ability to listen, and have patience during an abusive and emotional intense interaction were required in order to de-escalate the client and engage in problem solving. Cadman and Brewer (2001) noted, "Professionals … should be equipped to respond with empathy and warmth and be able to communicate genuine concern" (p. 322). One nurse put forward "if they are abusive to you, verbally abusive, just try to have a lot of patience."

Emotionally intelligent nurses have a choice about how to respond to the emotions of others (Vitello-Cicciu, 2003, p. 31). According to one nurse, "As a professional we have the ability to choose our responses to any situation." What helped one manager remain objective and nonreactive in highly charged emotional situations was to understand what she was saying may not be what the client was hearing: "What words did that person hear, how might they interpret it, what did they say, and what do I interpret." She went onto say, "Really differentiate and look at the conversation objectively, this helps you to respond appropriately" (Manager Focus Group).

Trust and Relationships

The need for trusting relationships between organizational leaders, managers, physicians, frontline nurses, and clients was identified throughout the data. One nurse talked about the importance of maintaining trusting relationships between all team members. She put forward, "When you can act as a team and trust each other as a team, I think that you stand a better chance against verbal abuse" (Nurse Focus Group). The literature demonstrated that if an organization's internal infrastructures empower nurses, the result would be work environments that have high levels of trust and respect (Spence-

Laschinger & Finegan, 2005, p. 6). According to Ray, Turkel, and Marino (2002), "All change in healthcare organizations is dependent upon trust, the foundation of all constructive human relationships" (p. 13).

The data from the frontline nurses demonstrated that a positive relationship with their manager is very important when dealing with verbally abusive clients. According to one nurse, if you have dealt with a difficult situation and successfully de-escalated the client a manager's acknowledgement is important. The nurse stated, "If a manager gives you a thank you card, immediate recognition of a job well done, it goes a long way in boosting confidence and reinforcing that your doing the right thing." The literature indicates the role of the middle managers is paramount in maintaining a positive culture on the care unit. The relationship with their manager is more important than compensation, benefits, or perks of the job (Booth & Farquhar, 2003, p. 3).

Ray et al. (2002) wrote, "Systems must become moral enterprises. Relational self-organization is established through the intentional, ethical caring relationship of the nurse and the administrator" (p. 13). When discussing caring for a verbally abusive client one manager noted,

> We have a mandated responsibility to ensure that a client is safe, but if they are safe, we have the right to leave and then re-approach later. As a leader we need to build confidence and trust by telling them [nurses] they do have that right to invoke their rights.

Trust represents a vital and ever changing element of a relationship. It cannot be taken for granted. Trust relies on the ability of the individuals involved to take personal responsibility, change when necessary and commit to the relationship (Solomon & Flores, 2001, p. 13).

Organizational Communication

According to data revealed by the managers' focus group, Carewest leadership has created resources to promote positive relationships and has attempted to create an awareness of these resources. However, my data suggest that this information has not yet reached frontline nurses. When the frontline nurses were asked what organizational initiatives are occurring within Carewest to deal with organizational culture or verbal abuse, one nurse stated, "Stuff is going on behind the scenes but we have yet to see what'll happen." The frontline nurses were unable to articulate any specific procedures, policies, or organizational initiatives directly linked to workplace culture or verbal abuse. If the nurses were aware of some of the communication forums and resources they did not connect them explicitly to the management of verbally abusive clients.

Data from the managers' group identified numerous communication forums and organizational initiatives to address the issue of verbal abuse within the organizations and improve workplace culture (see Figures 6 and 7). The data revealed that there is a disconnect between the resources developed by organizational leadership and the frontline nurses awareness and utilization of these resources. Two managers noted that there was a lack of resources to effectively implement these initiatives. One manager conceded, "It really needed a stronger roll-out, and that didn't happen, and so there was like a two-year gap." Another manager pointed out the same concern regarding the positive talk booklets, "My concern about the use of those resources is that there's not enough facilitation for staff to ingrain those principles into their everyday behaviour. They have a resource in their hand but it's not in their everyday practice." The literature revealed the importance of an organization to have a definitive framework for

communication. The literature also concedes that it is difficult to achieve (Haudan, 2009; Mellor & Dewhurst, 2009; Welch & Jackson, 2007). The data revealed a weakness in Carewest's communication framework.

Education and Training

The data demonstrated that both the managers and the frontline nurses' main priority was the need for ongoing education and training. The data identified the need for education specific to de-escalating verbally abusive clients, a specialized team, and specific information about disease processes that may impact the behaviour of clients. The data also identified the need to consider cultural diversity as part of the educational process.

Education and training was identified as a priority within the literature (Beacock, 1999; Cameron, 1998; DelBel, 2003; Oztunc, 2006; Richter, 2006; Sofield & Salmond, 2003; Wondrak, 1999). Nurses need to be taught how to cope with verbally abusive clients and how to protect themselves (Oztunc, 2006, p. 363). Richter noted, "At present staff are under trained and under equipped concerning non-physical interventions" (p. 126). One nurse stated, "If I was running the organization I would make sure my staff could handle these [verbally abusive] people."

The need for a specialized team with training about how to deal with verbal abuse was indicated in the data of both the managers and the frontline nurses. One nurse put forward the need for "a team somewhere that has been created that you can call in." One of the managers noted, "You want to know there is someone out there who you can call on to help you get out of a tough situation, whether it is verbal abuse or physical abuse, an additional resource on evenings and nights." The literature reviewed made only two

references to training healthcare professionals to manage verbally abusive clients. Paterson and Leadbetter (1999) believed in the need for the practice of de-escalation teams and individuals, but they cautioned that they "form only part of the co-ordinated action at the level of the organization" (p. 96). Beacock (1999), when referring to individuals with mental illness and other organic brain disorders, believed clients who have proven themselves to have a propensity for violent behaviour require "a skilled and specialist nursing staff" (p. 179).

The data also identified the need for education about specific disease processes that arose from both focus group discussions. One manager put forward, "I think we start with education around the disease processes and how they manifest in behaviours." Within the literature reviewed there was no explicit mention of education about disease processes as a strategy to help nurses deal with verbally abusive clients. One rational for this may be that the authors of the literature assumed nurses already had knowledge about specific diseases, as study of them is the main component of every nursing school's curriculum. It could also be that training to specific diagnosis is assumed to be already integrated into an organization's educational component.

Participants in both focus groups identified the need for education that addresses the organizations' culturally diverse workforce. Cultural sensitivity was also identified within the literature. In his discussion of different cultures and nonverbal communication Paterson and Leadbetter (1999) wrote, "It is important to note, however as language and dialect vary between cultures, so does non-verbal communication. Caution and sensitivity must, therefore, be exercised" (p. 104). One manager stated, "We're going to have to start

thinking about in the education field of management and staff and orientation is broaching the cultural diversity needs." Davis (1995) wrote,

> The multicultural workforce results naturally in a multicultural society, as customers and workers often are mirror images. Thus, a culturally diverse workforce should be a strength in meeting the needs of culturally diverse patients, clients or customers, and should be viewed as an asset. (Management Strategies section, ¶ 2)

Scope and Limitations of the Research

The results of this research should be considered in light of its potential limitations. I have been interested in the topic of caring for verbally abusive clients within the healthcare system for many years. I come to this topic with preconceived ideas. As a researcher I strive to remain as neutral on the topic as possible, but my values and beliefs about the topic may bias my interpretation of the findings. The data collected were interpreted by my personal frame of reference. Consciously, or unconsciously, I decided which information was important and that which could be set aside.

