

**VIOLENCE AGAINST STUDENT NURSES BY PATIENTS AND THEIR  
RELATIVES IN PUBLIC HOSPITALS IN KWAZULU-NATAL**

Dissertation submitted in fulfilment of the requirements of the degree of Master of  
Health Sciences (Nursing) in the Faculty of Health Sciences at the Durban University  
of Technology.

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**JANUARY 2017**

## **DECLARATION**

This is to certify that this dissertation is entirely my own work and not that of any other person, unless explicitly acknowledged (including citation of published and unpublished sources).

The study has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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DATE

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DR A. RAZAK

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DATE

## **ABSTRACT**

**BACKGROUND:** Quiet often when students return from clinical placement, complain of being abused by patients and their relatives. Student nurses view clinical placement as an anxiety producing part of the nursing programme (Magnavita and Heponiemi 2011: 208). As a result, some resign and leave nursing fearing for their lives.

**AIM OF THE STUDY:** To determine the extent and types of violence experienced by student nurses from patients and their relatives or friends in public hospitals in KwaZulu-Natal, and whether this leads to intentions to leave the nursing profession.

**METHODOLOGY:** A quantitative, descriptive cross sectional survey approach conducted amongst student nurses (n=421) at KwaZulu-Natal College Nursing R425 Program starting from their first year of training up to the midwifery module. Self-Administered Questionnaires (SAQ) were used to collect data and data analysed using SPSS version 23.

**RESULTS:** All respondents (n=421) completed the SAQ (annexure B). Many student nurses, especially female students, are victims of intimidation, bullying and verbal abuse as opposed to physical and sexual abuse by patients' relatives and patients. The workplace violence against student nurses resulted in anger and absenteeism. The majority have not reported any abuse and they were not even aware of any policy that exists in their institutions against any form of violence.

**DISCUSSION:** Findings in this study revealed that student nurses, like all other nurses, were also at a high risk of workplace violence. This may be because nurses have the closest contact with patients and their relatives; hence they are at high risk of exposure to violence. Since all settings are potentially high risk for violence, it is therefore necessary for the management to improve security in all high-risk areas for the student nurses to be safe.

**RECOMMENDATIONS:** Public hospitals and the Department of Health (DOH) needs to formulate clear policies regarding violence against student nurses, and information on how to report the occurrence. There is a need for development or improvement of policies, procedures and intervention strategies. The DOH needs to address the issues of violence by implementing strategies to create a supportive environment that facilitates empowerment for the positive emotional wellbeing of student nurses.

Managers have the responsibility to create and maintain zero tolerance regarding workplace violence. Public hospitals need to employ Managers with required skills and higher education to deal with workplace violence. There is a need for further research and more details on workplace violence and its cause.

## **DEDICATION**

I dedicate this work to my late caring mother, B.B. Gcwabaza, for her unceasing prayers, genuine delight in my achievements, being my pillar of strength, always encouraging and supporting me even on her sick bed until she was called to rest.

Lastly, to my late son Hector (Thule) whose presence I continue to miss.

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My true friend who was always by my side when I was collecting data in distant places, accompanying and reassuring me - thank you.

## **LIST OF ACRONYMS AND ABBREVIATIONS**

AIDS	Acquired Immune Deficiency Syndrome
DOH	Department of Health
HIV	Human Immunodeficiency Virus
KE VIII	King Edward VIII Hospital
KZN	KwaZulu-Natal
KZNCN	KwaZulu-Natal College of Nursing
R425	Regulation 425 (SANC)
SA STAT	South African statistics
SANC	South African Nursing Council
SAQ	Self-Administered Questionnaire
UN	United Nations
VAW	Violence Against Women
WCNOVAW	Western Cape Network on Violence Against Women
WHO	World Health Organisation



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## CHAPTER 1

### INTRODUCTION AND OVERVIEW OF THE STUDY

Workplace violence is reported all over the world by many health professionals. One of the significant issues reported by staff in healthcare services is violence against nurses (Aghajanloo, Nirumand-Zandi, Safavi-Bayat, Alavi-Majd 2011: 284). Workplace violence in the healthcare setting is increasing and poses a danger to healthcare professionals (Hahn, Hantikainen, Needham, Kok, Dassen, Halfens 2012: 2693). As a result, the World Health Organization (WHO) has defined violence as ‘the intentional use of physical force or power that causes physical and psychological harm’ (Roche, Duffield, Catling-Paull 2010: 14). This is affirmed by Stathopoulou (2014: 1) when defining violence as the assault of a person with the intent to cause harm. Stathopoulou (2014: 1) reported that, nearly 4% of healthcare professionals had suffered physical violence from people within the workplace.

Studies reported that nurses have a three times higher possibility of being exposed to violence in the workplace than any other professional group (Stathopoulou, 2014: 1 and Roche, 2010: 15). Most of the literature reports on professional nurses and not student nurses, yet these nurses are also victims. Aghajanloo *et al.* (2011: 285) reported that student nurses in Iran experienced the highest rate of violence by patients and their relatives, more than any other healthcare professionals.

Gender is statistically significant in abusive events, with evidence indicating that females report abusive events more often than men do (Fouché and du Toit, 2006: 83). According to Hinchberger (2009: 37), violence against women and girls happens everywhere, in every country, at every level of society and is seen as increasing significantly. Extremism and violence against women and girls is caused by deeply entrenched societal norms and the insidious belief that women are inferior (Agrawal and Banrjee 2010: 92-93). Due to the predominance of female student nurses, their vulnerability to abuse within healthcare settings is increased (Fouche and du Toit 2006: 77). The most common form of violence in hospitals in Switzerland is patient and visitor violence (Hahn *et al.* 2012: 2686). Countries report differently, like Fouché and du Toit (2006: 85) on the findings in Pretoria, where student nurses reported the majority of the abusive incidences by superiors.

## **1.1 BACKGROUND TO THE STUDY.**

The research exploring violence against student nurses by patients and their relatives is limited. Fouché and du Toit (2006: 77) concluded that student nurses at the University of Pretoria, following exposure to the clinical area, were victims of abuse in a hospital setting which occurred between student nurses and patients, and that this caused them to feel disempowered and vulnerable. Champion (2014) reported that in Brookdale, United States of America, a 40-year-old male patient brutally attacked a female nurse rendering her unconscious while she was removing his indwelling catheter. This demonstrates how nurses are at high risk from workplace violence and that there is a need for them to be supported. Workplace violence in the healthcare setting is a worldwide problem for health professionals (Hinchberger 2009: 37).

In South Africa, statistics on leading causes of morbidity and risk factors for morbidity following HIV/AIDS, show violence and injuries as the second main cause of death and disability (Karim, Churchyard, Karim and Lawn, 2009) and further report that, of the 3.5 million people who seek health services for non-fatal injuries, nearly half of these injuries are caused by violence. The statistics of South Africa from the SAPS 2015/16 reporting year are detailed below.

The South African Police released their statistics on the number of crimes recorded in the 2015/16 reporting year, running from 1 April 2015 to 31 March 2016, on the 2<sup>nd</sup> September in Parliament (Stats SA, 2016). South Africa reported 33.9 % nationally violence and KwaZulu-Natal 36%, rates per 100 000 people.

Research has shown that violence against women is globally widespread and is noticeable in all socio-economic groups (Hinchberger 2009: 37). Literature indicates that victims of workplace violence are those who have a lower level of education and include younger nurses who are less experienced in their work (Kitaneh and Hamdan 2012: 2). Student nurses who are particularly vulnerable are found early in their training (Hewett 2010). Victims of workplace violence frequently lack occupational power and consequently, the variables of age, gender, ethnicity and experience are important (Ferns and Meerabeau 2009: 2679). The violence that student nurses are exposed to varies from verbal abuse and harassment to physical abuse (Roche 2010: 13). Many studies report verbal abuse rather than reporting

physical violence, assault or threatening behaviours (Opie *et al.* 2009; Chapman *et al.* 2010; Roche 2010: 14).

The perpetrators of violence against nurses are mostly relatives or visitors, followed by the patients themselves who tend to be more violent than their relatives, and are mostly males between the ages of 15-40 years and 70-85 years (Hinchberger 2009: 42), (Hahn *et al.* 2010: 3536). Kitaneh and Hamdan (2012: 469) reported that the interactions carrying the greatest risk for patients' and visitors' violence are those with close physical contact between nursing staff and patients. This experience of violence in the workplace means student nurses might consider changing their place of work, or worse still, leaving the profession (Thomas and Burk 2009: 226). Workplace violence is a common reason for student nurses to resign and there are fewer choosing to enter nursing (Opie *et al.* 2009: 22). Student nurses, like all other health professionals, have the right to a safe and abuse free training environment at the workplace.

## **1.2 PROBLEM STATEMENT**

Placement in the clinical learning environment is a mandatory component of nurse training to ensure that the student nurse develops specific clinical skills. In order for a student nurse to grow and develop in the profession, s/he needs to be provided with an appropriate learning environment. Clinical practice provides student nurses with an opportunity to correlate theory with practice. However, the exposure to patients' and their relatives' violence, which could result in physical and psychological difficulties, might adversely affect the student nurses' abilities to develop the necessary professional skills and attitudes (Magnavita and Heponiemi 2011: 206).

Student nurses view clinical placement as the most anxiety-producing in the nursing programme (Magnavita and Heponiemi 2011: 208). This could be the reason why it is difficult to recruit people to nursing. The problem of violence in the workplace is not unique to student nurses and is a challenge for all healthcare professionals (Talas, Kocaoz and Akguc 2011: 197). However, student nurses are under-researched in terms of their experience of violence, and are particularly vulnerable to the effects of workplace violence. Healthcare workers in healthcare settings experience more violence than any other service workers (Hahn *et al.* 2010: 3536; Pazvantoglu *et al.* 2011: 496; Talas, Kocaoz and Akguc 2011: 197). There is a worldwide concern as the nurses are at high risk and the statistics continue to rise

(Hinchberger 2009: 40; Chapman 2010: 1; Aghajanloo *et al.* 2011: 284-287; Kitaneh and Hamdan 2012: 469). In Melbourne, Australia, student nurses and midwives launched a campaign calling the state government to stop the violence that they were subjected to at work. They asked the whole country to support them in their campaign (O'Rourke 2013: 20).

The student nurses are most vulnerable to this violence because they are young, inexperienced with inadequate training, have high patient contact time, and are in new environments (Ferns and Meerabeau 2009: 2679; Magnavita 2014: 203-210). Settings that are particularly high risk for violence to occur are psychiatric wards, emergency departments, waiting rooms and geriatric units (Hinchberger 2009; Pazvantoglu *et al.* 2011: 496; Talas, Kocaoz and Akguc 2011: 197). The studies reveal that the patients and relatives who are violent are often disruptive and intoxicated (Talas, Kocaoz and Akguc 2011: 197).

Hubbard (2014:16) states that the negative effects of bad experiences in the clinical settings create problems in the recruitment and retention of nurses. Of those student nurses who choose to leave the nursing profession or who decide not to accept placement in units which are known to be more violent, violence against student nurses is a feature (Hubbard 2014: 16). The student nurses further explained that these experiences left them feeling unsure about continuing with the profession or not, as they felt humiliated and frustrated and their self-esteem had been lowered, leading to depression and burnout which is linked to mental health problems (Janse Van Rensburg, Poggenpoel and Myburgh 2012: 762).

Student nurses working in fear of their safety can suffer from occupational stress, (Opie *et al.* 2009: 18) an increasingly important occupational disease. According to the South African Nursing Council in the Nurses' Bill of Rights, as cited in the Nursing Act No. 33 of 2005, as amended, students have the right to a safe and abuse-free training environment (SANC 2004-2014). The problem of assessing the prevalence of workplace violence is the difficulty in standardising the definition of workplace violence, under-reporting and the absence of mandated regulations for its prevention (Gacki-Smith, Juarez and Boyett 2009: 340). The prevalence of violence has been recognised as a major health priority by the WHO, the International Council of Nurses and Public Services International (Magnavita and Heponiemi 2011: 203).

Hinchberger (2009: 43-44) states that it is important that one understands the root causes in order to fully address and delimit the problems caused by such violence.

Although student nurses may be exposed to this type of violence, little is known about the extent to which South African student nurses are exposed to violence, especially in KwaZulu Natal. King and McInerney (2006: 70) state that one of the major reasons why nurses resign is the concern regarding occupational safety. It is important to understand violence against student nurses in order that they are retained in the healthcare sector and do not leave the profession.

### **1. 3 AIM OF THE STUDY**

The aim of this study is to determine the extent and types of violence experienced by student nurses from patients and their relatives in public hospitals in KwaZulu-Natal and whether this leads to an intention to leave the profession.

#### **1.3.1 RESEARCH QUESTIONS**

- What are the types of violence experienced by student nurses in public hospitals in KwaZulu-Natal?
- Does the violence experienced by student nurses in the workplace lead to an intention to leave nursing?

### **1.4 SIGNIFICANCE OF THE STUDY**

In South Africa, the training of student nurses is regulated by the South African Nursing Council in different programs. The curriculum of student nurses includes theory and practice, with a minimum requirement of 4000 hours in clinical settings (SANC, R425). The clinical practice provides the student nurse with the opportunity to correlate theory with practice, however, besides the opportunities the student nurse experiences, there are factors that hinder these opportunities in the clinical setting. One of them is the experience of violence perpetrated by patients and their relatives on student nurses in the clinical setting. This study seeks to gain a broader understanding of students' experiences of violence by patients and their relatives at different levels of their training.

The findings of this study will provide the nurse educators and the nurse administrators with a meaningful understanding of patients' and their relatives' violence against student nurses in clinical settings, as perceived by student nurses. The knowledge obtained will be useful in planning learning opportunities that will enable student nurses to deal with acts of violence against them in clinical settings. This study will be beneficial in creating awareness of the support needed by student nurses when working in the clinical setting with patients.

It is important to understand violence against student nurses in order that they are retained in the healthcare sector. In South Africa, there is a general shortage of nurses due to internal and external migration of nurses, as they leave to other countries with better conditions and which are free of violence (King and McInerney, 2006: 70). The high turnover of nurses creates a financial burden on the government of the country. The Department of Health recruits student nurses via the media in different provinces and provides bursaries and stipends to enable them to complete training. When a student nurse drops out of training, the government suffers a loss as the money is not returned, nor is the student nurse replaced by another student.

This study will assist the researcher to gain a broader understanding of student nurses' experience of violence by patients and their relatives when exposed to a clinical setting during their training in KwaZulu-Natal. The student nurses are vulnerable to patients' and their relatives' violence, and are at risk of deciding not to finish their nurse training which leaves the profession with a shortage of trained nurses.

## **1.5 THEORETICAL FRAMEWORK**

It is essential to examine and evaluate the theories in the literature to determine the one applicable for practice and usefulness for this study (Grove, Burns and Gray 2013: 127). A theory is critical to the extent that it seeks human emancipation, to liberate human beings from the circumstances that imprison them. However, the availability of research exploring this subject is limited. The lack of literature on violence against student nurses by patients or relatives has made it difficult to get a suitable theoretical framework for this study. Listed below are a few sources that could be used for this study, though not specific:

The World Health Organization, the International Labour Office, the International Council of Nursing and Public Services International collaborated, producing a document called 'Framework Guidelines for addressing Workplace Violence in the Health Care Sector' (Hinchberger, 2009:37).

Postmodernist Approach: Hinchberger (2009:42) states that this approach recognises that human experiences are diverse and complex, so it is not suitable for this study, which is specific to human experiences, and not workplace violence as focused upon.

Social Critical Theory: This is said to be the views of women's experiences and accepts basic assumptions about social relationships, society, values, and gender (Hinchberger 2009: 42; Crossman 2014). This theory is also not suitable for this study as it is not about the violence in the workplace affecting student nurses.

Feminism Theory: Hinchberger (2009:42) describes this as the understanding of all nurses regardless of sex, gender, sexual identity, race or culture which thus talks about nurses in general, not violence.