Nurses gave statements about strategies they used to care for a verbally abusive client that they could remember over their career. Most participants had been given information about the research and questions prior to the focus groups; however, many of the participants were introduced to them for the first time at the beginning of the focus group. Some of the participants had likely not reflected on the successful strategies they used to cope with verbal abuse prior to the focus group. Given this reality, their self-reporting may have been more limited then it otherwise would have been.

Data represented by word counts within the transcripts are not necessarily accurate as to the number of participants who agreed with or engaged in that strategy. One participant may have mentioned a belief, attribute, or strategy more than once. When

a strategy was brought up by one participant, other participants may have nodded in agreement. Head nods are not captured within the transcript. Once a belief, attribute, or strategy was brought up by one participant, it is possible that other participants did not feel the need to revisit it. Further research conducted in individual interviews may provide more accurate data.

The results that were obtained were based on nurses and managers who were employed within one healthcare organization. The total number of the participants involved was 16; a larger sampling is required to validate the data obtained within this research project. All participants but one were female; therefore, gender difference and perceptions should also be considered and researched. There may be great differences in not only the way verbal abuse is perceived by males, but the also the strategies used to deal with it. Future research should also consider more precisely the age, education level, and years of experience working in a healthcare facility. Student nurses should also be included in this research, as this group has been identified as experiencing the highest rate of verbal abuse (Wondrak, 1999, p. 79).

This research should be replicated by other types of healthcare facilities and the various programs contained within them (i.e., acute care, psychiatric facilities, and community services). Further research should also do a comparative study between the experiences in rural facilities versus urban facilities. It would also be interesting to extend research in this area to other staff working within the healthcare industry such as healthcare aids, therapists, housekeeping, food services, and maintenance.

CHAPTER FIVE: RESEARCH IMPLICATIONS

Introduction

The purpose of this research project was to answer the research question: What strategies do the leadership of healthcare organizations and frontline nurses need to empower themselves when confronted with verbally abusive clients? Subquestions include:

1. How do Carewest Leadership and other healthcare organizations empower themselves and their nurses to provide quality, respectful care to verbally abusive clients?
2. What philosophies, beliefs, attitudes, and societal trends empower (or could empower) Carewest, other healthcare organizations, and nurses to provide quality care to verbally abusive clients?
3. What empowers frontline nurses to be resilient and at peace when providing care to verbally abusive clients?

Study Recommendations

The contents of this chapter include three sections: study recommendations, organizational implications, and implications for future research. The recommendations contained within this chapter are based on the data obtained by the participants, my reflections on that data, and relevant literature. They emerge from the study findings and the study conclusions. The study recommendations are intended to optimize Carewest's ability to support nurses as they provide quality respectful care to verbally abusive clients. The following recommendations represent only part of an organization-wide initiative: (a) host a retreat to communicate and collaborate, (b) create a community of

practice, (c) create opportunities to dialogue on the care units, (d) develop an educational module for managers and frontline nurses based on the findings of this research, and (e) create a team of internal experts to assist care units with verbally abusive clients.

Recommendation #1: Host a Retreat to Communicate and Collaborate

The research data demonstrated that Carewest has dedicated human and financial resources in an attempt to positively impact workplace culture and provide staff with policies pertaining to verbal abuse. The data from the nurses' focus group, or the lack of data, indicate that there is a disconnect between organizational leadership and the frontline nurses. Workers on the frontline need to receive frequent, consistent communication about issues that matter to them. When organizations engage in an initiative that requires the enrollment and cooperation of workers on the frontline they need to include them from the outset. Briscoe (2002) stated, "One of the clearest ways of demonstrating that employees are valued partners is to communicate with them regularly and find ways to involve them directly in the planning processes of the organization" (p. 40).

Greater collaboration between the organization's management and the frontline nurses may help bridge the apparent disconnect. I recommend a half-day organizational retreat. An organizational retreat will provide a forum for interested parties to communicate and collaborate about the issue of caring for verbally abusive clients. Collaboration allows us to create new ways of doing things as opposed to following rules and directives that may not get the organization to where management wants it to go (McGehee, 2001, p. 55). Creating an opportunity for open dialogue and the sharing of

information may prove to be more effective then top-down distribution of already developed resources.

Having a retreat with key stakeholders is based on the premise that groups of people are often more intelligent than the individuals within them. Groups do not need to include brilliant people or experts in order to be smart. Bringing together groups of people can create a collective wisdom that results in wise decision-making (Surowiecki, 2005). A retreat will bring together a group of people with a common interest. It would demonstrate the organization's commitment to addressing the issue of caring for verbally abusive clients in the workplace and the creation of a positive workplace culture.

I recommend that Carewest's CEO, representatives from the executive leadership, participants in the research project and one frontline nurse and one manager from each Carewest site attend this retreat. Bringing groups of people together to dialogue on important issues is a powerful strategy when dealing with complex or perplexing issues.

I suggest that the retreat take the form of a world café. A world café allows people to have conversations around questions that matter to them. It is based on the assumption that people have the capacity to work with one another no matter who they are (Brown & Isaacs, 2005, p. xi). This process would be a natural progression of this project as it would expands the research to include the greater organization. The results of this research project could inform the questions for the world café. The questions will be formulated utilizing appreciative inquiry methodology. According to Cooperrider and Whitney (2000), "The most important insight we have learned with appreciative inquiry to date is that human systems grow towards what they persistently ask questions about" (p. 70).

Questions are posed at a series of conversational areas set up around the room. People are instructed to move between conversation areas to build on each other's ideas and gain new insights into the issue. One person from each conversation area stays behind to act as a host and synthesize ideas. The content of the conversations would be captured on flip charts in each area as well as by the participants doodling and writing on paper provided at the table. Through these conversations patterns and themes begin to reveal themselves. After all participants have contributed to every question, the whole group would engage in a conversation around the key ideas and themes revealed.

Recommendation #2: Create a Community of Practice

Continued dialogue about themes and activities revealed at the world café could occur through the creation of a community of practice. Communities of practice provide a new model for connecting people for learning, knowledge sharing and acquisition, and organizational development (iCohere, n.d., p. 1). Communities of practice are groups of people who share a concern, expertise, or passion for a topic. Individuals deepen their knowledge by interacting with others, sharing stories, and coaching each other on a regular basis.

Communities of practice provide members with a group of peers they can connect with quickly, receive information from, and apply newly acquired knowledge within a time sensitive framework (Hemmasi & Csanda, 2009, p. 263). In order to efficiently and effectively create and sustain a community of practice there must be active engagement with the organization. Design and development is more about eliciting and fostering participation then planning, directing, and organizing activities (Wenger, McDermott, & Snyder, 2002, pp. 1, 13).

Eliciting participation in a community of practice could begin with the retreat and continue through already developed communication avenues, such as Carewrite, keeping in touch sessions, unit meetings and managerial promotion. Fostering participation will include creating a virtual meeting place for participants using information technology applications and ensuring all frontline nurses have access to email. The creation of a virtual chat room dedicated to this topic would allow nurses and leadership from across the organization to share thoughts, stories, and experiences. It would allow its members to build on each other's expertise. This chat room will require a moderator to ensure rules of conduct and chat room content remains respectful and appropriate. The community of practice members could also talk with each other directly through prearranged teleconferences.

Recommendation #3: Create Opportunities to Dialogue on the Care Units

Participants in both focus groups identified the importance of trusting relationships with their manager and other members of the healthcare team when providing care to verbally abusive clients. Providing time to dialogue with each other about ongoing issues would create opportunities for problem solving and encourage supportive team relationships. The data indicated the need to have time allotted to discuss issues. One participant suggested that providing opportunities or discussion at unit meetings would provide staff with ownership and improve team cohesion (Manager Focus Group).

The ability to engage in dialogue is a major component of providing safe and respectful care. Without dialogue or conversation, collaboration and effective communication is not possible (Wesorick, 2002a, p. 27). Dialogue about interpersonal

challenges occurring on a care unit will not happen in already existing communication structures without corporate support. Interpersonal challenges could be a standing item on the agenda at monthly unit meetings. This action is easy to achieve and may indicate to frontline staff that Carewest cares about the psychological health and emotional wellbeing of its employees. It will also ensure that managers are made aware of the issue.

Having interpersonal challenges as a standing item will provide an opening for staff to raise concerns and share information with the team. Although time constraints will not allow an in depth dialogue about the issue at a unit meeting, a follow-up meeting can be set up in which staff can continue to dialogue about the situation, share strategies and create a plan of care. The nature of dialogue and the skills required to engage in it effectively, are explored in recommendation number four.

Recommendation #4: Develop an Educational Module for Managers and Frontline Nurses Based on the Findings of this Research

The research data revealed that education and training was the number one priority for both frontline nurses and managers: “Education is key number one, if I was running the organization, I would make sure my staff could handle these [verbally abusive] people” (Nurses Focus Group Participant). Education must be implemented to prevent and respond to verbally abusive clients (Sofield & Salmond, 2003, p. 282).

Empowering frontline nurses and managers through education and a strength-based framework of support will assist the organization in its quest to create a positive workplace culture. Recent research has discovered that strengths-based leadership positively impacts staff engagement, which translates into substantial gains for the organization’s bottom line and employee well-being (Rath & Conchie, 2008, p. 2). This

research project was conducted utilizing appreciative inquiry. Participants identified positive strategies to provide quality care to verbally abusive clients. I recommend developing a workshop that can be utilized in both traditional learning environments and online learning environments. The workshop could be based on the findings of this research project. It could include full-day workshops that would be offered quarterly to managers, frontline nurses, and healthcare aids. The contents of this workshop could focus on: emotional intelligence, the art of dialogue, personal style, and the introduction of selected organizational initiatives, policies, and available resources that seek to address and decrease the incidence of verbal abuse.

Examination and discussion of emotional intelligence will be a primary focus of the workshop. The data demonstrated that an individual's emotional intelligence is strongly correlated with the ability to be effective and resilient when caring for verbally abusive clients (see Figures 2 & 5). The data revealed by the research is confirmed by the literature. Individuals with high levels of emotional intelligence perform well when needing to resolve conflict (Jordon & Troth, 2002, p. 67). The data also indicated that emotional intelligence consists of skills that can be learned and are not unchangeable personality traits (Freshman & Rubino, 2002, p. 2). A nurse's ability to regulate their own emotions may enhance client outcomes and training professionals in the area of emotional intelligence may produce positive results (Quoidbach & Hansenne, 2009, p. 23).

As a suggested format participants could complete an emotional intelligence assessment tool to introduce them to the traits indicative of emotional intelligence and increase their self-awareness in this area. Goleman et al. (2002) put forward four

competencies associated with emotional intelligence: self-awareness, self-management, social awareness, and relationship management (p. 39). The emotional intelligence assessment tool will serve as a jumping off point for learning and discovery. See reference lists for links to emotional intelligence assessment tools (High Performing Systems, 2009; Multi-Health Systems Inc., 2009). The content and structure of the emotional intelligence component of the workshop could be developed in conjunction with an expert in this area.

The nature of dialogue will also be explored in the educational module presented to managers and frontline nurses. Engaging in dialogue is a deeper and more meaningful process then having a discussion and requires more active empathic listening. Discussion is like a game of pool and the individuals involved want to win. While one participant puts forward their position the other participants are planning their rebuttal in order to reinforce their position. The purpose of dialogue is to go beyond any one individual's understanding. In dialogue a group explores complex issues from many points of view. Individuals suspend their assumptions but feel free to explore them. Through the process of dialogue the group begins to participate in a pool of common meaning, which is capable of constant development and change (Senge, 1990, p. 242). Learning the art of dialogue will help staff to more effectively participate in conversations around dealing with verbally abusive clients and the creation of a supportive team environment.

Recommendation #5: Create a Team of Internal Experts to Assist Care Units with Abusive Clients

The data in both the managers' and the frontline nurses' groups identified the need for access to a specialized team. The literature also indicated that access to a

specialized team is a good idea, but must be part of a coordinated organizational response (Beacock, 1999, p. 179; Paterson & Leadbetter, 1999, p. 96). Creation of a team of nurses that specialize in this area may be advantageous and cost-effective to the organization.

Having specialists with various areas of expertise is not a new practice for Carewest. The organization has nurses that specialize in pain and palliative care, skin and wound, and continence. I suggest that we replicate the model used for nurses that specialize in skin and wound care and apply it to caring for verbally abusive clients. There are nurses at each Carewest site that care units can call upon to assist them with the management of wounds that are difficult to treat. These nurses attend advanced training seminars in this area. Once they have received advanced education, they may be designated as the facilities skin and wound resource person. In order to stay current and up to date with their skills, nurses attend structured meetings and have guest speakers from various vendors. In these meetings nurses learn specifics about the indications for use of new products and discuss difficult cases with one another. Replication of this model would be cost-effective and have a minimal financial impact on the organization. Interested nurses from each care site will require an interview targeted to reveal their attributes, philosophies, beliefs, and experience providing care to verbally abusive clients. Two nurses from each site could be selected.