Oppression Theory: Hinchberger (2009:42) defines the oppression theory as the ill-treatment of one group of people by another group, or by society with institutional power as a means of asserting that mistreatment. Oppressed group behaviours are described and frequently found in nurses over the past years (Roberts, Demarco and Griffin 2009: 290). Hubbard (2014:17) states that nurses are seen as an oppressed group because the nursing profession is dominated by females in a patriarchal society and they work in a hierarchal system. This behaviour relates to negative aspects of the nursing workplace. The oppression theory appears to be the best suited in an attempt to understand the violence and bullying that takes place in healthcare settings among student nurses (Hinchberger 2009: 40). Here, not all the factors required by this study are mentioned.

Therefore, none of the above-mentioned theories are suitable for this study, and so the 'Ecological occupational health model of workplace assault' was chosen to examine some factors hypothesised as contributing to workplace violence (Levin, Hewitt, Misner, and Reynolds, 2003). This model was used by researchers to explore contributing factors, consequences and solutions to assault of long-term care personnel, where the nursing personnel are the most frequent victims of assault. In this study, some of the factors are not considered, such as the effects on patient care. The factors used are discussed in chapter 4 with the results of the study. The theory will be tested via a self-administered questionnaire since there is no elaborate

theoretical framework underpinning this study. In this study, the effects on patient care under the consequences of the model will not be applied or examined. The model will be modified to suit this study.

This model was adopted in 1998 by Levin, Hewitt and Misner to examine the factors contributing to the likelihood of assault in the workplace and how these are related to each other (Levin, Hewitt and Misner 1998).



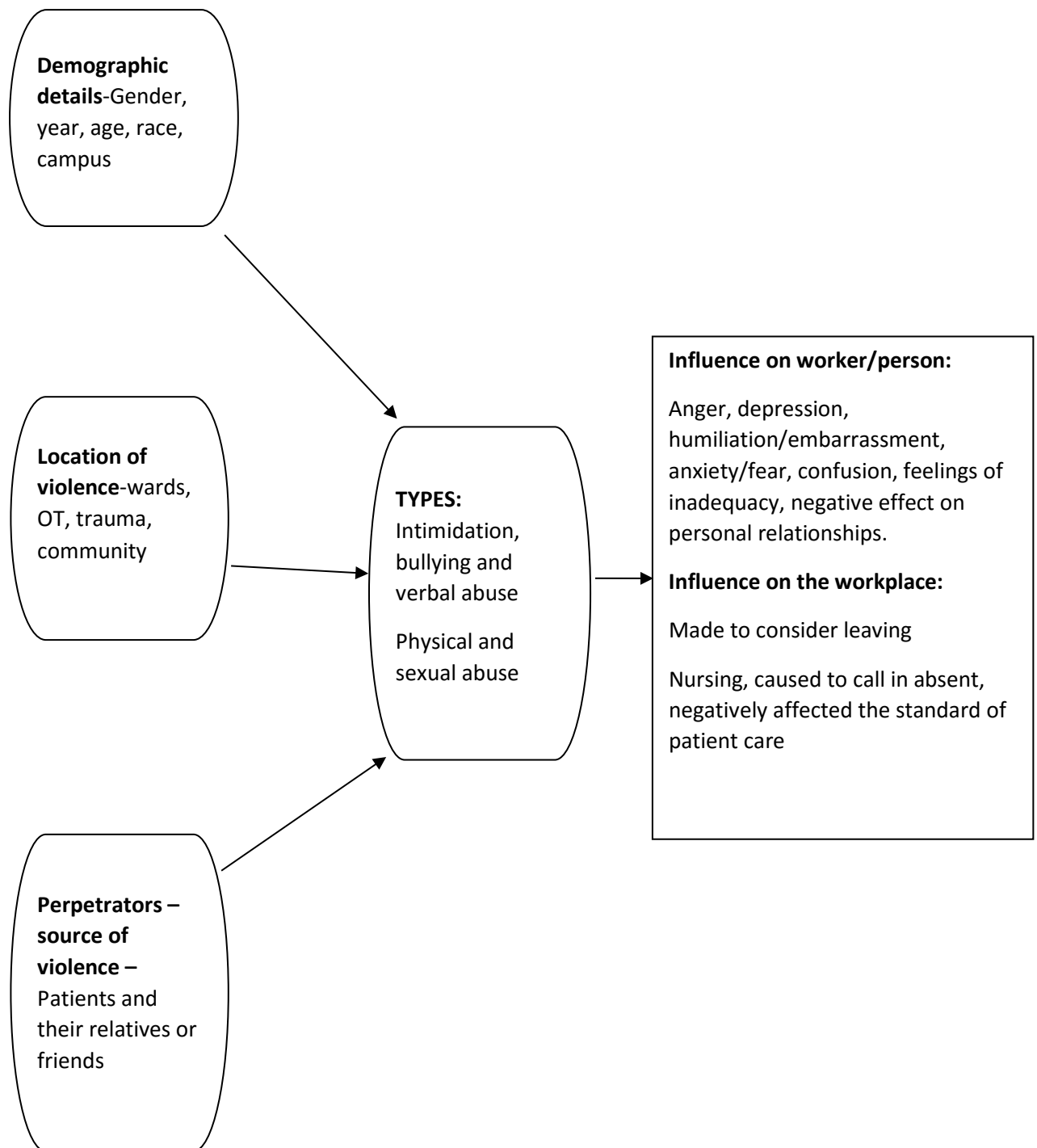


Figure 1.1 Ecological occupational health model of workplace violence (Levin, Hewitt & Misner, 2003)

## **1.6 DEFINITION OF TERMS AND OPERATIONAL DEFINITIONS**

### **STUDENT NURSES**

In this study, 'student nurse' will refer to a student registered for the R425 course leading to registration with the South African Nursing Council as a professional nurse.

### **CLINICAL SETTING/CLINICAL LEARNING ENVIRONMENT**

The clinical learning environment will refer to the clinical setting, which includes the medical, surgical and midwifery wards in which South African student nurses are placed (SANC, 2011:1).

### **PATIENTS**

In this study, patients are described as any individual participating in the healthcare system for the purpose of receiving therapeutic, diagnostic, or preventive procedures (Hahn, 2014).

### **VISITORS**

Visitors are relatives or friends in direct or close contact with the patient, and who are visiting or accompanying the patient in the hospital (Hahn, 2014).

### **VIOLENCE**

For this study, the violence in healthcare settings is any incidence of threatening behaviour, verbal threat, physical assault and sexual assault inflicted by the patient, the patient's relatives or any other individual which constitutes a risk for health staff (Unal, Hisar and Gorgulu 2012: 11).

## **1.7 CONCLUSION**

The nurse-patient relationship plays an important role in nursing. The quality of patient care rendered by nurses is determined by the wellness of the caregiver. Nurses in South Africa often leave the country for greener pastures overseas, or just leave nursing for another profession. The most reported reason for leaving is workplace violence (Boafo, Hancock and Gringart 2015: 100). During evaluation, post student-nurses' placement in the clinical area, there are many complaints and

details of their dissatisfaction there. Some of the student nurses see workplace violence as part of the job, causing them to feel angry.

It is crucial to retain the nurses in this country, so that they can take care of their own people who need them. The authorities/stakeholders need to identify and prevent the causes that lead to a high turnover of nurses versus other professionals. The Department of Health needs to recruit more student nurses for the community and the country and to retain them. Therefore, it is important to identify areas where workplace violence is a common occurrence.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

This chapter presents the literature review which highlights experiences of violence against student nurses by patients and their relatives in the workplace setting in different countries around the globe. A search of the literature was conducted using 'violence against student nurses by patients and their relatives' as key words. Titles and abstracts were assessed for suitability for inclusion in the literature review on Google scholar databases, journals, CINAHL, Medline, PubMed, Sabinet, and materials on the World Wide Web, including a review of recent relevant research results and findings.

Although there is interconnection of literature describing violence in the workplace, not many studies were directed at the experiences of student nurses at the hands of patients. Few articles from the previous ten years dealing with this topic were located. Most of the literature found referred to lateral violence (nurse to nurse) (Woelfle and McCaffrey 2007a: 123; Becher and Visovsky 2012: 210; Hubbard 2014: 16).

Violence against women is reported globally, and seems to be affecting all ethnic, racial, religious, and socioeconomic groups (Hinchberger 2009: 37). Studies on violence against women, served as a forerunner to studies on violence in the workplace, healthcare settings and against all categories of nurses (Hinchberger 2009: 37). According to studies, the majority of nurses are women dominating and working in unsafe environments, Hinchberger (2009:37) states that there is a relationship between the risk of violence experienced by women in general and the violence risk of female nurses.

In South Africa there is an annual campaign of 16 days of activism - 16 days of no violence against women which is supported by Government and its parliament from November to December. In the campaign, awareness is raised and policy issues addressed regarding violence against women and children i.e. physical rape, sexual harassment and child abuse, emotional and financial abuse. According to Statistics in South Africa, violence in any form of act is more than USA statistics despite the decline in femicide (Stat SA, 2015).

In the Western Cape, there is a network on Violence Against Women (VAW) called the Western Cape Network on Violence Against Women (WCNOVAW) serving as

collaborative platform for all who are committed to ending violence against women. Violence against women results in tremendous costs, from greater healthcare and legal expenses, and losses in productivity, to impacting national budgets and overall development (USAID and Foundation for Professional Development 2015: 18). Therefore, violence against women in South Africa is a major health problem calling for immediate intervention focusing on primary prevention.

The National Institute for Occupational Safety and Health (2006:8-11) have identified factors such as a lack of worker empowerment and a lack of written policy, as common barriers to the implementation of strategies to prevent workplace violence. In this study attention was given to the violence perpetrated by patients and their relatives against student nurses in the public hospitals.

## **2. 2 THE TERM 'VIOLENCE' AT WORK**

Violence is a subjective phenomenon, therefore people interpret it differently. It is true that the definition of violence is difficult to get the accurate one as perception varies in cultures and social background (Stathopoulou 2014: 1). There are many definitions of violence locally and internationally. To make it less complicated, the workplace violence is defined. Herewith are few of literatures defining workplace violence:

Workplace violence, is defined by (Magnavita and Heponiemi 2011: 204) as violent acts directed toward workers, includes physical assault, the threat of assault, and verbal abuse, and is widely recognized as having far-reaching consequences for workers' health and safety. Unal, Hisar and Gorgulu (2012:11) define workplace violence in the health care institutions as any incidence of threatening behaviour, verbal threat, physical assault and sexual assault inflicted by the patient, the patient's relatives or any other individual constituting a risk for health staff. According to Hahn *et al.* (2011:54) patient and visitor violence is defined as any verbal, non-verbal or physical behaviour that is threatening or harmful to people or property.

The European Commission's definition for workplace violence, which was adopted by the South African government, labour and business, relates to "incidents where employee(s) are physically or emotionally abused, harassed, threatened or assaulted (overt, covert, direct, indirect) in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health" (WHO, 2002:4).

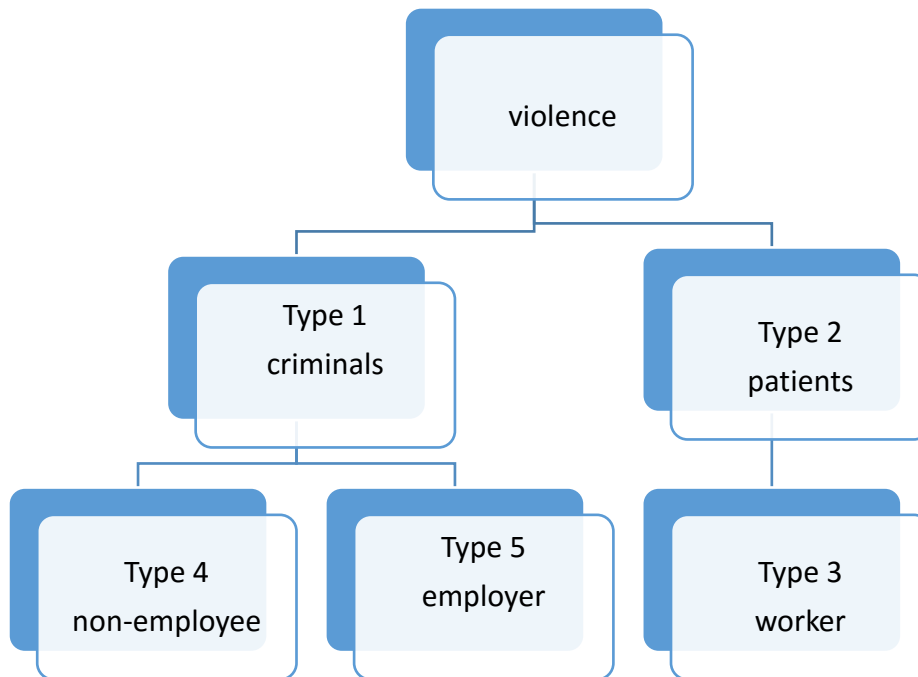
The meaning of violence preferred, as this is about the violence that takes place in the Department of Health, is the World Health Organisation's (WHO) definition of violence which is used to prevent problems that can arise. The World Health Organisation's definition is global and defines violence as "...the intentional use of physical force or power, threatened or actual against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (WHO, 2002:4). The incidence of violent episodes is so overwhelming and continues to rise that it is now recognised as a major health priority by the World Health Organisation, the International Council of Nurses, and Public Services International (Magnavita and Heponiemi 2011: 203; Al-Omari 2015: 112).

For the student nurses, violence by patients and their relatives (workplace violence) is defined as aggressive behaviour towards another person, or object of that person, finding expression in physical assault, sexual harassment and non-physical violence such as verbal abuse, impoliteness, bullying and intimidation (Hewett, 2010:22). But while this can be caused by any person in the workplace, according to Hewett's study, it's not only caused by patients and relatives.

The studies by (Unal, Hisar and Gorgulu 2012: 11) define violence in healthcare institutions as any incidence of threatening behaviour, verbal threat, physical assault and sexual assault inflicted by the patient, the patient's relatives or any other individual, which constitutes a risk for health staff. This is the most accurate one for use in this study, as its concepts are in the questionnaire used in the collection of data for this study.

## 2.3 THE CLASSIFICATION OF VIOLENCE

Below is the figure of classification of violence that occurs in the workplace:



**Figure 2.1 THE CLASSIFICATION OF WORKPLACE VIOLENCE**

### 2.3.1 THE CLASSIFICATION OF WORKPLACE VIOLENCE

- ❖ TYPE 1: Is that violence which is committed by the criminals who enter the workplace with intention to commit a crime (criminals).
- ❖ TYPE 2: Are violent acts committed by the recipients of healthcare services being provided and have a legitimate relationship with the workplace (patients).
- ❖ TYPE 3: Are violent acts by worker to worker in the workplace also known as vertical violence which can be a nurse to nurse, but irrespective of the status of the perpetrator. It is an abusive behaviour by a colleague in a superior position to a subordinate (worker).
- ❖ TYPE 4: Are those acts committed by a non-employee who has a relationship with the worker (non-employee).
- ❖ TYPE 5: Is an act of violence committed by the employer on the employee at the workplace (employer).

This is how Hewett (2010:17-18) classifies workplace violence into five types. In this study, we look at Type 2, which is the violence that takes place in the healthcare services by patients and their relatives who are the recipients of healthcare in this case.

Student nurses are seen as the providers of those services during placements in the clinical area while they acquire skills in nursing to correlate theory taught in classrooms.

### **2.3.2 Type 2 – PATIENTS WHO ARE PRONE TO CAUSE VIOLENCE**

- Men over the age of 74 years with cognitive impairment and aggressive
- Suffering from dementia or delirium
- Drug and alcohol abuse
- And with psychiatric illness (Hahn *et al.*, 2010:3540).

There are many methods by which a perpetrator can show an act of violence towards the victim, like bullying, intimidation, verbal, physical, sexual, horizontal and vertical. These are the ones mostly discussed in the literature on workplace violence.

## **2.4 TYPES OF VIOLENCE**

The literature revealed that in nursing, non-physical forms of violence, for example, verbal aggression, rudeness, bullying and intimidation, are more common than actual physical assault, and that there are only a few instances where weapons are used (Ferns and Meerabeau 2009). Workplace violence in nursing is regarded as inclusive of aggression, harassment, bullying, intimidation and assault (Johnson 2015: 2389).