Nurses would have specialized training in this area. Training would include the workshop as discussed previously. In addition role playing, video taping and reviewing their skills will be included. Effective debriefing skills could be learned by an individual that is an expert in this area. Trained nurses could connect with each other face-to-face or

via teleconference to brainstorm dialogue about potential strategies and obtain support from each other.

Nurses that have been trained and designated as the onsite resource would make themselves available to meet with the unit staff to discuss the situation and to receive information about what strategies and interventions have been tried. Specialized nurses would only be called upon if the team has been working on the issue and have been unable to resolve the situation. A specialized nurse could also be called upon if the situation is having a negative emotional impact on the morale of the nurses or is impacting their ability to provide respectful care to the client. The specialist would find out which strategies have been effective, those that have not and formulate a plan of action with the team. The specialist could also provide informational sessions with team members to increase their confidence and resilience when providing care to verbally abusive clients.

For more intense incidents of verbal abuse, a nurse trained in this specialty area could provide a debriefing session with involved stakeholders. Debriefing could also occur with a colleague, manager, or mentor facilitating the discussion. One manager participant stated, “After an interaction that was really difficult, was had debriefing session where all of the players sat at the table. It was very helpful.” Debriefing sessions allow the incidence of verbal abuse to be reviewed.

During a debriefing session the context in which the abuse occurred is examined as well as events leading up to the incident. A supportive and nonblaming approach is required in order to prevent secondary trauma. However, it is important to reveal residual feelings about the incident as needed. A debriefing session allows for an examination of

how the verbal abuse was handled, what was good about how it was handled, and what was not good. From this debriefing session a plan of action can be decided as to how the team should move forward in resolving the current situation and what actions are required to prevent or manage future incidents (Bowie, 1999, p. 170; Wondrak, 1999, p. 92). When addressing violence in healthcare staff, debriefing and the opportunity to learn from the incident must be provided after the event (McPaul & Lipscomb, 2004, Conceptual Frameworks section, Table 1).

Nurse specialists could attend structured meetings quarterly to continue the educational process, share information, and brainstorm about various cases. An online bulletin board that nurses could access would further minimize the financial impact to the organization. Nurses could share information and experiences, ask questions, and receive ideas from each other online in a timely manner. Access to an online bulletin board created for this purpose would also decrease the number of times nurses would need to meet face-to-face.

Organizational Implications

Throughout this research project, the underlying theme was building on the strengths of both the individual and the organization as they provide quality care to verbally abusive clients. The literature identified that there is a lack of concrete strategies and knowledge about how to deal with it (Kidd & Stark, 1995; Richter, 2006; Rowe & Sherlock, 2005; Turnbull & Paterson, 1999). One participant from this research project identified that, if we could be resilient and at peace when dealing with verbally abusive clients, “we would be the employer of choice” (Manager Focus Group). Implementation

of the recommendations may empower nurses and managers to become more confident and resilient when providing care to verbally abusive clients.

Jackson et al. (2007) wrote, “Nurses can actively participate in the development and strengthening of their own personal resilience to reduce their vulnerability to workplace adversity and thus improve the overall health care setting” (p. 1). Implementation of the recommendations will allow nurses and managers to actively participate and make decisions about how to respond to the issue of verbal abuse within the organization. Participants in this research project shared their knowledge and expertise in this area. Implementing these recommendations would create the opportunity to share the information already discovered and continue expanding our knowledge in this area.

Educating, training, and supporting managers and nurses is only one part of a total organizational response when dealing with the issue of verbally abusive clients. Identifying what we are doing right in caring for verbally abusive clients does not mean ignoring issues that are negatively impacting the behaviours of staff and clients. Clients often become verbally abusive when they are fearful and frustrated. Their frustration may be the result of delays in access, increased wait times for care, and anger with systems processes; as well as other stressors clients face when they find themselves receiving care within the healthcare system.

A nurse’s ability to deal with verbally abusive clients will be impacted by workload and staffing issues. One research participant believed that the anger a client experiences is often directed “more at the process and the systems, rather than at me as an individual” (Manager Focus Group). The current conditions within healthcare

organizations may inadvertently be encouraging workplace aggression. The healthcare environment has drastically changed. There are increased levels of stress for both the staff and the clients due to less staff caring for more clients (DelBel, 2003, Telling Research section, ¶ 1). Solutions to the systemic problems of the healthcare system are often beyond an organization's influence. Arming staff with strategies to deal with verbal abuse will improve their competence in this under reported, emotionally draining, and stressful issue. The behaviour of staff, clients, and their resulting interactive relationships will impact the quality of an organization's workplace culture.

If the organization chooses not to implement the recommendations identified by the study's findings and conclusions, nurses will continue to cope with verbally abusive clients on their own. Literature indicates that verbal abuse impacts nurses' emotional and physical well-being and also increases staff turnover rates. Rowe and Sherlock (2005) wrote,

> Verbal abuse in nursing is quite costly to the individual nurses, the hospitals and the patients. Nurses who regularly experience verbal abuse may be more stressed, may feel less satisfied with their jobs, may miss more work and may provide a substandard quality of care to patients. (pp. 246–247)

Nurses cannot avoid a verbally abusive client indefinitely. They are bound by their association to provide care and gain the skills necessary to provide that care (Davies, 2006). This research project discovered that education and training about verbal de-escalation is lacking within the healthcare industry. The focus remains on responses and techniques to use when a client engages in physical violence. Nurses skilled in verbal de-escalation may decrease threats and the incidence of violence (Anderson & Clarke, 1996; Richter, 2006).

This research project uncovered strategies that could empower frontline nurses and managers as they provide care to verbally abusive clients. If the organization does not implement the recommendations provided in this report, they would not be acknowledging an important stressor in a nurse's day. Without the opportunity to acquire the skills and competencies necessary to interact with verbally abusive clients, many nurses will continue to experience the negative impact of verbal abuse and its resulting impact on costs, workplace culture, and quality of care.

Implications for Future Research

There is significant amount of literature about the high incidence of verbal abuse towards nurses and the negative personal and organizational consequences that go with it (Cox, 1987; Oztunc, 2006; Sofield & Salmond, 2003). To minimize and eradicate abuse towards nurses, much of the literature calls for an organizational response by implementing zero tolerance to abuse initiatives (Curwin & Mendler, 1999; Oztunc 2006). The pervasive belief within the healthcare system that nurses should not tolerate verbal abuse may be a primary driver behind the lack of knowledge in this area as indicated by the extensive literature review. If nurses do not need to tolerate abuse, then there is no need for training in verbal de-escalation skills or strategies that would empower nurses to cope effectively. Future research needs to focus on how organizations can support nurses as they gain competencies and learn to tolerate verbally abusive clients. Healthcare organizations need to recognize that due to the numerous factors faced by individuals receiving services from the healthcare system, verbal abuse will never be eradicated (Holmes, 2006).

This research project had a small number of participants. It included 9 frontline nurses and 7 managers in two separate groups. A combination of focus group and learning circle methodologies was utilized. In order to achieve a broader understanding of frontline nurses' and managers' beliefs about verbal abuse, a survey in conjunction with action-based research would be advantageous. Action research studies need to understand how things are happening and not what is happening. Quantitative information often provides a significant amount of information and is a body of knowledge that needs to be integrated into the data (Stringer, 2007, pp. 19–20). Research based on action research methodology could be augmented and enriched by the addition of quantitative data.

Carewest is a wholly owned subsidiary of the Calgary Health Region. Carewest operates nine separate sites and numerous community services. The result of this research project and the responses of the participants may have been impacted by the positive small town culture created by Carewest leadership. Conducting this research project within other long-term and acute care settings would allow for the comparison of similarities and differences in the strategies of nurses as they provide care to verbally abusive clients.

There are a significant number of individuals that find themselves interacting with clients everyday, for example, healthcare aids, therapists, housekeeping, maintenance, unit clerks, physicians, food services and others. They too have interaction daily with the clients and may end up being on the receiving end of a verbally abusive client. Expanding the research base to include these stakeholders would be valuable. If further research on this topic is to be conducted within Carewest I would suggest starting with Healthcare Aids.

Healthcare aids within Carewest spend the greatest amount of time doing bedside care. They spend more time with clients than any other discipline. Healthcare aids need to provide care to verbally abusive clients and receive no formalized training on how to do so. Healthcare aids intuitively look after this group of clients. By repeating the research done with frontline nurses, healthcare aids would be provided with the opportunity to discuss this topic and identify positive strategies they use to look after verbally abusive clients. They could also discuss the organizational response to this issue and what initiatives they would like to see. The data collected from an action research project that targets healthcare aids could be shared with their colleagues. It could also be compared with the data collected from frontline nurses and managers.

This research project had one male participant and he was in the managers group. Future research specific to frontline nurses of male gender would provide interesting and valuable information. The findings of research specific to the male gender could be compared to the findings of this research project for similarities and differences.

The frontline nurses group included 2 participants out of 9 who had different cultural backgrounds. The manager's group had 1 participant out of 7 who had a different cultural background. Healthcare organizations have a large representation of individuals from other countries; they speak different languages and have different cultural beliefs, which is "something we're going to have to start thinking about in the education field of management and staff and orientation is broaching the cultural diversity needs" (Managers Focus Group). An action research project that targets individuals of various cultural backgrounds would increase knowledge about the perceptions they have. The

similarities and differences contained within the data would indicate if different approaches to education and training are required.

Conclusion

This research project utilized appreciative inquiry methodology that focused on individual and organizational strengths. In this chapter, I have made recommendations based on the study findings and conclusions. These recommendations included: (a) hosting a retreat to communicate and collaborate, (b) create a community of practice, (c) create opportunities to dialogue on the care units, (d) develop an educational module for managers and frontline nurses based on the findings of this research, and (e) create a team of internal experts to assist care units with abusive clients. I discussed the organizational implications of implementing these findings, as well as the implications of not implementing these recommendations. Implications for future research were discussed and suggestions put forward.

CHAPTER SIX: LESSONS LEARNED

Background

I entered into this program at Royal Roads University (Royal Roads) with a healthy dose of cynicism. I have never been an advocate of traditional learning methods. I had attended many university courses, but I found the experience less than satisfying. In order to be successful in traditional learning, the learner required money for tuition, the ability to read and then figure out what the professor's beliefs were about any topic, then reiterate them during exams: a process that did not consist of learning how to think, learn, and discover new knowledge. The overall philosophy of Royal Roads intrigued me. Royal Roads is a university whose target market is professionals already working in their chosen field. I also loved the topic area: Master in the Art of Leadership–Health Specialty. If there was any field in need of strong, capable, and informed leadership, it was the healthcare industry.

Throughout my life, I have connected myself with individuals who were experts in and passionate about their fields. As my passion aligned with their own, they were more than happy to share their expertise. Although this experiential learning did not result in educational degrees, the learning was far richer then any other learning I received within a traditional educational classroom. That is, until I engaged in the learning processes offered by Royal Roads. It was innovative and novel, and they included on their reading list authors who were not particularly traditional learning friendly. Vaill (1996) wrote, "Institutional learning is as much a system for indoctrination and control as it is a system for learning" (p. 40). I was impressed that the Royal Roads

program included this book as required reading. It was my first glimpse into the reality that Royal Roads and its learning processes would be innovative and interesting.

Project Overview

Writing a thesis based on a project that includes action based research is much like getting thrown into the deep end of a swimming pool without knowing how to swim. You need to learn how to swim, while at the same time trying not to drown. As you can imagine, this is no easy feat. This action research project begins by gagging, choking, and flailing about in the water. Your organizational sponsor and project supervisor are coaching and encouraging you. They are warm, dry, and at times, exasperated on the sidelines. Just as you are about to give up and embrace drowning as a relief, someone throws you a lifeline. They do not actually pull you to the safety of solid ground, but the lifeline does allow you an opportunity to catch your breath. This process is repeated over the course of many months as you more competently learn how to stay afloat and even do a few cool moves. It is actually not until the end of the project that you find out that you could actually breathe underwater all along. Of course, had I known that, I would not have all the rich memories and tall tales of overcoming adversity to tell my grandchildren. When pushing through adversity, whether it is writing a thesis or recovering from an illness, the journey needs to be embraced. It is what gives meaning to life. It determines your character and ultimately your destiny.

Action Research

Action research resonated deeply with me. The researcher is involved and participative. Change is occurring throughout the process. Action research is based on a very simplistic premise that includes an interacting spiral. The basic action research

routine provides a simple, yet powerful, framework: “look, think, act” (Stringer, 2007, p. 8). The basic premise of action research is very simple, but there is nothing simple about action research. Many times though this experience, I needed to start over and rewrite entire sections and chapters. I sifted through my data over and over, rereading and rethinking to pull out what was important and what the hidden meaning was behind the words. The process was unpredictable, chaotic, and left me uncertain at many turns. Just when I thought I was going down the right path my supervisor would tell me to make a U turn. Action research is not a linear process. Stringer wrote, “People will find themselves working backward through the routines, repeating processes, revising procedures, rethinking interpretations, leapfrogging steps or stages, and sometimes making radical changes in direction” (p. 9). Given the complex nature of action research, it is advantageous to be passionate about your topic. This will sustain you during the dark times.

Spend all the time you need to clarify your research question and your sub questions. Action research is complex enough; make your research question broad enough to challenge you and narrow enough to keep the experience meaningful. Remember you are learning how to do action research as you are doing it. Not only do you need to keep your focus on your area of interest, you need to engage in the meaningful collection and interpretation of data.

If you are passionate about your topic area, this project allows you to dig deep. It is easy to get lost and stuck in your literature review. Researching one topic with too much depth can become a red herring. You get so immersed in the topic you can forget that it is only one topic among three or four on which you need to do a literature review.

Digging too deep into one topic may lead you away from connecting it to your research question. Keep in mind that the literature review is an ongoing process and will be revisited throughout the project. As you move along, changes will occur.