### **2.4.1 BULLYING**

Bullying is one form of abuse mostly described in the literature and which victims complain about. Blackstock *et al.* (2014:1106) define bullying as any type of repetitive abuse in which the victim of the bullying behaviour suffers verbal abuse, threats, humiliating or intimidating behaviours. Bullying starts at an early stage, even in primary schools, and continues if not stopped (Roche *et al.* 2010: 14; South Africa. Department of Basic Education 2016). This type of violence can be identified at an early stage of an individual and the behaviour changed accordingly. Bullying behaviours exist because of a white wall of silence that often protects the bully (Roche *et al.* 2010: 14).

Often, workplace bullying involves abuse or misuse of power and authority within an organisation (Roche *et al.* 2010: 16; Johnson 2015). Bullying behaviours create feelings of defencelessness in the victim and significantly demoralise his or her right to dignity in the workplace (Roche *et al.* 2010: 14). Bullying is a serious issue affecting the nursing profession and nurses may bully others for a number of reasons (Roche *et al.* 2010: 17). Roche *et al.* (2010:15) is of the opinion that verbal abuse in nursing is like 'eating our



young' and that bullying of this form is costly to the individual nurse, exploding as job stress, job dissatisfaction, missed work and perhaps decreased quality of patient care.

Bullying is seen as a serious, complex and on-going problem in the healthcare workplace (Roche *et al.* 2010: 13). Hubbard (2014:18) is of the opinion that managers and institutions have a responsibility to create and maintain a bully-free workplace. The effective prevention of workplace bullying requires departmental and organisational initiatives (Johnson 2015: 2390). Bullying behaviours are also seen in healthcare centres where patients and their relatives apply bully behaviours to nurses especially the student nurses who are new in the nursing profession.

#### **2.4.2 INTIMIDATION**

By definition, intimidation serves to make someone feel timid, fearful, scared or threaten them in order to persuade them to do something (*Stanford Encyclopedia of Philosophy* 2005). In the workplace, intimidation refers to a repetition of mistreatment or behaviour to frighten someone into doing something, by means of violence, threats or blackmail, to create a feeling of fear, astonishment, or inadequacy in another person (Arnetz *et al.* 2014: 342). It includes a wide variety of situations in the workplace like putting you down, ridiculing in front of others and many more (Arnetz *et al.* 2014: 342).

#### **2.4.3 VERBAL VIOLENCE**

Verbal violence is defined by Hahn *et al.* (2010) as the use of abusive or offensive language, including sexually abusive language, insulting remarks or disrespectful and obscene comments (Hahn *et al.* 2010: 3536). The other definition from researchers is hostile, aggressive and harmful behaviour by a nurse or group of nurses towards a co-worker or group of nurses via attitudes, actions, words and or behaviours (Becher, & Visovsky, 2012:210). Verbal violence has been found to be the most commonly encountered and frequent form of violence experienced in general hospitals, followed by physical violence and threats (Kwok *et al.* 2006: 7). According to Chapman *et al.* (2010:479-487), the type of violence experienced most in the research findings was verbal abuse, followed by physical threats and assaults. The most common type of violence experienced by the student nurses was verbal, followed by bullying and a few instances of physical abuse (Hinchberger, 2009:37-46). Student nurses reported verbal violence associated with high job strain, low social support and low organisational justice (Magnavita and Heponiemi, 2011:207). Therefore, from the study on patient and visitor violence experienced by nurses in public hospitals, student nurses are more susceptible

than other nurses to experiencing verbal patient and visitor violence (Hahn *et al.* 2012: 2695-2696). The researchers recommend the need for evidence-based strategies to decrease and eliminate verbal abuse and to help new nurses cope with abuse, including structured interventions (Spence Laschinger *et al.* 2009: 304).

#### **2.4.4 PHYSICAL VIOLENCE/AGGRESSION**

Violence in health institutions has been described as any incident which puts a healthcare worker at risk, and includes verbal abuse, threatening behaviour or physical abuse by a patient or member of the public (Gillespie, Gates and Berry, 2013:9). Aggression is also described as physical abuse that is characterised by the intention to harm another person (Stathopoulou 2014: 44). Violent behaviour can be caused by many different people in a workplace (see Figure 2.1). Violent behaviour is exhibited much more frequently by patients than by visitors (Hahn *et al.* 2010: 3538). The most commonly reported types of physical violence have been hitting, punching, kicking, biting, threat with weapons, and throwing objects and body fluids, others even death threats (Gillespie, Gates and Berry 2013: 9). The more common injury has been non-fatal injuries (Gillespie, Gates, and Berry, 2013:3). This type of violence against nurses is an endemic, occupational hazard (Powley 2013: 27). Gillespie, Gates and Berry (2013:1) in their findings on stressful incidents of physical violence against emergency nurses, noted that it is not only the psychiatric, under influence of drugs or alcohol, type of patient who commits physical violence.

According to researchers, nurses who are physically attacked are found in nearly all work environments of the world (Gillespie, Gates and Berry, 2013:9). Nurses are attacked during the commission of nursing practice, for example, while starting an intravenous line (Gillespie, Gates and Berry 2013: 7). Studies reported that nurses, in terms of occupation, are more frequently the targets of such behaviour as they are the first health personnel to come into contact with the receiver of healthcare (Pazvantoglu *et al.* 2011: 496). The department with the greatest risk of physical violence compared to others is the emergency department where this occurs almost daily (Gillespie, Gates and Berry, 2013:1). The reported consequences of physical violence for the nurses include acute stress, decreased work productivity, physical injuries and death (Gillespie, Gates and Berry, 2013:9). Other nurses reported more physical assaults, threats and sexual harassment than student nurses by patients or their relatives and friends (Magnavita and Heponiemi, 2011:207). The study done by Aghajanloo *et al.* (2011:284-

287) found that student nurses experienced physical assault, threats and rudeness as the greatest forms of abuse.

#### **2.4.5 SEXUAL VIOLENCE**

Studies by Boafo, Hancock and Gringart (2015:100) define sexual harassment as any unwanted, unwelcomed and unreciprocated act of a sexual nature that is offensive to the person involved. In the literature search done in Ghana on violence against nurses, the medical doctors were found to be the most frequent perpetrators of sexual harassment against nurses (Boafo *et al.*, 2015:100). Kwok *et al.* (2006:7) in Hong Kong, reported patients and their relatives as the greatest perpetrators of sexual harassment against nurses in the workplace. A study done in Germany reveals that sexual abuse is one of the major problems facing the developed and developing countries (Boafo *et al.*, 2015:100).

Surprisingly, the study in Ghana showed a large number of nurses as the victims of sexual harassment, yet only three reported the incidences (Boafo *et al.*, 2015:100). The reason given for not reporting such acts was that it was seen by victims as part of the job, so it was not important to report it. Responses to sexual harassment were that they pretended nothing had happened (Boafo *et al.*, 2015:100). The only way that they decided to combat the problem was to quit or to leave the nursing profession (Boafo *et al.*, 2015:100). The person involved in this type of violence ended up embarrassed, threatened, and humiliated (Boafo, Hancock and Gringart 2015: 101).

#### **2.4.6 HORIZONTAL/ LATERAL VIOLENCE**

Horizontal or lateral violence is any act of aggression or unwanted abuse or hostility within the workplace (Becher and Visovsky 2012: 210). According to Hubbard (2014:16), horizontal violence is an act of aggression that's perpetrated by one nurse colleague towards another nurse colleague causing hostility within the workplace. Further literature by Hubbard (2014:16) explains it as indirect, like gossiping about the victim, criticising them in front of others, or keeping important information from them to keep them at a disadvantage. The more overt forms can include yelling or even physical violence (Magnavita and Heponiemi 2011: 204). The perpetrator displaces part of his/her frustration to others in the form of negative verbal or nonverbal expression (Woelfle and McCaffrey 2007b: 126). This type of violence is said to be common among an oppressed group like the nurses (Becher and Visovsky, 2012:213). Hubbard (2014:17) states that

this type of violence affects almost half of nurses and student nurses, despite the zero tolerance policies in place.

Roche *et al.* (2010:13) states that horizontal violence is more distressing to nurses than physical assault by patients. It is an expression of oppressed group behaviour evolving from feelings of low self-esteem and lack of respect from others, which is supported by the theory of oppression (Woelfle and McCaffrey 2007b: 129). The result of horizontal violence affects nurses, nursing managers, other medical and administrative staff, patients and their families (Woelfle and McCaffrey, 2007:129). There is also the problem of recruitment and retention of nurses, including the graduates after six months of employment (Hubbard 2014: 18). Becher and Visovsky (2012:2013) recommend that counselling be given to the victims to support their emotional needs, as soon as possible before emotional turmoil and the compromise of patient care. Nurses can be so affected that they end up taking more sick days as this disturbs their mental and physical health (Hubbard 2014: 18). Student nurses are also victims of this type of abuse though is not going to be discussed any further in this study.

#### **2.4.7 VERTICAL VIOLENCE**

Vertical violence is a term used to describe the way a senior colleague behaves towards a subordinate (Cantey 2013: 1). Student nurses are also exposed to lateral and vertical violence from other healthcare workers (Magnavita and Heponiemi 2011: 208). Cantey (2013:1) defines vertical violence as any act of violence, such as yelling, sarcastic comments, withholding pertinent information, rudeness, ignoring, and humiliating behaviours, which occur between two or more persons on different levels of the hierarchical system.

Student nurses are also reported as the victims of this type of treatment in the workplace, whether in a medical-surgical unit or in a community setting (Cantey 2013: 1). Students' learning may be affected as fear appears every time they have to enter the clinical area for learning experiences, leading to withdrawal from the learning process. (Cantey 2013: 1). It is said that vertical violence has several negative effects on the student nurse, feelings of inadequacy and depression leading to tearfulness and the desire to seek out a hiding place after such victimisation (Cantey 2013: 1). The student may decide not to finish his/her academic goal to become a nurse, which leaves the profession with one less future nurse (Cantey 2013: 1). This type of violent act results in prohibiting professional performance or dissatisfaction in the work environment.

## **2.5 INCIDENCE AND PREVALENCE**

The WHO reported workplace violence in the healthcare sector of various countries and their percentages, and South Africa is among those countries with the highest number of reported cases with 61 per cent incidences (Al Omari, 2015:111-118). Hahn *et al.* (2010:3536) state that almost all nurses experienced patient and visitor violence during their career. Hahn *et al.* (2012:2693) state that existing research has also reported that young, inexperienced nurses are more exposed to patient and visitor violence than their more experienced colleagues, and that the patient and visitor violence is higher in those in close contact with patients.

The study by Magnavita and Heponiemi (2011:207) reports that 34 per cent of their respondents (student nurses) reported episodes of physical and verbal violence in the workplace during clinical exposure, and as a result, they felt more frequently humiliated and often had a desire for revenge, considered changing their place of work or leaving the profession. Researchers have identified physical violence in healthcare that affects nurses in nearly all regions of the world (Gates, Gillespie, and Succop, 2011:65; Magnavita and Heponiemi, 2011:208). In the study done on hospital workplace experiences of registered nurses who have contributed to their resignation in the Durban metropolitan, by King and McInerney (2006:75), under working conditions, workplace violence from patients and their relatives was reported at both public and private hospitals.

## **2.6 PERPETRATORS**

The classification of workplace violence describes the types of perpetrators in Figure 2.1. This study focuses on the patients and their relatives as the cause of violent acts directed towards the student nurses. Globally, there is literature that also confirms this in the discussion below. Boafo, Hancock and Gringart (2015:99) in their research on sources, incidence and effects of non-physical workplace violence against nurses in Ghana, revealed that relatives of patients were the most frequent verbal abusers.

Hahn *et al.* (2011:55) state that the most common form of violence in hospitals is patient and visitor violence. However, studies which assess patient and visitor violence are rarely performed. Talas *et al.* (2011:197-203); Aghajanloo *et al.* (2011:284-287); Hinchberger (2009:37-46) and Hahn *et al.* (2012:2695-2696), in their findings, confirmed the findings of other researchers that relatives or friends accompanying the patients were most often responsible for the violence in the healthcare departments.

Studies done by Kitaneh and Hamdan (2012:469) on workplace violence against physicians and nurses in Palestinian public hospitals, found that the perpetrators were mostly the patients' relatives or visitors, followed by the patients themselves, while the victims had a lower level of education.

The perpetrators of violence, in the research, were found to be mostly males, aged between 50-65 years, affected by their diseases or drugs (Hahn *et al.* 2012: 2695-2696). Surprisingly, in Ghana, research shows that sexual harassment was perpetrated by the doctors (Boafo, Hancock and Gringart 2015). Hahn *et al.* (2010:3537) are of the opinion that verbal violence is the most frequent form practised by patients rather than with visitors.

## **2.7 FACTORS INFLUENCING VIOLENCE**

### **2.7.1 PREDISPOSING FACTORS TO ACTS OF VIOLENCE BY PATIENTS AND THEIR RELATIVES**

Patient and relative violence is related to staff and patient characteristics, their interactions and environmental characteristics. Here are some of the common factors mentioned in the literature:

- Studies have found that violent patients suffer from a variety of health conditions, including cognitive impairment, confusion or delirium, dementia, alcohol and illegal drug intoxication or withdrawal, and mental health challenges (Hahn *et al.* 2010: 3536).
- Patient and relative violence can also occur due to organisational procedures, such as checking identity, prolonged waiting times, lack of physician availability, imposition of hospital policies and rules, and discharge procedures (Hahn *et al.* 2010: 3536).
- In general hospitals, staff-patient interactions in which patients or relatives endure frustrating experiences, such as pain, anxiety or the feeling that they are not being taken seriously, appear to be precursors for patient and visitor violence (Hahn *et al.* 2010: 3536).
- The patient and relative violence is mainly initiated by male patients over the age of 65 with medical diagnoses resulting in cognitive impairment (Hahn *et al.*, 2010:3543).

- Lack of information concerning the estimated waiting time, difference of language and culture can give rise to misunderstandings between staff, patients and their relatives.
- Additionally, violent events can occur when hospital staff attempt to enforce limits on food or drink consumption, or smoking in hospital areas (Stathopoulou 2014).
- Being required to assist with close physical intervention, negotiating treatment acceptance, discussing decline of care or treatment, providing counselling during difficult times and when encroaching private zones are all related to predisposing violence (Hahn *et al.* 2010: 3536).

Palestinian public hospitals were found to have a higher rate of violence than any other country studied (Kitaneh and Hamdan, 2012:469). The factors that contributed in the study done were:

- Understaffing
- Inadequate working conditions
- Frequent shortages of medicines and supplies
- Overcrowded hospitals
- Delays in receiving care
- Unmet patient needs/expectations (Kitaneh and Hamdan, 2012:469).

## **2.8 AREAS OF VIOLENCE / LOCATION**

With the exclusion of psychiatric departments, high levels of violence are reported worldwide in emergency units also known as trauma units, medical wards, surgical settings and intensive care units, OT (operating theatre) and community settings like clinics (Kwok *et al.* 2006: 7; Gillespie, Gates and Berry 2013: 7) Chapman *et al.*, 2010:479-487). It has been reported that 43.2 per cent of emergency nurses were assaulted by patients or visitors on a daily, weekly, or monthly basis (Gillespie, Gates and Berry, 2013:3). Maternity units or paediatric settings were also listed as being high-risk settings for verbal abuse or threatening behaviour (Hahn *et al.* 2010: 3540).

The area of work was the main factor, rather than the personal characteristics like age, or educational qualifications in determining the nature of workplace violence (Chapman *et al.*, 2010:479-487). Therefore, the area of work had a direct impact on workplace violence, as the nurses in the paediatric and maternity had the lowest number of reports.

## **2.9 VIOLENCE AGAINST HEALTH CARE WORKERS**

From the literature on 'dealing with violence from a mentally disturbed individual' the participants explained that violence and aggression were the worst aspect of caring for individuals with mental illness (Mhaule and Ntswane-Lebang 2009: 129). Magnavita (2014:366) found that health care workers experienced workplace violence and those patients and visitors are mainly responsible for the occurrence. All professional categories may become victims, besides nurses and doctors, and this is seen as a serious problem (Magnavita 2014: 366) and (Lepping *et al.*, 2013:543).

## **2.10 VIOLENCE AGAINST NURSES**

The findings of nurses interviewed in the study by (Chapman 2010: 1), were that the majority of nurses globally, have been involved in workplace violence. Hinchberger (2009: 42) research findings, states that one hundred per cent of the student nurses who responded to the survey questionnaire had either observed or experienced violence in their clinical placements. The study done by Hahn *et al.* (2010:3541), on nurses involved in violence by patients and their relatives, reported that violence took place on registered nurses and the staff working or spending over 40 per cent of their time in direct contact with patients. Nurses who reported patient and visitor violence were more likely to be postgraduates with over four years professional experience, and those who were non-registered or less experienced in contrast to other studies (Hahn *et al.* 2010: 3536).

Student nurses are not excluded among nurses exposed to workplace violence. Violence against student nurses exists at a similar rate to that against staff nurses (Hinchberger, 2009:42). There are studies indicating that student nurses are subjected to verbal violence during their practical training (Unal, Hisar and Gorgulu 2012: 11).

## **2.11 CONSEQUENCES OF VIOLENCE**

### **2.11.1 INFLUENCE ON THE WORKPLACE**

Jackson (2010:114) asked the question "who would want to be a nurse?" stating that the recruitment and retention of nurses becomes a problem. It goes with the hypothesis that "there is a decreased interest in nursing" (Mkhize and Nzimande 2007: 24). All this dissatisfaction has resulted in low morale in nursing, causing tension and conflict in the workplace, as nurses feel disempowered and vulnerable (Fouché and du Toit, 2006:82).



Work related violence by patients and their relatives results in considerable financial loss for the healthcare system (Hahn *et al.* 2010: 3536). The cost of violence in the workplace leads to an increased nurse turnover rate and deterioration in staff health (Roche *et al.* 2010: 14). Stathopoulou (2014:14) states that the impact of violence at the hospital level is the following:

- Increased absenteeism and use of sick leave
- Loss of employee morale and motivation
- Avoidance behaviour affecting employee performance
- Increased costs for installation and maintenance of security equipment.

### **2.11.2 INFLUENCE ON THE WORKER**

The reaction by victims was sadness and anger; they did nothing and remained silent as a coping mechanism (Talas *et al.*, 2011:200-203). A certain percentage took sick leave after being abused, others reported that their clothing, spectacles or jewellery ended up being damaged or destroyed. Some reported physical injuries requiring and not requiring medical treatment (Hahn *et al.*, 2010:3542). All these types of violent acts had an impact on the psychological well-being of nurses (Boafo, Hancock and Gringart, 2015). The professional nurses who were victims of violence had intentions of leaving nursing as a result of workplace violence (Boafo, Hancock and Gringart, 2015). This study is consistent with other studies that conducted research on qualified nurses.

Studies done by Fouché *et al.* (2006:77-85) on a needs analysis for a non-abusive intervention programme in the school of healthcare sciences in Pretoria, state that the violence has resulted in student nurses feeling nervous and inadequate with their practical skills and concerned with recurring abusive events, causing them to be disempowered and vulnerable during their clinical placements (Fouché *et al.*, 2006: 77-85). Student nurses feel unprotected and unsupported in the workplace setting when abused by patients and their relatives. Each individual has different goals when they start training, for example, some use the stipend they receive monthly to support their families. When the student nurse leaves training, the people at home also suffer. Besides their significant others, the student nurse her/himself also suffers financially as s/he may use the stipend for different reasons. The very same patients that are violent to nurses suffer from the shortage of nurses in the end. The effect of violence towards student nurses by patients and their relatives affects job satisfaction, causing short and long term problems (Aghajanloo *et al.* 2011: 287).

## 2.12 REPORTING INCIDENTS OF VIOLENCE

Under-reporting of violent acts in the healthcare facilities has been identified internationally as a limitation, leading to incomplete data collection when researching violence in the workplace (Ferns and Meerabeau 2009: 2680). Under-reporting of violent incidents is a widespread phenomenon in the nursing profession. Magnavita and Heponiemi (2011:204) confirm that workplace violence in the healthcare environment is severely under-reported. The results of a study done over 6 years on workplace violence among healthcare workers shows that the occurrence was severely under-reported (Magnavita, 2014:369).

Personal experiences are said to play a key role in the willingness to report violent incidents (Ferns 2006: 41). Gender and childhood socialisation, like parents who tolerated aggression from boys rather than girls, is said to explain why nurses do not report incidents of violence (Ferns 2006: 41). Nurses in violent relationships may be less likely to report workplace violence in their professional lives (Ferns 2006: 42). Personal life experiences, historical, cultural and organisational issues, play a key role in the under-reporting of violence due to childhood socialisation and experiences of sexual, physical or verbal abuse and its management (Ferns and Meerabeau 2009: 2680). Some of the participants stated that they had reported the incidents of violence that took place in the workplace, and the reasons of those who did not report such incidents, were that workplace violence was part of their jobs as it happens all the time (Hinchberger, 2009:37-46). The other reason was that, even if they did report such actions, the hospital management failed to do anything about it (Chapman *et al.*, 2010:479-487). A very small percentage reported the matter to the security or police (Hinchberger, 2009: 37-46).

Student nurses regard it as part of their job when they suffer violent acts by patients and their relatives (Magnavita and Heponiemi 2011: 204). Studies on student nurses report an alarming reluctance to report incidents of violence in the workplace, as they have the belief that being attacked is part of the job as it happens all the time (Chapman *et al.* 2010: 481). While the majority of the incidents of violence in the workplace which were reported, student nurses were not happy saying that the state and the management failed to act on these reports (Chapman *et al.* 2010: 484).

Student nurses may be tolerant of abusive violence because they are expected to be tolerant (Ferns 2006: 43; Ferns and Meerabeau 2009). Student nurses are afraid to report violence in patients for fear of having to recognise it in themselves and their

families (Ferns and Meerabeau 2009: 2680). Doing nothing against violence is the most commonly used coping method among student nurses (Unal, Hisar and Gorgulu 2012: 16). There is an alarming reluctance by student nurses to report violence in the workplace as they feel that reporting is an empty gesture and that there is a lack of support for the victims (Roche *et al.* 2010: 15).

Violent incidents which go unreported in emergency departments are associated with excessive paperwork, lack of support from management and poor or ineffective reporting systems (Powley 2013: 27). The problem is that sometimes violent incidents occurring to nurses are reported to administrators who are not necessarily members of the nursing profession, which is a bureaucratic process (Ferns 2006: 42-43). It shows that nurses are not independent, have little authority to instigate changes autonomously thus managing the safety of their colleagues (Ferns 2006: 43).

Most nurses are committed to the welfare of their patients, their purpose being to care for the people, so nurses have to have the courage and skill to report reckless and suspected criminal behaviour (Wolf 2012: 16).

One nurse in America who was said to be recovering from assault by a patient wanted to raise awareness about workplace violence and advocated for strategies to prevent its re-occurrence (Unal, Hisar and Gorgulu 2012: 16). Talas *et al.* (2011:202) opined that more than half of their participants stated that they had never reported an incident of violence. Here are some of the reasons given by participants in the research studies as to why student nurses do not do anything or report violent acts:

- Shyness and ignorance about what to do
- Not believing that attitudes will change
- The idea of not being supported
- Shame and fear of obtaining low grades in clinical practice training
- Lack of knowledge about personal rights
- Concern about what others will think about their behaviour
- Anxiety owing to lack of confidence and poor self-esteem
- Fear of other people's hostility
- Being afraid of anger or negative responses (Unal, Hisar and Gorgulu 2012: 16).

**Other reasons for not reporting from other nurses:**

- Belief that there is insufficient time to complete reports
- No real benefit is gained from reporting incidents

- Excessive workloads
- Perception by some nurses that violence is an expected workplace hazard (Ferns and Meerabeau 2009: 2679).

Under-reporting of violent acts is the reason why there is no action taken by the organisation and government to prevent workplace violence, since there is a lack of evidence (Chapman *et al.* 2010: 481).

## **2.13 RECOMMENDATIONS BY RESEARCHERS**

The researchers recommended that the policy and strategies for prevention and management of workplace violence provide adequate physical and psychological support to victims of health workplace violence (Kitaneh and Hamdan, 2012:469). They also see the need to encourage reporting and following-up on incidents (Kitaneh and Hamdan, 2012:469).

- To reduce violence, a strong organisational strategy and commitment is imperative as an international recommendations (Hahn *et al.* 2012: 2695-2696).
- The staff require appropriate training, considering communication skills and appropriate management of patient and visitor violence and which is centred on patient care (Hahn *et al.* 2012: 2695-2696).
- More comprehensive research on the patients' and visitors' perspectives is required (Hahn *et al.* 2012: 2695-2696).
- Urgent preventative action is needed to control the patient-to-worker and worker-to-worker violence in the workplace (Magnavita and Heponiemi, 2011:207).
- Multi-level programs of violence prevention to benefit student nurses are required (Magnavita and Heponiemi, 2011:207).
- The researchers recommended that every hospital should have reporting procedures that staff will feel comfortable using and a comprehensive programme of support services for all the victims (Talas *et al.*, 2011:200-203).
- Student nurses should be supported from the beginning of the violent action to reduce its complications by necessary follow-ups and consultations (Aghajanloo *et al.*, 2011:284-287).
- Nursing colleges should develop educational programs regarding communication with staff and patients and dealing with workplace violence to prepare them for the clinical exposure (Aghajanloo *et al.*, 2011:284-287).

- Determine the extent and causative factors of violence and minimise it by careful planning (Aghajanloo *et al.*, 2011:284-287).
- Increase incidence of reporting by subsequent research conducted to understand the nurses' decision-making processes in reporting (Chapman *et al.*, 2010:479-487).
- To provide the clinicians, managers, educators and administrators with an understanding on how nurses cope with workplace violence (Chapman *et al.*, 2010:479-487).
- To conduct more studies to check how the nurses adapt to violence in the workplace (Chapman *et al.*, 2010:479-487).
- Hospital administrators, staff, and student nurses should be taught that workplace violence will not be tolerated and should adopt a zero-tolerance approach (Hinchberger, 2009:37-46).
- The student nurses need to see, practice and model effective methods for reducing hostility and understand that workplace violence is not part of being a nurse (Hinchberger, 2009:37-46).
- Clear policies should be instituted to address the problem (Boafo, Hancock and Gringart, 2015).
- Based on the findings of study, the researchers strongly recommend the implementation of a non-abusive intervention programme (Fouché *et al.*, 2006:77-85).

The researcher recommends that the nursing personnel be educated regarding reporting and management's support when faced with workplace violence (King and McInerney, 2006:80).

## **2.14 CONCLUSION**

It is clear that the research reviewed in the literature, globally, has identified that student nurses are also being abused by their patients and their relatives in the workplace. Some studies report that the abuse remains an on-going problem. Violence has an impact on the student nurses' attitudes towards work, but also influences their decisions about whether to stay in their current positions. Further studies continue to indicate that if hospital and health systems want to retain these new nurses, they need to make changes that will end this kind of abuse.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

Quantitative research approaches and designs are essential to develop the body of knowledge in nursing which is needed for evidence-based practice (Grove *et al* 2013:34). The researcher gathered information directly from the people that are affected by violence from patients and their relatives.

#### **3.2 RESEARCH DESIGN**

A quantitative descriptive cross sectional survey design was used to gain more information on the problem of violence experienced by student nurses (Grove, Burns and Gray 2013: 256). Quantitative research is most likely to lead to valid answers to the questions, and to achieve objectives, as it is a formal, objective, systematic study process to describe cause and effect among variables (Grove, Burns and Gray 2013: 706). The numerical information gathered in the research process was analysed using statistical procedures.

Descriptive studies according to Creswell (2012: 13), the research problem can be answered best by study from individual responses and how it can vary among the people. A cross sectional study is used to examine participants in various stages simultaneously (Grove, Burns and Gray 2013: 691). In this study a cross-sectional survey was conducted across all groups of the 4 year programme at different levels of training with the exclusion of students placed in Psychiatric settings who it was assumed had acquired skills in managing violent people.

#### **3.3 SETTING**

KwaZulu–Natal is one of the nine provinces in South Africa, and it is situated on the east coast of the country, populated with 10.8 million residents (Stats SA 2015).The study was carried out at four different campuses of the KwaZulu-Natal College of Nursing (KZNCN). KZNCN falls under the KZN Department of Health, situated in Pietermaritzburg which is the capital city of KwaZulu- Natal. This College is approved by South African Nursing Council (SANC) to offer several nursing programs including the R425 course that leads to registration as a Nurse (General, Psychiatric and Community) and Midwifery on completion (KwaZulu-Natal College of Nursing 2013). The course is offered over four academic years (KZNCN 2005:8, 9). The KZNCN comprises 25 sites

that are made up of 11 campuses and 14 sub campuses. The 11 campuses are situated throughout the KZN Health Districts. Only ten of these campuses offer the four year diploma course (R425), namely: Addington, Benedictine, Charles Johnson Memorial (CJM), Edendale, Greys, Madadeni, Ngwelezane, Port Shepstone, Prince Mshiyeni Memorial and RK Khan. The eleventh campus, King Edward V111 is offering the post basic courses. Some campuses are in or near the cities while others are in more rural areas of the province (KZN DOH 2001a). The advantage of these campuses is the affiliation to the hospitals, where nurses are placed for their clinical practice as soon as they finish the first six weeks of theory in the college.

### **3.4 POPULATION**

The target population consisted of all SANC registered student nurses studying the R425 diploma in nursing+ midwifery at the KZNCN. KZNCN had two intakes each year on the first of January and the first of July. The number of students varies per Campus each year. The student nurses do not have employee status, and work within the public hospitals and other clinical areas as determined by the curriculum.

In 2014 the KwaZulu-Natal College of Nursing recruited 600 student nurses for the R425 programme distributed between the ten campuses. The small campuses, like RK Khan Hospital, recruit twenty five student nurses every six months and the bigger campuses like Greys Campus recruit forty student nurses every six months so the number of student nurses varies and is determined by the allocated budget from the Department of Health. The total study population consisted of all first, second, third and some of the four- year student nurses who had not started Psychiatric nursing (n=1479) at the selected colleges.

### **3.5 SAMPLING METHOD**

Sampling is a process of selecting a group of people to participate in a study (Grove, Burns and Gray 2013:351). It is important that the subgroup selected represents the target population as much as possible (Creswell 2012: 206). It is important to have individuals with the same characteristics (Brink, Van der Walt and Van Rensburg 2012: 125).

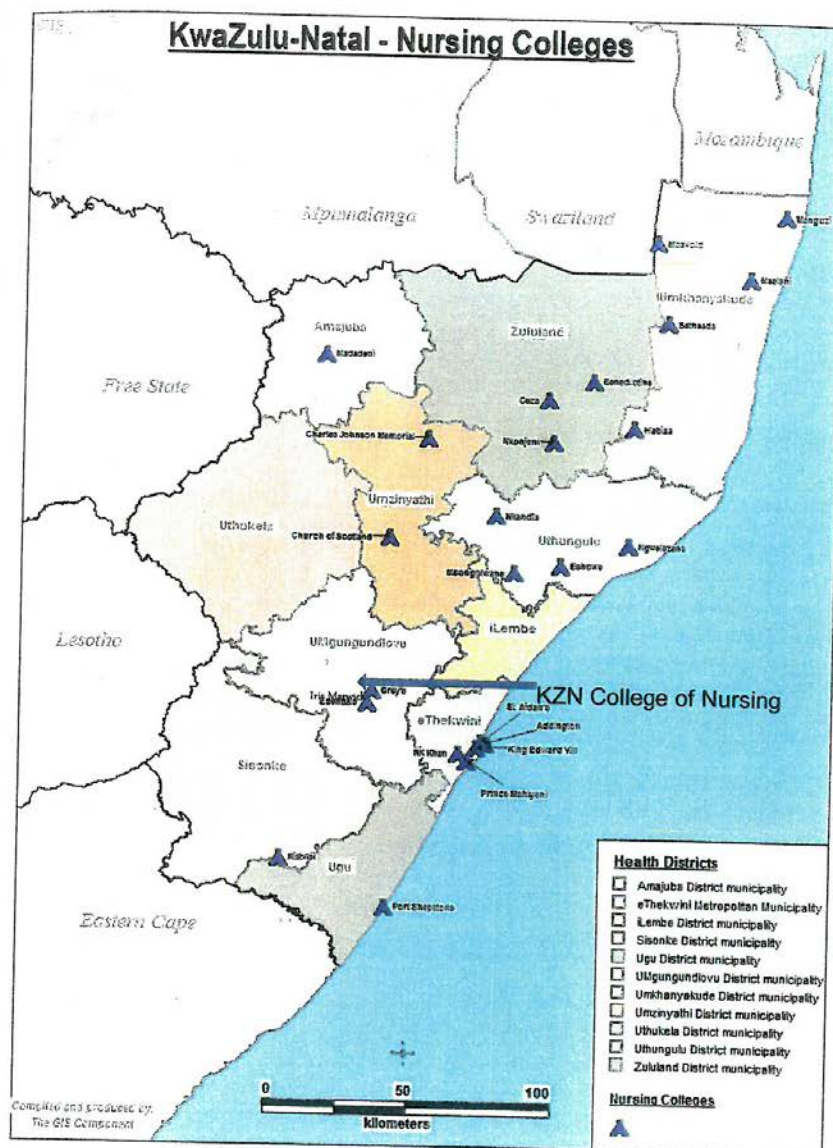


Figure 3.1: Map showing location of KZNCN Campuses



### **3.5.1 SAMPLING OF CAMPUSES**

A simple random selection of four of the nine campuses in the province of KZN that offer the R425 course was done to increase the validity of the study. A randomly selected sample is more likely to be representative of the population because all subjects have an equal chance of being included in the study (Creswell 2012: 143), though there can be differences in the probability if it is not properly done. Random sampling was done using the fish bowl method (Grove, Burns and Gray 2013: 358) to select the campuses. The names of all ten campuses were written on separate pieces of paper, put into a bowl and shaken well making sure all were visible plus not attached to one another. One paper was pulled out, and the campus was considered as selected. The piece of paper was then replaced immediately so that statistically, everyone still had a one in ten chance of being selected. The next piece of paper was drawn out and if the same name was drawn out, it was replaced, the bowl given a good shake again, and the procedure continued until the desired number (four) of campuses were obtained. During this process, the campus where the researcher is employed was not selected in order to ensure objectivity (Grove, Burns and Gray 2013: 358).