Make sure you build into your schedule enough time to reflect on the literature and data you are collecting. Sometimes it may need to be done in your sleep. That can be quite effective too. Keep a digital recorder at your bedside, and capture your insights in the moment. That way you will not forget any of your middle-of-the-night epiphanies. I find those ones are often the most interesting.

Organizational Learning

Conducting action research within the organization in which you are employed provides an opportunity to study its mission, values, and framework of supports in depth. It also allows you to become very familiar with initiatives, policies, and procedures implemented that pertain to your research question. Research in your own organization allows you to build relationships with individuals across the organization in a new context. It also brings with it some challenges. Doing research within your organization runs the inherent risk of uncovering data that is not flattering to the organization. As a researcher you may find yourself in the middle of a field full of political landmines. Even the most benign research topic may go sideways as action research creates its own path of discovery. I believe using appreciative inquiry methodology in framing my participant recruitment letter and my research questions mitigated the risk within my project.

When research participants work on the frontline in healthcare, anticipate the number of expected participants to decrease at the last minute. Out of the 10 frontline nurses, 8 confirmed to participate were working the day of the focus group. One of those

nurses had an emergency on their unit and could not attend. All 8 of the managers were working on the day of the focus group. One was unable to attend due to an expected situation. Try to recruit enough participants to absorb one or two losses.

Conduct of the Research

Have two digital recorders at your interviews or focus groups. It is unlikely that two will malfunction at the same time. As one of mine malfunctioned, I was glad to have another. Hire a transcriptionist. This allows you more time to analyze the data instead of spending hours typing it out. Be adaptive and flexible. If you are not, this project could be painful.

To collect my data I chose a focus group and learning circle blend. I wanted the participants to build on each other's ideas and experiences but in a controlled manner. Therefore, I introduced the talking stick, which made the participants engage in the conversation one at a time. Participants enjoyed this format and it allowed the tape recorder to catch all the dialogue. If I were to begin this process again, I would have included a survey. A survey could have captured opinions about caring for verbally abusive clients from a broader audience. I believe the addition of quantitative data would have enhanced my research findings.

Other Helpful Hints

Set Up Consistent Virtual Meetings with Your Advisee Team

At the first residency, our cohort made the decision to be a strong team and committed to one another's success. As we each entered into our major project, we set up a monthly meeting. This meeting took place via the World Wide Web, utilizing *Skype* (2009) software. This monthly meeting allowed us to share our learning, discuss where

everyone was at, share information about deadlines, as well as what needed to be submitted where, by whom, and when. This was by far the best resource and proactive act we could have entered into. It was not only a great venue for information sharing; we also shared each other's challenges and successes in our personal, professional, and home life.

Utilize the Major Projects Discussion Group

The discussion group found on the Royal Roads website for learners writing their thesis was a very good resource and a way to stay connected with the greater cohort. Questions can be asked and answered, and resources shared. After being immersed in online classes and team projects, writing your thesis can be very isolating.

Track References

I personally did not have much success with *RefWorks* (2009) and other reference software. I did learn it, but I found myself spending too much time trying to manipulate the program. I did not find this software to be very helpful. After having to spend hours looking for a quote or finding the source of a quote, I learned to write the quote and immediately get the reference. Make sure you capture all the information you will need for a reference, even if your APA (American Psychological Association, 2002) abilities are sketchy at first. If there is a quote you love, but do not know where to put it, start a page of favourite quotes and source them. It will save time and come in handy.

Get Organized

I am not the most organized person in the world. Throughout my career, I have created strategies to manage my chaos. One of the best things I did in this project was create two binders: one for thesis administration information and one for the actual

content of the thesis itself. I created tabs for each section I was aware of and made new dividers as new categories evolved.

Maintain a Balanced Lifestyle

A balanced lifestyle is very important, having said that, for the last 2 years I failed miserably. I neglected my health, my children, my husband, and anything to do with household chores. I hired a professional wife to help me out. That was my best idea.

Life Sometimes Interferes with Your Best-Laid Plans

Sometimes you just need to let go and let God. We all live busy professional and personal lives. As many of us are the sandwich generation, we are looking after young children and tending to aging parents, not to mention the fact that we are getting older. We are not 20 years old anymore. We are human; life happens. Communicate with involved players: that is your best strategy. Push your way through when you are able. Most of the supervisors have been where you are. They have experiential understanding of the obstacles that may stall your journey.

Conclusion

I gained relationships with my advisee group and cohort, both formally through classes and teamwork to informally at the cafeteria, residency common areas, and local pubs. Relationships are everything. If you can create authentic relationships no matter what context or setting you find yourself in, you will be successful. The entire cohort is in this together. It is the journey that counts not the destination.

My greatest accomplishment through this journey is that I made lifelong friends. We shared heated discussion, dirty looks, shared tears of despair and joy, and had the greatest laughs. We went through a “screeching in” ceremony together. This ceremony

included running into the freezing water of the Pacific Ocean and kissing the backend of a cod. Any group that kisses cod together stays together.

The course workload is overwhelming at home and on campus. Make the time to laugh, connect, and commiserate. In the end, genuine relationships are this journey's greatest gift. Our advisee team did not always like each other, but dare I say, we did love each other. Wheatley (2006) wrote, "If power is the capacity generated by our relationships, then we need to be attending to the quality of those relationships. We would do well to ponder the realization that love is the most potent source of power" (p. 40).

When my thesis has been filed in the library, gathering dust, and long forgotten, memories of the journey will remain. The faculty at Royal Roads has an often repeated the mantra: Trust the process. To be quite honest, I did not really trust the process as much as I trusted the individuals involved in the process with me. They gave me the power to finish.

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APPENDIX A: LETTER OF INVITATION TO MANAGERS

►Are you a manager with an interest in verbal abuse against nurses?

►Do you want to share your experience and ideas about how Carewest Leadership and other healthcare organizations can empower themselves and their nurses to provide quality respectful care to verbally abusive clients?

If your answer is yes, I am looking for you!

My name is Wendy Dixon, Manager of Neurological Rehabilitation at the Dr. Vernon Fanning Center. I would like to invite you to be part of a research project that I am conducting. This project is part of the requirement for a Master's Degree in Leadership (Health), at Royal Roads University, Victoria, B.C. My credentials with Royal Roads University can be established by calling Stan Amaladas PhD, committee chair, at xxx xxx-xxxx or by email at xxxxxxxxxx@rxxxxxxx.xxx

My research question is

What strategies do the leadership of healthcare organizations and frontline nurses need to empower themselves when confronted with verbally abusive clients?

Benefits to Participants

- An opportunity to share knowledge and experiences about how Carewest and other healthcare organizations you may have worked for empower nurses to provide quality respectful care to verbally abusive clients?
- How does Carewest and other health care organizations empower themselves and their nurses when confronted with verbally abusive clients.
- An opportunity to build relationships with colleagues through the process of mutual inquiry
- An opportunity to inform Carewest leadership and other healthcare organizations and front line nurses about potential strategies to provide quality respectful care to verbally abusive clients.