Of the nine KZN CN Campuses the four sampled, included Greys (Campus1), Ngwelezane (Campus 2), Port Shepstone (Campus 3) and Prince Mshiyeni Memorial Campuses (Campus 4). These four campuses selected had a full complement of student groups from year one to year four and are in different areas of the province. Campus 1 is situated in the capital city of KZN in the UMgungundlovu district. Campus 2 is situated in northern KZN serving uThungulu, uMkhanyakude and Zululand districts. Campus 3 is situated in southern KZN in the UGu district and Campus 4 is situated on the outskirts of EThekweni Health district.

### **3.5.2 SAMPLING OF PARTICIPANTS**

A non-probability convenience sample technique was used to sample student nurses across the 4 years of training. The sample method used was the convenience, as data was collected when students were at their campuses attending lectures at the time of planned visit by the researcher (Polit and Beck 2012: 239). In convenience sampling (nonprobability), participants happened to be at the right place at the right time meeting the eligibility criteria (Grove, Burns and Gray 2013: 363). Creswell (2012: 145) states that nonprobability sampling is selecting individuals that are available, convenient and participants agree to be studied. This method is suitable when the population is large and participants available not known. The students, who were attending lectures at the

campus during the time of data collection, were all invited to participate in the study. Students from all four years of the R425 programme at the chosen campuses were potential participants in the study except those in the mental health module (psychiatry). The sample size was determined using the total number of students.

Overrepresentation or underrepresentation of the sample has been prevented by the researcher inviting a statistician to assist in the sampling size. The sample size has been determined using an Alpha value of .05 and an acceptable margin of error of .05. The sample size required was 366 student nurses from a total population of 1479 student nurses. This included an extra 20% in case of non- response. To prevent sampling error, the researcher used large number of participants. Sampling error according to Creswell (2012:146) is the difference between the sample estimate and the true population score.

Permission was obtained from the Principal of KZNCN to access student numbers from each campus Principal (Annexure G). All available students in year one to year four on the day that the researcher attended the campus to collect data were sampled. Student nurses were sampled following the information session and they were willing to participate. All students in a chosen group who consented to participation were included. A fair representation of the student population was considered to have been obtained from the four campuses. The majority of students gave consent to participate in all four selected campuses in the study.

An advertisement printed on A4 size coloured paper was displayed on notice boards of campuses in the study before date of data collection (Annexure A). Arrangements were made with individual campus principals after permission was obtained (Annexures K-R). Group lecturers were also involved for times to be allocated during college day for students to be addressed and given letter of information for the informed consent to be obtained (Annexure C) and the questionnaire to be completed (Annexure B).

#### **The eligibility criteria for the study participants:**

- Student nurses registered with SANC for the R425 diploma course leading to registration as a Nurse (General, Community, and Psychiatric) and Midwife both males and females.
- The student nurses in their first, second, third and in midwifery module of the fourth year of training at the four chosen campuses (Annexure K-R).

**The exclusion criteria applied in this study:**

- Any student nurse who was not in their first, second, third or midwifery module of the fourth year.
- Student nurses who were not doing the R425 programme.
- Student nurses that were not doing their training at KZNCN.
- Student nurses from Addington Campus where the researcher was employed.
- The fourth year students who have been trained in psychiatric nursing, as they are expected to be knowledgeable on how to manage a violent patient.

**3.6 DATA COLLECTION**

The College Principal was given a poster and the proposal, explaining about the proposed study. Posters (Annexure A) advertising the study were given to all identified colleges explaining clearly about the proposed study and displayed on the campus/college notice boards where all students had access to them. The permission was granted by the Department of Health (see Annexure E) and KZNCN (Annexure G) to conduct the study, the researcher then had a brief meeting with the different lecturers in different campuses running the groups of students to explain the study.

The permission obtained from the principal of each college/campus who in turn discussed with her/his lecturers. The lecturers explained about the proposed study to their group of student nurses in their first, second, third and midwives in fourth year of training when they were at college for predetermined periods of tuition which vary from two to five weeks at a time. The researcher was not a lecturer in the campuses/colleges chosen to collect data. Most of the data was collected during planned times to minimise disruption to the scheduled time tables as determined by individual campus lecturers.

The researcher invited these students to participate in the research and then issued the information sheets, consent forms and the instruments. The researcher explained the instrument on the day of data collection. The participants informed that they were not forced to participate in the study. They would be allowed to leave anytime should they feel discomfort during filling of the instrument, and there was no penalty.

Prospective participants were encouraged to make a voluntary decision to participate by reading the letter of information and signing the consent when understood the implications of their participation. Participants were given sufficient time to consider their participation before filling in the instrument. The self-administered questionnaires filled in

at a convenient time to avoid any disruption to classes in the afternoon or during study time not inconveniencing anyone. The student nurses encouraged to complete the instrument on that same day. Contact details of the researcher were written on the letter of information shared with the participants. The completed instruments collected in a sealed box placed in the classroom separately from the consent form to avoid the identification thus maintaining confidentiality.

### **3.7 RESEARCH QUESTIONNAIRE**

A self-administered structured questionnaire (SAQ) with open and close-ended questions was used to collect data between November 2015 and February 2016 (Annexure B). Close-ended questions are more efficient and less time consuming for respondents (Polit and Beck 2012: 297). In close-ended questions have options where participants choose the answer that most closely matches their experience which is seen in section D, multiple-choice question offer 3 or 7 questions for attitude as seen on section B and C (Polit and Beck 2012: 298). For factual information, dichotomous questions used in section A are appropriate to choose between 2 alternatives for example gender, race and year of study (Polit and Beck 2012: 298). Likert –type questions were used to express a viewpoint in section B and C (Polit and Beck 2012: 301). Open-ended questions allow people to respond in their own words e.g. question 24 regarding the suggestions for the management of workplace violence targeting student nurses in the clinical area an example of which can be found at the end of the questionnaire. Adequate space was provided to permit the participants to respond adequately (Polit and Beck 2012: 297).

The questionnaire adopted was developed by Hewett (2010: 131-137) on workplace violence, targeting student nurses in the clinical areas in Western Cape. Permission was obtained from the author (See Annexure I). The instrument was adapted to the KwaZulu-Natal setting. The instrument is in English and as it is the academic language of instruction at the college participants were deemed competent to answer the questions in English. The variables were not manipulated but presented the facts as it happens in the clinical area (Grove, Burns and Gray 2013: 425).

The questionnaire contains five sections: Section A which is the Socio-demographic data used to establish factors which impact students' experience of violence. Variables included the level of training of the student, gender, age, race and campus. Section B is focused mainly on data related to workplace violence. Section C requires the source of

the violence, influence on work and personal consequences due to violence. Section D is on reporting of workplace violence, Section E, and is about the management of workplace violence. The instrument yielded quantifiable data (see Annexure B). The questionnaire asks the following:

- The types of abuse and violence the student nurse are experiencing at the workplace
- The common areas or departments where this violence is taking place
- The student nurse response following the abuse or violence
- The perpetrators of violence towards student nurses
- If the abuse or violence has been reported or not
- If the public hospitals do have any policies that address workplace violence or not.
- If the student nurses have any suggestions regarding the management of workplace violence targeting student nurses.

### **3.7.1 RELIABILITY**

Reliability refers to the accuracy of measurement (Polit and Beck 2012:196). Reliability for quantitative research focuses mainly on stability and consistency (Polit and Beck 2012:196). It is used to check if the questionnaire is able to yield the same data when it is re-administered under the same conditions (Polit and Beck 2012:196).

The instrument has been used in a previous study where (Hewett 2010: 131-137), reported reliability. The questionnaire was adapted and used in a study amongst Western Cape University students, including student nurses. The questionnaire was found to be reliable with a Cronbach's alpha value of 0.05. The reliability of the questionnaire in the current population under study computed and reported as Cronbach's Alpha, in the final report. The Cronbach's alpha measures the internal consistency, scale reliability and coefficient of reliability (Creswell 2012: 159).

For the fact that the questions were based on the literature review on workplace violence affecting student nurses enhanced reliability. Questions measured the occurrence of events as identified in literature.

### **3.7.2 VALIDITY**

Instrument validity seeks to determine whether an instrument accurately measures the things it is expected to measure within the context in which it is used (Creswell 2012: 159). The tool has been tested in the Hewett (2010) on 'workplace violence targeting

student nurses in the clinical areas' study. Hewett (2010:37-40) in developing the questionnaire reported content and face validity was done.

### **3.7.3 FACE VALIDITY**

Face validity checks that the instrument has measured the target construct whereas the content validity checks that there are enough relevant questions covering all aspects being studied (Polit and Beck 2012:336). The researcher chooses the face validity to measure the validity of instrument used on target population, determines if the instrument measures what it is meant to measure.

Prior to the current study, the questionnaire was tested on 20 student nurses across all levels of study that were from a campus not sampled for the main study. Participants were asked to rate the clarity of wording.

### **3.7.4 CONTENT VALIDITY**

Content validity assesses how effectively the questionnaire represents all the parts of the variable are to be measured (Creswell 2012: 161). Content validity also assesses the representativeness of the question to the phenomenon being studied (Hewett 2010: 42). This was secured by ensuring that all of the relevant components of workplace violence as on literature review were represented by the questions and found appropriate by the statistician.

## **3.8 ETHICAL CONCEPTS**

Ethical considerations were applied throughout the study. Permission was approved by Durban University of Technology (DUT), and Institutional Research Ethics Committee (IREC) number 106/15 (Annexure J). National Health Research Department (NHRD) approved number 276/15 (Annexure E) and all were obtained in November 2015. Before the commencement of data collection, permission was sought from KZNCN, Campus Principals and student nurses after explaining to them the purpose of the study. They were assured of confidentiality. Participants were not allowed to write their names or any information that could be used to trace them.

### **3.8.1 PRINCIPLE OF RESPECT FOR HUMAN DIGNITY**

#### **3.8.2 COERCION**

Coercion includes the right to self-determination, free from threats to participating in a study or the rewards from agreeing to participate (Polit and Beck 2012:154).

The researcher honoured and protected the potential participants from coercion. The student nurses were participants in the study. Participants were given sufficient time to consider their participation before filling in the instrument. The lecturers at different campuses explained the study to the participants: that they were free to withdraw at any time without any prejudice.

#### **3.8.3 ANONYMITY**

Anonymity was guaranteed and is the most secured means of protection for the participants. Participants were told that they were going to be anonymous throughout the study. Self-administered instruments were used to collect data and had no names of participants, but numbers that were only written out of the classroom just to identify the number of responses and were not linked to the participants. The informed consent forms were returned separately from the questionnaires and placed in a specific container made available for that purpose. Completed instruments were placed in a sealed container provided, thereby ensuring the upholding of complete anonymity.

#### **3.8.4 CONFIDENTIALITY**

The researcher assured the participants that their confidentiality would be maintained throughout the study by using numbers instead of their names on the self-administered questionnaire. Participants were informed that data collected would remain confidential and that only the researcher and the statistician would have access to it. The questionnaires would be kept under lock and key and thereafter disposed of by shredding; computed material would be protected by password on the researcher's personal computer. Data would be kept secure for a period of 5 years. After which it will be destroyed by the researcher. Hard copy questionnaires and consent forms will be shredded. Electronic data will be deleted off the hard drive of the researcher's computer.

### **3.9 DATA ANALYSIS**

Descriptive statistics were computed and displayed in the form of tables and graphs. In order to test for significant trends in the data, inferential statistics were applied. These included Pearson's correlation, t-tests, Anova and chi-square tests. Where the conditions

were not met for the application of these tests, non-parametric equivalent tests or exact tests, were applied. Throughout a p-value of 0.05 was used to indicate significance. The analysis was carried out using the SPSS version 23.

Further, the validity of results depended on the correct and appropriate use of statistical tests such that assumptions were not violated.

- Descriptive statistics including means and standard deviations, where applicable. Frequencies are represented in tables or graphs (see Chapter 4).
- Chi-square goodness-of-fit-test: A univariate test, used on a categorical variable to test whether any of the response options were selected significantly more/less often than the others. Under the null hypothesis, it is assumed that all responses are equally selected.
- Kruskal Wallis Test: Non parametric equivalent to ANOVA. A test for several independent samples that compares two or more groups of cases in one variable.
- Mann Whitney U Test: Non parametric equivalent to the independent samples t-test and tests for significant differences in an ordinal measure across two groups.
- Spearman's correlation: Correlations measure how variables or rank orders are related. Spearman's correlation coefficient is a measure of linear association for ordinal data.

### **3.10 CONCLUSION**

The study involved four KZN CN Campuses within the Province of KZN. Data obtained from student nurses in all levels of study (R 425) program with the exception of student nurses doing psychiatric nursing module. Questionnaire used, was modified to suit this study with the permission from the researcher (see Annexure H and I). The questionnaire consisted of 5 sections:

- Section A-Demographic data
- Section B- Data related to workplace violence
- Section C-Source of violence influence on work and personal consequences.
- Section D- Reporting of workplace violence
- Section E- Management of workplace violence

All data collected by the researcher.



## **CHAPTER 4**

### **PRESENTATION OF RESULTS AND ANALYSIS**

#### **4.1 INTRODUCTION**

This chapter will present the results of this study. The aim of this study is to determine the extent and types of violence experienced by student nurses from patients and their relatives in public hospitals in KwaZulu-Natal, and whether this leads to their intention to leave the nursing profession. All respondents had experiences with clinical placement as data was collected towards the end of the year in 2015, and so even first year students had had sufficient clinical exposure to enable them to relate their experiences in clinical practice.

The research objectives were:

- To describe the types of violence experienced by student nurses in public hospitals in KwaZulu-Natal.
- To describe whether the violence experienced by student nurses in the workplace settings leads to an intention to leave nursing.

#### **4.2 PRESENTATION OF SURVEY RESULTS**

The results are presented using the objectives defined for this study. Using a convenience sample resulted in data being collected from a slightly larger number of students than was recommended for the study. Descriptive and inferential statistics were computed and included tests such as chi-square goodness-of-fit test, Spearman's correlations, Kruskal Wallis test, Spearman's correlation and Mann Whitney U Test. Frequencies are represented in tables and graphs.

##### **4.2.1 PRE-TESTING THE QUESTIONNAIRE**

It was essential to use a small-scale version of the proposed study, with the intention of refining the methodology and testing the instrument to be used in the main survey (Polit and Beck, 2012:195). The respondents who took part in the study were from the campus not included in the sampling frame. The campus used for pre-testing is also one of the KZNCN's and students doing the R425 program and all levels of training similar to the chosen campuses. Convenience sampling was used to select the sample as those chosen were willing and available to be studied, five in each group (Creswell, 2012:145).

A total of 20 respondents completed questionnaires for pre-testing the instrument to be used for the main study to ensure clarity, relevance, understanding and ease to answer.

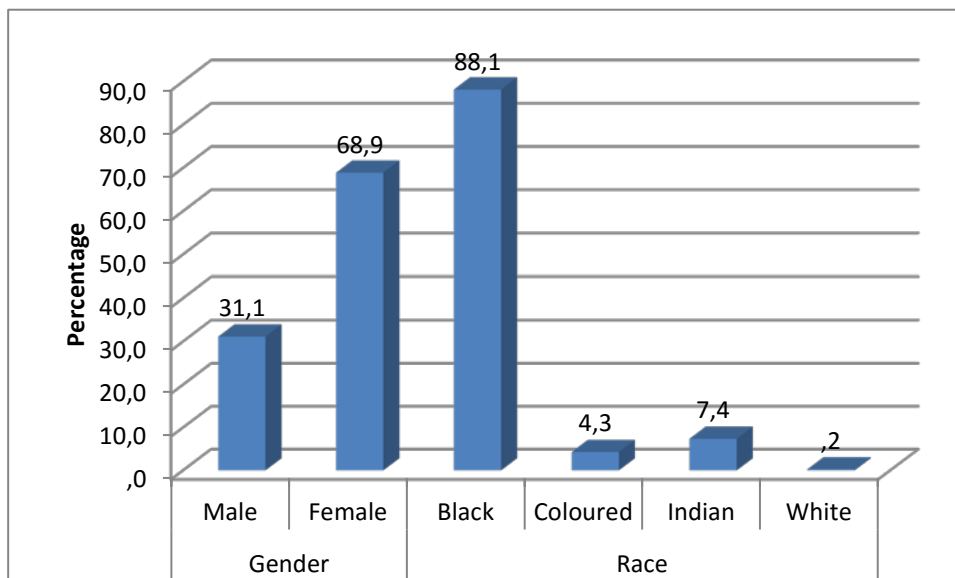
Subsequently, the researcher was able to assess the questionnaire to see if it was realistic and workable, and identified problems which might occur during the main study. The pilot study turned out to be a reassuring experience for the researcher after a correction was made, this being the addition of an instruction to section B, as in section C. Once the amendment was done, full ethics approval was given by the DUT Institutional Research Ethics Committee.

### 4.3 SAMPLE REALISATION

A sample size of 366 was intended. This sample size was determined by a statistician using an Alpha value of .05 and an acceptable margin of error of 0.05. There were 421 questionnaires distributed and 100 % were completed with a sample realisation of N=421 across four campuses.

### 4. 4 SECTION A: DEMOGRAPHIC DATA OF THE PARTICIPANT

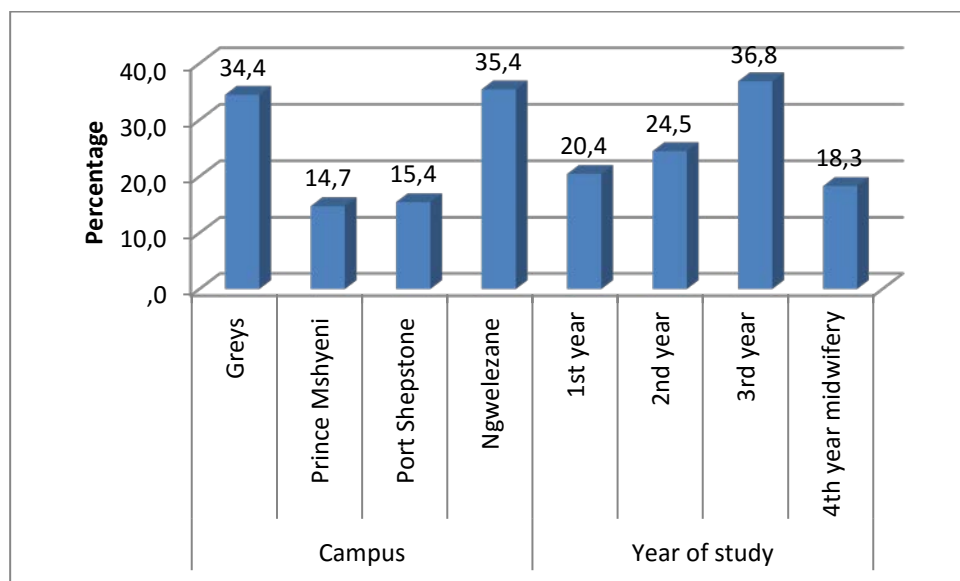
The respondents in this study were predominantly female, 68.9 % (n=290), with 31.1 % (n=131) being male. The dominant racial group comprised 88.1 % (n=371) Black students, with the other racial groups represented but in very small numbers, 18 (4.3 %) Coloured, 31 Indian (7.4 %) and only 1 (0.2 %) White respondent. Refer to figure 4.1. The age of the respondents ranged from 18 years to 50 years.



**FIGURE.4.1 Gender and race**

The number of respondents from each campus varied. The largest number of respondents (n=149) came from the Ngwelezane campus and comprised 35.4 % of the

respondents. The PMMH campus contributed the smallest number (n=62) which comprised 14.7 % of the sample. Refer to figure 4.2 below.



**Figure 4.2 Campus and year of study**

The biggest group of respondents were in their third year of training (n=155, 36.8 %), with the fourth year midwifery respondents (n=77, 18.3 %) being the smallest group. Refer to Table 4.1 and Figure 4.2.

**Table 4.1 Year of study**

Year of study	Frequency	Percentage
1 <sup>st</sup> year	86	20.4
2 <sup>nd</sup> year	103	24.5
3 <sup>rd</sup> year	155	36.8
4 <sup>th</sup> year midwifery	77	18.3
Total	421	100

## **4.5 SECTION B: DATA RELATED TO WORKPLACE VIOLENCE**

### **OBJECTIVE 1: To describe the types of violence experienced by student nurses in public hospitals in KwaZulu-Natal**

The respondents were instructed to use the following response key:

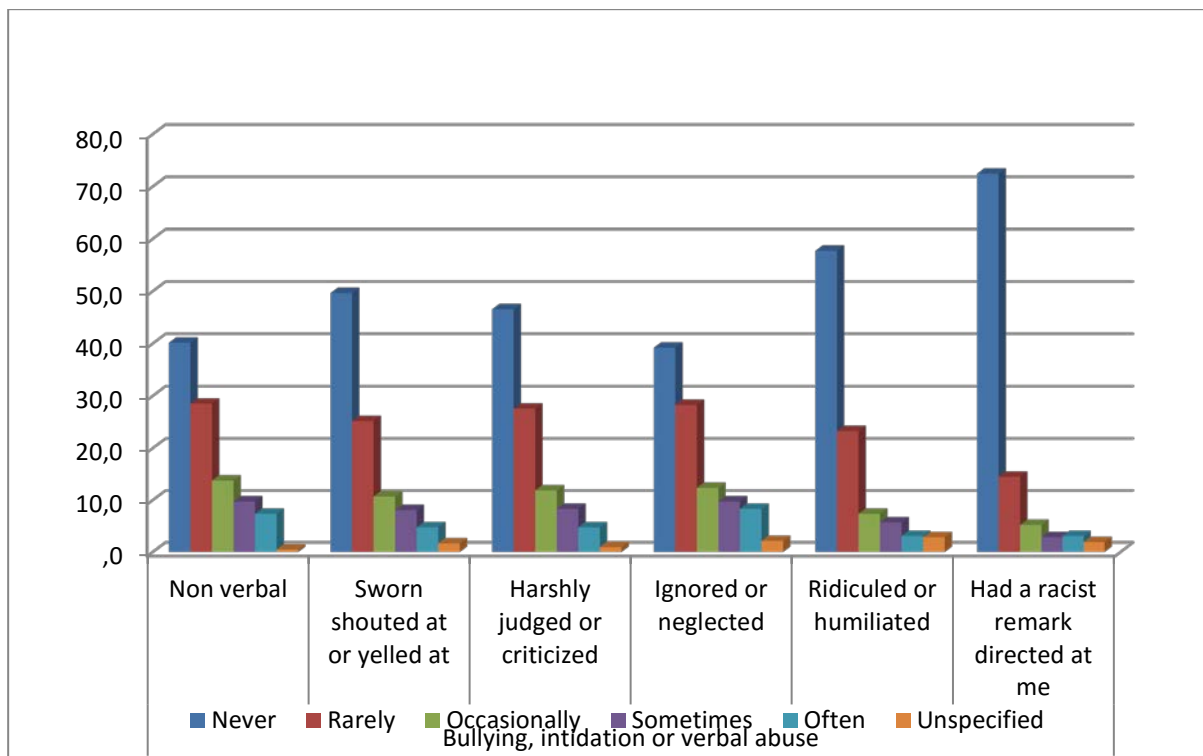
- Never
- Rarely (1-2 times)
- Occasionally (3-5 times)
- Sometimes (6-8 times)
- Often (>8 times)

On the questionnaire, the item 'other' was excluded from the analysis, and therefore the percentages reported do not always add up to 100 %. Research variables were characterised by a high percentage of 'never' responses.

#### **4.5.1 Intimidation, bullying and verbal abuse in clinical areas**

Respondents were asked to indicate whether they had experienced intimidation, bullying and verbal abuse in the clinical area.

Nearly half the respondents, 49.6 % (n=209), indicated that they had never been sworn at, shouted at or yelled at. Only 12, 9 % (n=54) reported having been shouted at sometimes, or often. See figure 4.3 below.



**Figure 4.3 Intimidation, bullying and verbal abuse**

#### **4.5.1.1 Non-verbal abuse e.g. raised eyebrows, rolling eyes**

Figure 4.3 above shows that although 68.9 % of the respondents reported never or rarely experiencing non-verbal abuse in the clinical area, 31 % had occasionally, sometimes, or often experienced this behaviour. A significant number of respondents indicated that they had never or had rarely been abused non-verbally, e.g. raised eyebrows ( $\chi^2 (4, n=419) = 165.332, p<.0005$ ).

#### **4.5.1.2 Sworn, shouted or yelled at**

Almost half the respondents ( $n=209, 49\%$ ) indicated that they had never been sworn at, shouted at or yelled at in the clinical area. Only a small number ( $n=54, 12.9\%$ ) had sometimes, or often been sworn at, shouted at or yelled at ( $\chi^2 (4, n=414) = 292.498, p<.0005$ ).

#### **4.5.1.3 Harshly judged or criticised**

Nearly three quarters of those who participated, 74.2 %, reported never or rarely having experienced being harshly judged or criticised in the clinical area, but a small number ( $n=55, 13.1\%$ ) reported having sometimes, or often being harshly judged or criticised (Harshly judged/criticised ( $\chi^2 (4, n=417) = 254.427, p<.0005$ ).

#### 4.5.1.4 Ignored or neglected

Just over two thirds of the respondents, 67.5 %, reported that they had never or rarely been ignored or neglected in the clinical area, however, a small number (n=76, 18 %) reported that they were sometimes or often ignored or neglected (Ignored or neglected ( $\chi^2$  (4, n=412) = 158.340,  $p < .0005$ ).

#### 4.5.1.5 Ridiculed or humiliated

Less than ten % (n=37), 8.8 % of the respondents reported sometimes or often being ridiculed or humiliated in the clinical area. The Chi-square goodness-of-fit indicated that this was significant  $p < .0005$  (Ridiculed or humiliated ( $\chi^2$  (4, n=409) = 451.134,  $p < .0005$ ). Refer to table 4.2.

#### 4.5.1.6 Had a racist remark directed at them

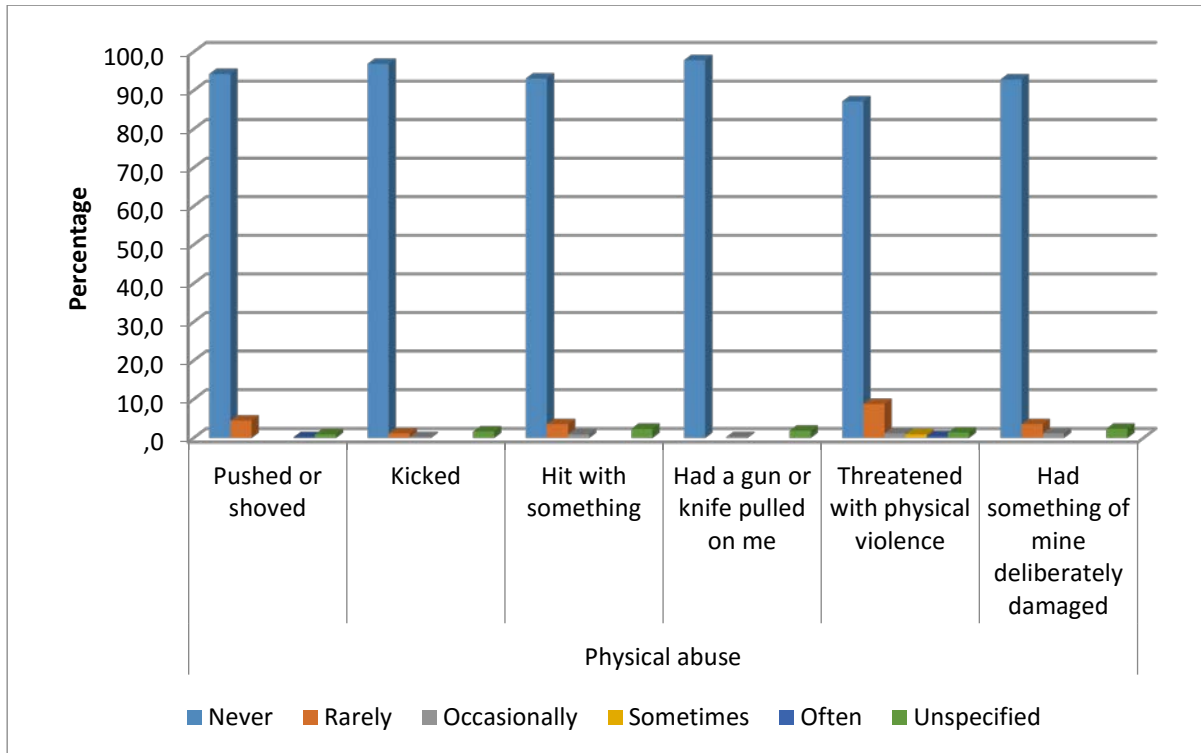
Most respondents (n=305, 72.4 %) had not experienced a racist remark directed at them. Only (n=13, 3.1 %) reported often having a racist remark directed at them (Had a racist remark directed at them ( $\chi^2$  (4, n=413) = 767.908,  $p < .0005$ ).

**Table 4.2 Intimidation, bullying and verbal abuse**

Question number	6.1 non verbal	6.2 sworn, shouted at or yelled at	6.3 harshly judged or criticised	6.4 ignored or neglected	6.5 ridiculed or humiliated	6.6 had a racist remark directed at me
Chi-square	165.332	292.498	254.427	158.340	451.134	767.908
df	4	4	4	4	4	4
Significance (p)	.000	.000	.000	.000	.000	.000

## 4.5.2 PHYSICAL ABUSE IN THE CLINICAL AREA

Respondents were asked about various forms of physical abuse exposed to in the clinical area. Analysis shows that a significant number of the respondents indicated that they have never, or rarely ever suffered from physical abuse in the form of pushing or shoving; kicking; being hit with something, had a gun or knife pulled on them, been threatened with physical violence or had something of theirs deliberately damaged.



**Figure 4.4 Physical abuse**

### 4.5.2.1 Pushed or shoved

Although a significant number of respondents indicated that they have never or rarely ever been pushed or shoved, there is some report from the respondents who reported pushing and shoving often directed at them (Pushing or shoving ( $\chi^2$  9n=416) =1477.137,  $p<0.0005$ ) (n=1, 0.2 %).

#### **4.5.2.2 Kicked**

Significantly more respondents than expected indicated that they have never or rarely ever been kicked. ( $\chi^2$  (4, n=413) =1596, 749 p <.0005). A very small percentage had been subjected to kicking (n=1, 0.2 %).