Managers who volunteer to participate in the focus group will be asked to share their knowledge and experience around successful experiences in organizations or nurses dealing with client verbal abuse. The focus group will consist of 8-10 participants and will be one hour in duration. You may be asked to participate in a half-hour, one-to-one interview as a follow up to the focus group. Participation is voluntary and you may withdraw from the project at anytime without consequence. All documentation will be kept strictly confidential. In a focus group setting, your anonymity among your peer participants and the researcher does not exist.

As I am currently a Manager at Carewest, I do not want my colleagues to feel compelled to participate due to our relationship; therefore, please direct any interest in this project by phone or email to Kate Ceglarek xxx xxx-xxxx or

xxxxxxxxxx@rxxxxxxx.xxx. I will remain unaware of individuals who are interested in participating. Participants will be selected on a first-come / first-serve basis until all participant seats are filled. I will only be given a list of confirmed participants by Kate.

Please feel free to contact me at any time should you have general questions regarding the project and its outcomes.

Sincerely Yours,

Wendy Dixon
Primary Investigator
Royal Roads University Graduate Student
Master's degree in Leadership (Health)
Phone: xxx xxx-xxxx
Email: xxxxxxxxxx@rxxxxxxx.xxx

APPENDIX B: INVITATION TO FRONTLINE NURSES

- Are you a front line nurse who has mastered the ability to maintain a positive professional demeanour while providing quality competent care to verbally abusive clients?

- Would you like share your experiences and explore your strategies by engaging in a process of mutual inquiry with other nurses that share your ability?

If the answer is yes, I am looking for you!

My name is Wendy Dixon, Carewest, Manager at the Dr. Vernon Fanning Center. I would like to invite you to be part of a research project that I am conducting. This project is part of the requirement for a Master's Degree in Leadership (Health), at Royal Roads University, Victoria, B.C. My credentials with Royal Roads University can be established by calling xxxxxxxx, committee chair, at xxx xxx-xxxx or by email at xxxxxxxxxx@rxxxxxxx.xxx

My research question is:

What strategies do the leadership of healthcare organizations and frontline nurses need to empower themselves when confronted with verbally abusive clients?

Benefits to Participants

- An opportunity to share knowledge and experience about how to empower yourselves when confronted with verbally abusive clients
- An opportunity to build relationships with colleagues through the process of mutual inquiry
- An opportunity to inform Carewest leadership and other healthcare organizations and front line nurses about how to provide quality care to verbally abusive clients.

Nurses who volunteer to participate in the focus group will be asked to share their knowledge and experience around successful experiences in dealing with client verbal abuse. The focus group will consist of 8-10 participants and will be one hour in duration. You may be asked to participate in a half-hour, one-to-one interview as a follow up to the focus group. Participation is voluntary and you may withdraw from the project at anytime without consequence. All documentation will be kept strictly confidential. In a focus group setting, your anonymity among your peer participants and the researcher does not exist.

I do not want my colleagues to feel compelled to participate due to our relationship; therefore, please direct any interest in this project by phone or email to Kate Ceglarek xxx-xxxx or xxxxxxxxxx@rxxxxxxx.xxx. I will remain unaware of individuals who are interested in participating. Participants will be selected on a first-come / first-

serve basis until all participant seats are filled. I will only be given a list of confirmed participants by Kate.

Please feel free to contact me at any time should you have general questions regarding the project and its outcomes.

Sincerely Yours,

Wendy Dixon
Primary Investigator
Royal Roads University Graduate Student
Master's degree in Leadership (Health)
Phone: xxx xxx-xxxx
Email: xxxxxxxxxx@rxxxxxxx.xxx

APPENDIX C: RESEARCH CONSENT FORM

Research Project Title:
Leadership and Empowerment:
individual and organizational strategies to support front line nurses as they provide quality respectful care to verbally abusive clients.

My name is Wendy Dixon, and this research project is part of the requirement for a Master's Degree in Leadership (Health), at Royal Roads University, Victoria, B.C. My credentials with Royal Roads University can be established by calling My credentials with Royal Roads University can be established by calling Stan Amaladas PhD, committee chair, at xxx xxx-xxxx or by email at xxxxxxxxx@xxxxxxxx.xx

This document constitutes an agreement to participate in a follow-up, half-hour, interview to clarify statements or dig deeper into subjects or topics which were revealed during the focus group process around the issue of client verbal abuse against frontline nurses in healthcare organizations. This interview will be tape recorded for later transcription by either myself or a research assistant bound by confidentiality. Information will be summarized, and at no time will any specific comments be attributed to a specific individual unless your specific agreement has been obtained beforehand. All documentation will be kept strictly confidential. All data collected will be shredded and audiotapes erased six months after session.

If you choose to participate, your interview will be conducted in confidence with your identity known only to the researcher. Interviews will be one-half hour long, tape recorded, and later transcribed by myself or a research assistant. The timelines for the one-to-one interviews are projected for the beginning of March 2009.

Participation in this research project is voluntary. If you choose to participate, you may withdraw from the project at any time without prejudice or fear of negative consequence. Your comments and contributions will be extracted and your documentation and audiotapes destroyed.

Wendy Dixon, the researcher, will endeavour to ensure that no harm comes to individuals who participate in one-to-one interviews. The Royal Roads University Research Ethics policy will be adhered to throughout the research project.

Once the information from the transcripts has been themed, it will be sent back to individual participants for validation. At their request, participants will also receive the final report to ensure their confidentiality has not been compromised. One-to-one or group debriefing will be made available on request of the individual or the group as a whole.

In addition to submitting my final report to Royal Roads University in partial fulfillment for a Master's degree in Leadership, I will also be sharing my research

findings the project sponsor, Carewest, and any of the research project participants who request it. At the discretion of the Chief Executive Officer of Carewest, the findings may be presented to the board of the organization or the executive leadership committee. This report may also be housed on the Carewest website for members and may inform other aspects of research and quality improvement initiatives that are being undertaken by Carewest. The findings may also be published as articles in journals or published in book format to add to knowledge in this area and inform other healthcare organizations, nurses, and future researchers. A copy of the final report will be housed at Royal Roads University, available online through UMI/Proquest and the Theses Canada portal, and will be publicly accessible. Access and distribution will be unrestricted.

By signing this letter, you give free and informed consent to participate in this research interview.

Name (Please Print) _____

Signed _____

Date _____

APPENDIX D: POSTER INVITING PARTICIPATION

Attention LPNs, and RNs

Research Participants Needed

April 24th Fanning 10-11 a.m. Conf Rm #1

Please contact Kate Ceglarek at xxx-xxx to sign up

Are you a front line nurse who has mastered the ability to maintain a positive professional demeanour while providing quality competent care to verbally abusive clients?

Would you like share your experiences and explore your strategies by engaging in a process of mutual inquiry with other nurses that share your ability?

If the answer is yes, I am looking for you!