#### **4.5.2.3 Hit with something**

A significant number of respondents indicated that they have never or rarely ever been hit with something ( $\chi^2$  (4, n=407) =1461.324, p <.0005), and only 1.0 % (n=4,) were hit with something occasionally.

#### **4.5.2.4 Had a gun or knife pulled on me**

The vast majority of respondents indicated that they had never or rarely ever had a gun or knife pulled on them ( $\chi^2$  (4, n=412) =1642.024, p <.0005) whereas a small number of respondents had occasionally had a gun or knife pulled on them (n=1, 0.2 %).

#### **4.5.2.5 Been threatened with physical violence**

A significant number of respondents indicated that they had never or rarely ever been threatened with physical violence. ( $\chi^2$  (4, n=404) =1224.795, p <.0005). A few respondents occasionally, sometimes or often reported being threatened with physical violence (n=11, 2.7 %).

#### **4.5.2.6 Had something of mine deliberately damaged**

Significantly more than expected respondents indicated that they had never or rarely had something of theirs deliberately damaged ( $\chi^2$  (4, n=406) =1451.908; p <.0005), whereas n=5, (1.2%) reported they had occasionally had something of theirs deliberately damaged. Refer to Table 4.3 below.

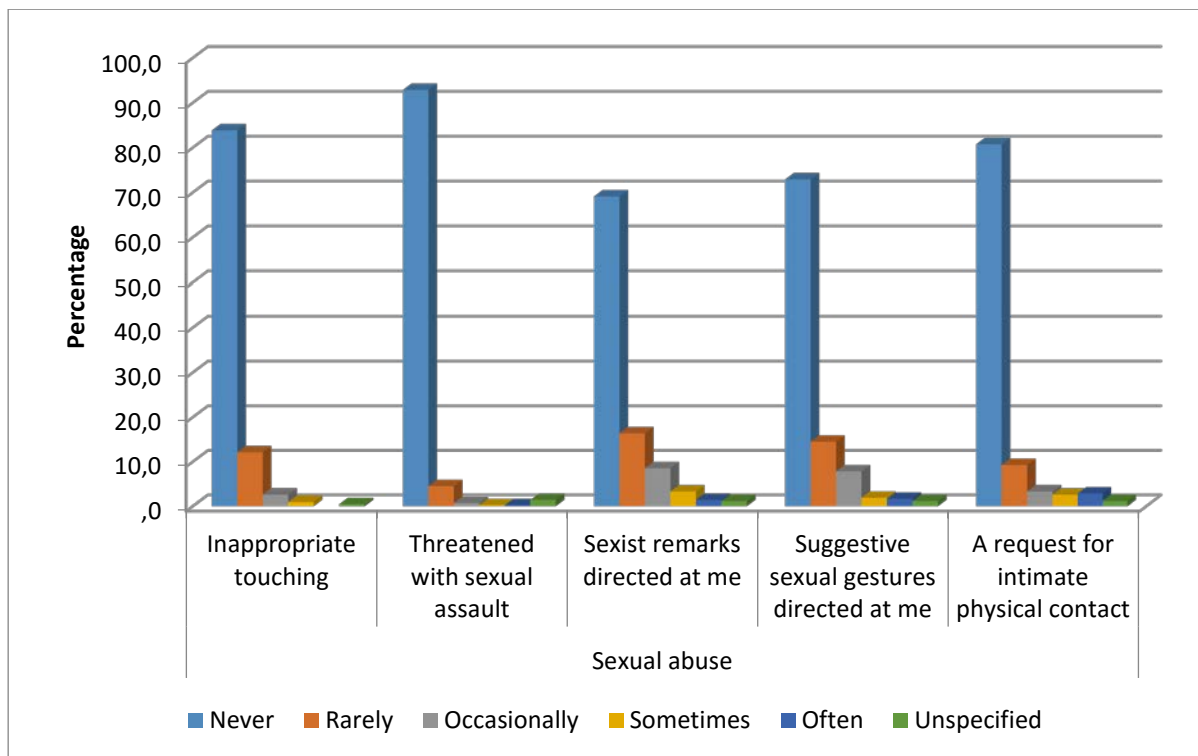


**TABLE 4.3 Physical abuses in clinical areas**

Question number	7.1 pushed or shoved	7.2 kicked	7.3 hit with something	7.4 had a gun or knife pulled on me	7.5 threatened with physical violence	7.6 had something of mine deliberately damaged
Chi-square	1477.137	1596.749	1461.324	1642.0240	1224.795	1451.908
df	4	4	4	4	4	4
Significance (p)	.000	.000	.000	.000	.000	.000

#### **4.5.3 SEXUAL ABUSE IN CLINICAL AREAS**

Students were asked about any experience of sexual abuse in the clinical area. Significantly more than expected indicated that they had never experienced sexual abuse in clinical areas.



**FIGURE 4.5 Sexual abuses in clinical areas**

#### 4.5.3.1 Inappropriate touching

The majority, 95.9 % (n=404) of those who participated, reported never having been or rarely ever having been inappropriately touched ( $\chi^2$  (4, n=419) =1100.654,  $p < .0005$ ), and only 3.6 % (n=15) had occasionally, or sometimes been inappropriately touched.

#### 4.5.3.2 Threatened with sexual assault

Most of the respondents (n=410, 97.4 %) had never or had rarely ever been threatened with sexual assault ( $\chi^2$  (4, n=415) =1431.422,  $p < .0005$ ) and only a few (n=5), 0.11 %) reported that they had occasionally, sometimes, or often been threatened with sexual assault.

#### 4.5.3.3 Sexist remarks directed at me

A large number (n=360, 85.5 %) of the respondents reported that they had never or had rarely ever had sexist remarks directed at them ( $\chi^2$  (4, n=416) =677.389,  $p < .0005$ ), with a small number (n=56, 13.3 %) indicating that they had had sexist remarks directed at them.

#### 4.5.3.4 Suggestive sexual gestures directed at me

The majority of respondents (n=368, 87.4 %) indicated that they had never or had rarely ever had suggestive sexual gestures directed at them ( $\chi^2 (4, n=416) = 775.971, p < .0005$ ) however, more than 10 %, (11.4 % n=48) had had suggestive sexual gestures directed at them.

#### 4.5.3.5 Request for intimate physical contact

The majority (n=379, 90.1 %) of the respondents reported that they had never or had rarely ever been requested to have intimate physical contact ( $\chi^2 (4, n=416) = 997.245, p < .0005$ ), although 8.8 % (n=37) of the respondents reported having received a request for intimate physical contact as shown below in table 4.4.

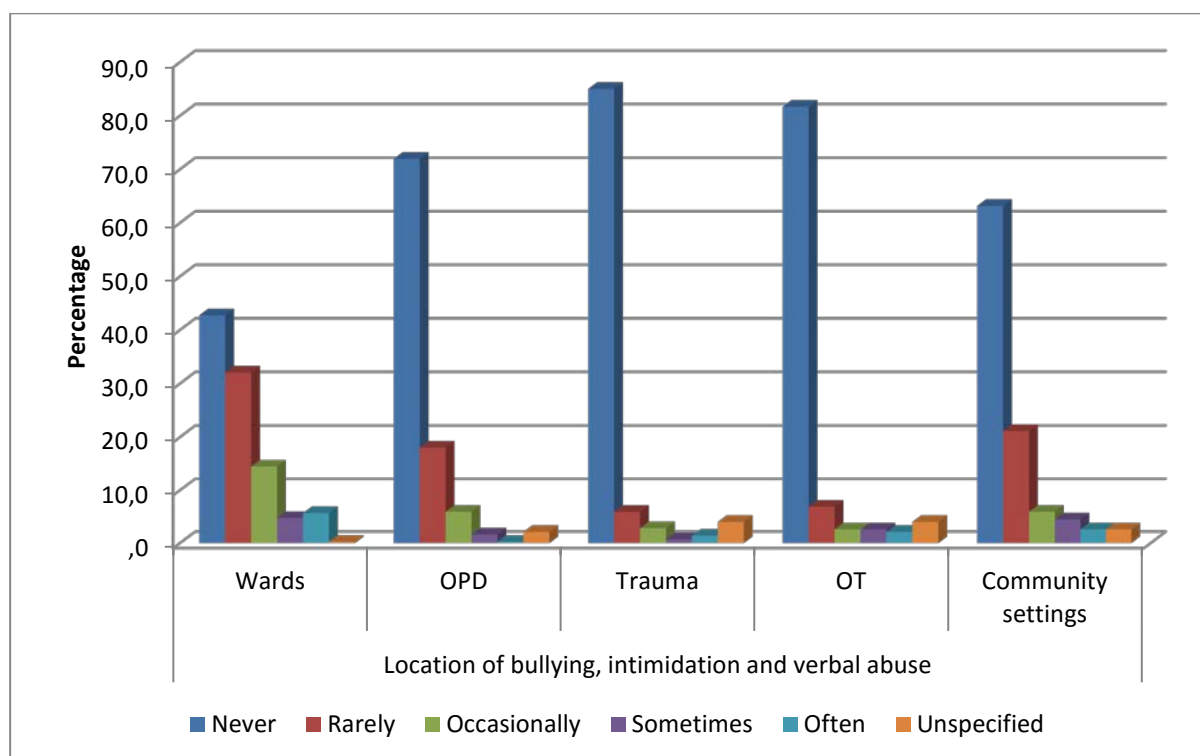
**TABLE 4.4 Sexual abuse in clinical areas**

Question No	8.1 Inappropriate touching	8.2 Threatened sexual assault	8.3 Sexist remarks directed at me	8.4 Suggestive sexual gestures directed at me	8.5 A request for intimate physical contact
	n=419	n=415	n=416	n=416	n=416
Chi-Square	1100.654	1431.422	677.389	775.071	997.245
df	4	4	4	4	4
Significance	.000	.000	.000	.000	.000

## 4.6 SECTION C: SOURCE OF VIOLENCE, INFLUENCE ON WORK AND THE PERSONAL CONSEQUENCES

### 4.6.1 LOCATION OF INTIMIDATION, BULLYING AND VERBAL ABUSE

Respondents were asked to indicate the location of any intimidation, bullying or verbal abuse in the clinical area and the following options were available: Wards, Outpatient Department (OPD), Trauma, Operating Theatre (OT), and Community settings, e.g. Clinics. Refer to figure 4.6 below.



**FIGURE 4.6 Location of intimidation, bullying and verbal abuse**

Most respondents reported never, rarely or occasionally being subjected to intimidation, bullying and verbal abuse in trauma, OT and OPD.

#### 4.6.1.1 Wards

The wards were reported by the respondents as the most likely site in which to experience intimidation, bullying and verbal abuse. Data showed that 74.9 % (n=315) of the respondents had never, or had rarely ever been intimidated, bullied and verbally abused in the wards, while 25 % (n=105) reported having been intimidated, bullied and verbally abused in the wards.

#### **4.6.1.2 OPD**

The majority, 90.1 % (n=379) of the sampled respondents, indicated that they had never or had rarely ever been intimidated, bullied or verbally abused in the OPD and 7.8 % (n=33) had been intimidated, bullied or verbal abused in the OPD.

#### **4.6.1.3 Trauma**

The trauma unit was found to be the least likely location to experience intimidation, bullying or verbal abuse as 90.9 % (n=383) had never or had rarely ever been intimidated, bullied or verbally abused in the trauma units. A few respondents, 1 % (n=38), had occasionally, sometimes or often been intimidated, bullied or verbally abused in the trauma units.

#### **4.6.1.4 OT**

More than two-thirds of the respondents, 88.6 % (n=373), had never or had rarely ever been intimidated, bullied or verbally abused in the OT, and 7.3 % (n=31) had occasionally, sometimes or often been intimidated, bullied or verbally abused in the operating theatre. The operating theatre also emerged as the least likely location for intimidation, bullying or verbal abuse to students.

#### **4.6.1.5 Community settings**

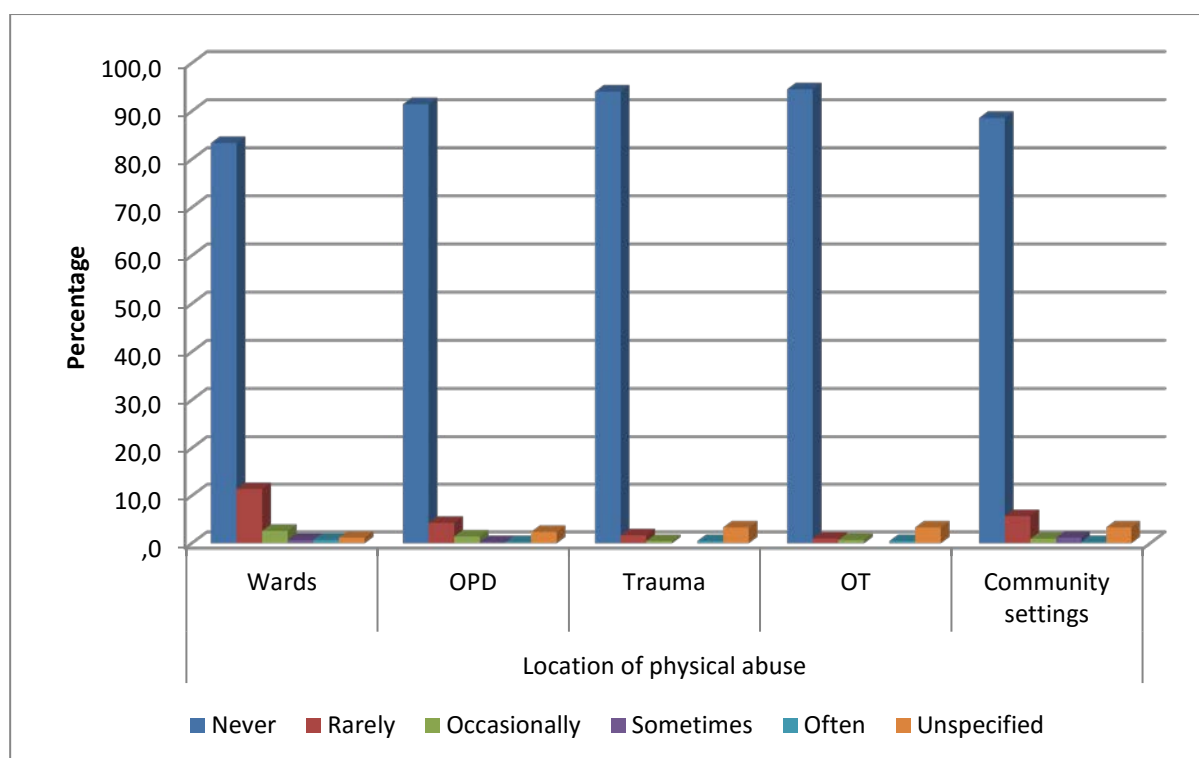
More than three-quarters of the respondents, 84.3 % (n=255), noted that in community locations like clinics, they had never or had rarely ever been intimidated, bullied or verbally abused, whereas 13 % (n=55) had occasionally, sometimes or often been intimidated, bullied or verbally abused in community settings.

**TABLE 4.5 Location of intimidation, bullying and verbal abuse**

Question No	9.1 Wards	9.2 OPD	9.3 Trauma	9.4 OT	9.5 Community settings
Chi-Square	238.595	780.476	1192.262	1074.960	562.976
df	4	4	4	4	4
Significance (p)	.000	.000	.000	.000	.000

#### 4.6.2 LOCATION OF PHYSICAL ABUSE

The respondents were asked about the location of any physical abuse. The same options were available as before, namely, the wards, OPD, trauma, OT and community settings. See figure 4.7.

**FIGURE 4.7 Location of physical abuse**

#### **4.6.2.1 Wards**

A significant number (n=399, 94.8 %) of the respondents indicated that they had never or had rarely ever been physically abused in the wards and only 3 % (n=17) had occasionally, sometimes or often been physically abused in the wards.

#### **4.6.2.2 OPD**

Analysis shows that a significant number (n=403, 95.7 %) of the respondents indicated that they had never or had rarely ever been physically abused in the OPD, yet 1.8 % (n=8) had occasionally, sometimes or often been physically abused in the OPD.