Benefits to Participants

- An opportunity to share knowledge and experience about how to empower yourselves when confronted with verbally abusive clients
- An opportunity to build relationships with colleagues through the process of mutual inquiry
- An opportunity to inform Carewest leadership and other healthcare organizations and front line nurses about how to provide quality care to verbally abusive clients.

For Further Details Contact

Wendy Dixon
Primary Investigator
Royal Roads University Graduate Student
Master's degree in Leadership (Health)
Phone: xxx xxx-xxxx
Email: xxxxxxxxx@xxxxx.xx

APPENDIX E: FOCUS GROUP QUESTIONS – MANAGERS

1. What philosophies or beliefs empower us to be resilient and at peace when confronted with verbally abusive clients?

2. How can we, as leaders within a healthcare organization, support nurses in their quest for empowerment when dealing with verbal abuse?

3. What initiatives have your organization engaged in that have had a positive impact on workplace culture or specifically addressed the issues of nurses providing care to verbally abusive clients?

4. From a leadership perspective what is the very best we can imagine from our organization as it strives to empower managers and nurses as they provide care to verbally abusive clients?

5. If we all felt empowered resilient and at peace when caring for our verbally abusive clients what would the possibilities be for our organization's future?

APPENDIX F: FOCUS GROUP QUESTIONS – FRONTLINE NURSES

1. What philosophies or beliefs empower you to be resilient and at peace when confronted with a verbally abusive client?

2. Describe a situation in which you felt extremely successful in caring for a verbally abusive client

3. If all nurses within the organization felt empowered, resilient and at peace when caring for verbally abusive clients what would the possibilities be for your personal wellbeing and workplace culture

4. What is the very best you can imagine from yourself as you provide care to verbally abusive clients?

5. What is the best you can imagine from your organization and its leadership as you provide care to verbally abusive clients?

APPENDIX G: EVALUATION FORM

Focus Group Evaluation

1. What did you enjoy most about this focus group?

   _____
   _____
   _____

2. What was the most interesting story or concept that came out of today's focus group?

   _____
   _____
   _____

3. Overall, what is your sense of what is most important for the participants in this group?

   _____
   _____
   _____

4. What are the top 3 positive themes and/or strategies that stood out for you during the focus group?
   a. _____
   b. _____
   c. _____

5. What is one Strategy that you will utilize to empower yourself or your organization when caring for verbally abusive clients?

   _____
   _____
   _____

Additional Comments

_____
_____
_____

Please Turn Over

Researcher/Facilitator Evaluation

An Evaluation of Researcher/Facilitator Wendy Dixon

1. Her explanation of the project and the expectations of the behaviours of herself and participants during and after the focus group were clear and understandable.
   Disagree Agree (please circle)
   Example _____
   _____

2. Her written communication was clear and she communicated orally using a variety of styles and abilities to guide and control the flow of conversation.
   Disagree Agree (please circle)
   Example _____
   _____

3. She was able to change her facilitation style in order to engage or intellectually stimulate participants?
   Disagree Agree (please circle)
   Example _____
   _____

4. I believe she was sincere and authentic in her quest to gain knowledge from the expertise of her participants.
   Disagree Agree (please circle)
   Example _____
   _____

5. She encouraged all participants to contribute to the conversation.
   Disagree Agree (please circle)
   Example _____
   _____

6. She encouraged us to use our imagination and look at old problems in new ways.
   Disagree Agree (please circle)
   Example _____
   _____

Thank you for sharing your intelligence, insights and experience with others.

APPENDIX H: DEFINITIONS OF RESILIENCE, EMPOWERMENT, AND VERBAL ABUSE

Table H4. *Definitions*

Term	Definition
Verbal Abuse	Anderson and Clarke (1996) wrote that "verbal abuse is communication through words, tone or manner that disparages, humiliates, intimidates, patronizes, threatens, accuses or is disrespectful toward another" (p. 95).
Resilience	***YourDictionary*** **("Resilience," 2008) defined resilience as "**the ability to bounce or spring back into shape, position, etc. [or] the ability to recover strength, spirits, good humour, etc. quickly; buoyancy" (¶ 1–2).
Empowerment	In the *Merriam Webster Online Dictionary* ("Empowerment," 2009), empowerment is identified as a transitive verb, which means to "enable" (¶ 2).
Enable (2009)	is defined as "to provide the means or opportunity, to make possible, practical or easy" (¶ 1).

APPENDIX I: RESEARCH TEAM MEMBERS' CONFIDENTIALITY AGREEMENT

Thank-you for your interest in joining my research team for this research project that I am conducting as part of the completion of a Master of Arts in Leadership in Health Care Program at Royal Roads University. You may check my credentials as a student at Royal Roads University by calling Stan Amaladas, Acting Program Head, MA-Leadership, School of Leadership Studies at (xxx) xxx-xxx ext. xxx.

The student concerned is: Wendy Dixon

This document constitutes an agreement to take participate on a research team for a research project with the objective providing opportunity for the researcher, Wendy Dixon, to answer the following question: *What strategies do the leadership of healthcare organizations and frontline nurses need to empower themselves when confronted with verbally abusive clients?* The research topic, questions, and methods have been approved by the Royal Roads University Ethics Review Board and the Carewest Ethics Review Committee. No person under the age of 18 is permitted to be involved in this research project, without independent research ethics board approval.

As a member of my research team, you may be asked to assist with piloting questions, scribing during a focus group session, and/or assisting with the analysis of data obtained through the focus groups, as well as potentially assisting with facilitating either of the focus groups.

Information gathered during the focus groups will be recorded in hand-written format, and as an audio recording. Data will be summarized in anonymous format in the body of the final report. At no time will any specific comments be attributed to any individual unless specific agreement has been obtained beforehand. No videotaping and picture taking can be undertaken without a secondary release from the participant.

Research team and/or individual meetings will be held as needed and not more than six times through the duration of the project. The dates and times of meetings will be agreed upon by individuals required to attend and will not exceed more than one hour per meeting.

As a member on the research team, you agree to honour individual and corporate confidentiality and non-disclosure guidelines. All raw documentation will be kept strictly confidential and secured within the home of Wendy Dixon This means that it will be used for purposes of this project only. Analysis will involve assisting with the summarization of information gathered in this project for a final report.

A copy of the final thesis will be housed at Royal Roads University, available online through UMI/Proquest and the Theses Canada portal and will be publicly accessible. Access and distribution will be unrestricted.

The research team members agree that the final project report and supporting materials will remain the intellectual property of the author, Wendy Dixon.

You are not compelled to take part in this research project. If you do choose to take part, you may withdraw at any time without prejudice or consequence. If a participant chooses to withdraw, any research material that can be explicitly linked to a withdrawing participant will be destroyed. Similarly, if you choose to not take part in this research project, this information will also be maintained in confidence.

By signing this form, the individual agrees to abide by the arrangements and statements contained in this Letter of Agreement.

Date: _____Name (Please Print): _____

Signed: _____