#### **4.6.2.3 Trauma**

Significantly more than expected respondents (n=403, 95.8 %) indicated that they had never or had rarely ever been physically abused in the trauma unit and one % (n=4) had occasionally or often been physically abused in the trauma unit.

#### **4.6.2.4 OT**

A significant number (n=402, 95.5 %) of the respondents indicated that they had never or had rarely ever been physically abused in the OT and 1.2 % (n=5) had occasionally or often been physically abused in the OT.

#### **4.6.2.5 Community settings**

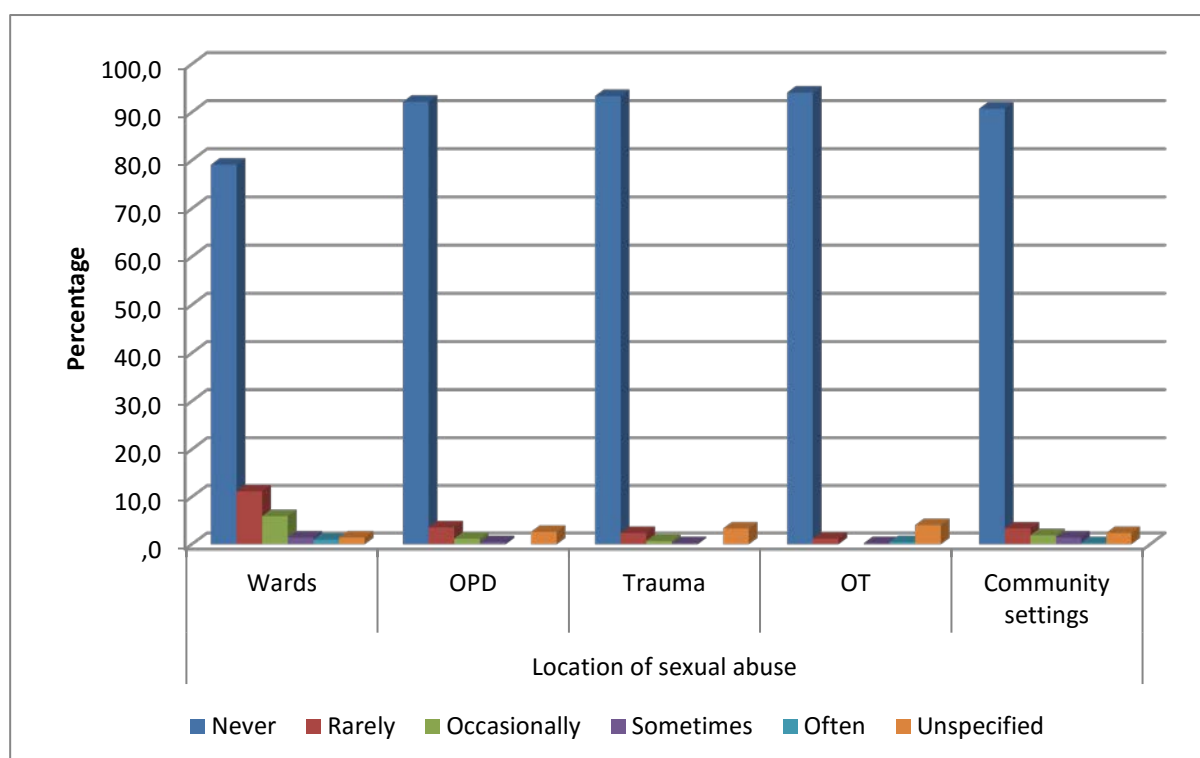
A significant number (n=397, 94 %) of the respondents indicated that they had never or had rarely ever been physically abused in community settings while 2.4 % (n=10) had occasionally, sometimes or often been physically abused in community settings as seen in figure 4.7 above and table 4.6 below.

**TABLE 4:6 Location of physical abuse**

Question No	10.1 Wards	10.2 OPD	10.3 Trauma	10.4 OT	10.5 Community settings
Chi-Square	1094.144	1396.628	1520.187	1539.351	1309.794
df	4	4	4	4	4
Significance (p)	.000	.000	.000	.000	.000

#### 4.6.3 LOCATION OF SEXUAL ABUSE

The respondents were asked about the location of any sexual abuse. The same options were available as previously, namely the wards, OPD, trauma, OT and community settings. See figure 4.8. A significant number of respondents had never or had rarely ever been sexually abused.

**FIGURE 4.8 Location of sexual abuse**



#### **4.6.3.1 Wards**

A large number (n=377, 90.3 %) of the respondents reported that they had never or had rarely ever been sexually abused in the wards while 8.3 % (n=35) had occasionally, sometimes or often been sexually abused in the wards.

#### **4.6.3.2 OPD**

The majority (n=403, 95.8 %) of the respondents had never or had rarely ever been sexually abused in the OPD and a few, 1.7 % (n=7) had occasionally or sometimes been sexually abused in the OPD.

#### **4.6.3.3 Trauma**

The majority (n=403, 95.7 %) of the respondents reported that they had never or had rarely ever been sexually abused in the trauma unit and 0.9 % (n=4) had occasionally or sometimes been sexually abused in the trauma unit.

#### **4.6.3.4 OT**

The majority (n=401, 95.3 %) of the respondents had never or had rarely ever been sexually abused in the OT with 0.7 % (n=3) reporting having sometimes or often been sexually abused in the OT.

#### **4.6.3.5 Community settings**

The majority (n=396, 94 %) of the respondents indicated that they had never or had rarely ever been sexually abused in community settings with 3.5 % (n=15) reporting having been sexually abused in the community settings, as shown in figure 4.8 above and table 4.7 below.

**TABLE 4.7 Location of sexual abuse**

Question No	11.1 Wards	11.2 OPD	11.3 Trauma	11.4 OT	11.5 Community settings
Chi-Square	955.783	1429.000	1491.759	1537.163	1367.844
df	4	4	4	4	4
Significance (p)	.000	.000	.000	.000	.000

#### **4.7 SOURCE OF VIOLENCE IN CLINICAL AREAS**

The source of violence in clinical areas was more likely to be from patients, relatives and friends, than from patients themselves.

**TABLE 4.8 Source of violence in the clinical area**

Source of violence	Frequency	Intimidation, bullying or verbal abuse	Physical abuse	Sexual abuse
Patients	Never	323 (76.7%)	396 (94%)	388 (92.2%)
	Occasionally	93 (22.1%)	20 (4.8%)	29 (8.9%)
Relatives or Friends	Never	322 (76.5%)	394 (93.5%)	392 (93.1%)
	Occasionally	94 (22.3%)	20 (4.7%)	21 (5%)

#### **4.7.1 INTIMIDATION, BULLYING AND VERBAL ABUSE**

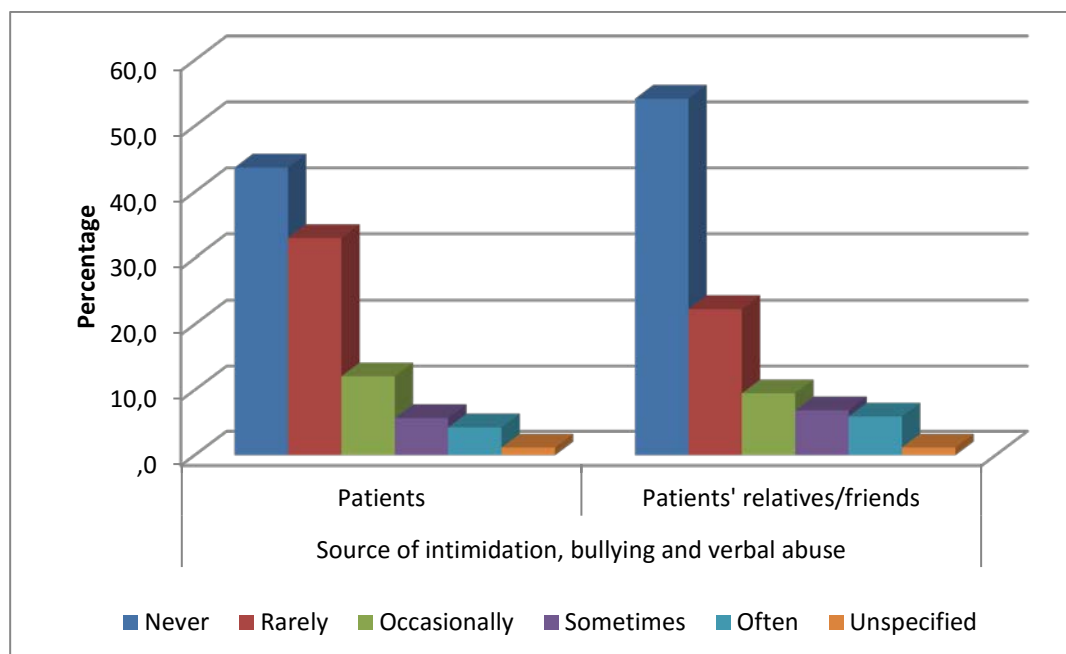
##### **4.7.1.1 PATIENTS**

Surprisingly, the majority of respondents were not intimidated by patients, but by the patients' relatives or friends. The majority (n=323, 76.7 %) of the respondents reported

that they had never been intimidated, bullied or verbally abused by patients and 22.1 % (n=93) had occasionally, sometimes or often been intimidated, bullied or verbally abused by patients.

#### 4.7.1.2 PATIENTS' RELATIVES OR FRIENDS

The source of violence in clinical areas was more likely to be from patients' relatives and friends than from the patients themselves. The majority, 76.5% (n=322) of the respondents, indicated that they had never or had rarely ever been intimidated, bullied or verbally abused by patients' relatives or friends, while 22.3 % (n=94) had occasionally, sometimes or often been intimidated, bullied or verbally abused by patients' relatives or friends. See figure 4.9 below.



**FIGURE 4.9 Source of intimidation, bullying and verbal abuse**

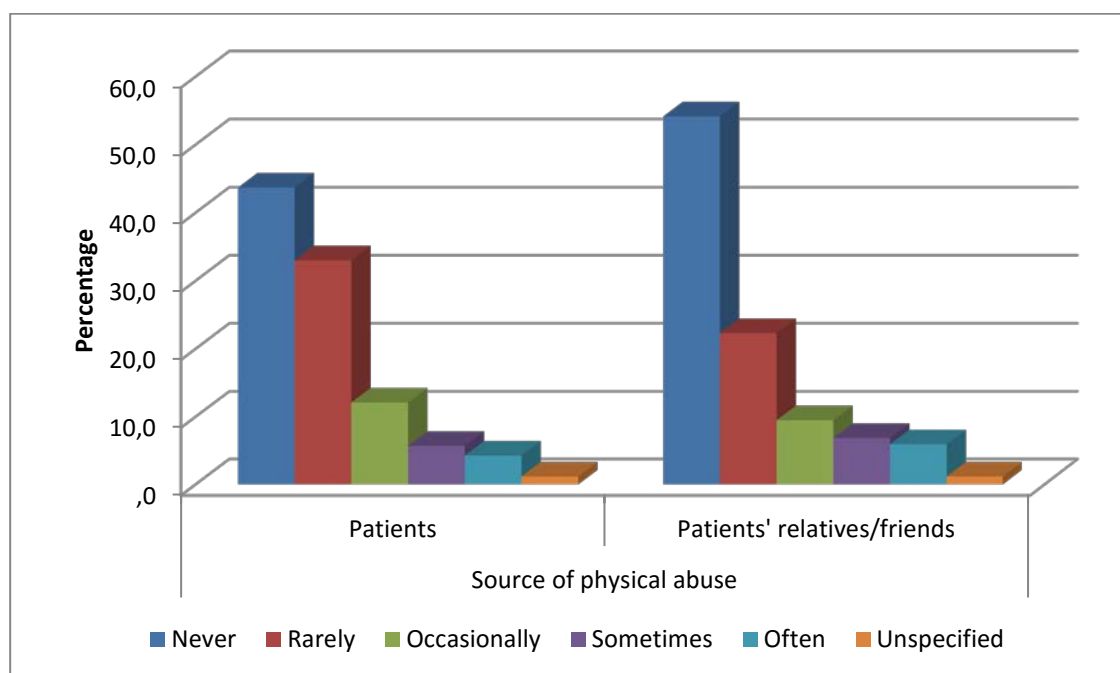
#### 4.7.2 SOURCE OF PHYSICAL ABUSE

##### 4.7.2.1 PATIENTS

The majority (n=396, 94 %) of the respondents reported that they had never or had rarely ever been physically abused by patients and 4.8 % (n=20) had occasionally, sometimes or often been physically abused by patients as shown in figure 4.10 below.

#### 4.7.2.2 PATIENTS' RELATIVES OR FRIENDS

A significant majority (n=394, 93.5 %) of the respondents indicated that they had never or had rarely ever been physically abused by patients' relatives or friends, whereas 4.7 % (n=20) had occasionally, sometimes or often been physically abused by patients' relatives or friends.



**FIGURE 4.10 Source of physical abuse**

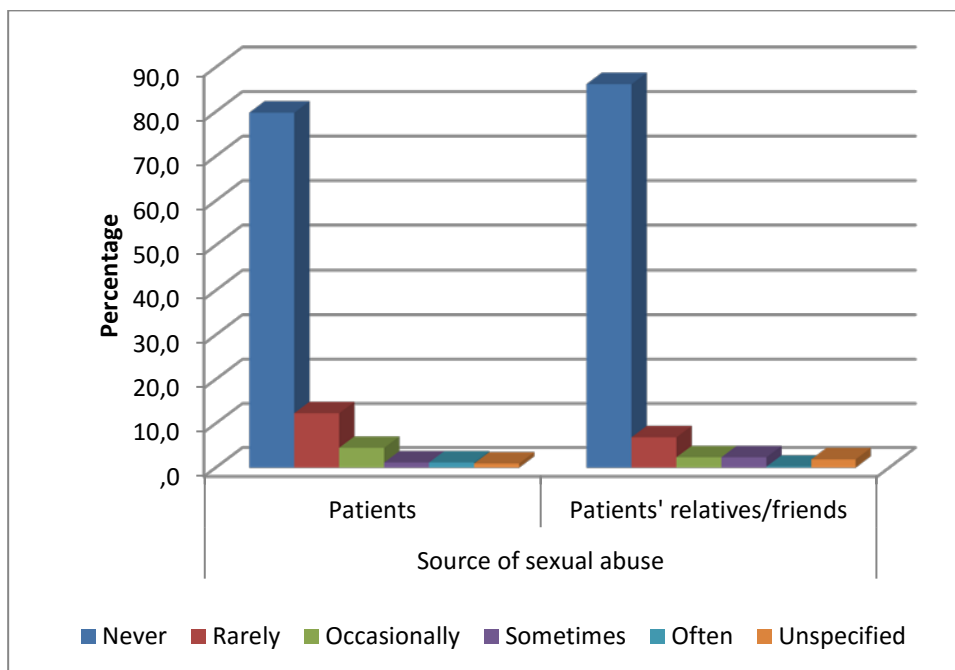
### 4. 7.3 SOURCE OF SEXUAL ABUSE

#### 4.7.3.1 PATIENTS

The majority (n=388, 92.2 %) of the respondents suggested that they had never or had rarely ever been sexually abused by patients and 8.9 % (n=29) had occasionally, sometimes or often been sexually abused by patients as shown in figure 4.11 below.

#### 4.7.3.2 PATIENTS' RELATIVES OR FRIENDS

The majority (n=392, 93.1 %) of the respondents indicated that they had never or had rarely ever been sexually abused by patients' relatives or friends and five % (n=21) had occasionally, sometimes or often been sexually abused by patients' relatives or friends.



**FIGURE 4.11 Source of sexual abuse**

**OBJECTIVE 2: To describe whether the violence experienced by student nurses in the workplace settings leads to an intention to leave nursing**

#### **4. 8 INFLUENCE OF VIOLENCE ON WORK PERFORMANCE**

The students were asked to indicate the influence of violence on their work performance with regards to intimidation, bullying and verbal abuse. The following options were given: made me consider leaving nursing, caused me to call in absent and negatively affected my standard of patient care.

##### **4.8.1 INTIMIDATION, BULLYING OR VERBAL ABUSE**

It was significant that the majority of respondents reported that intimidation, bullying or verbal abuse did not lead them to consider leaving nursing, call in absent nor did it negatively affect their standard of patient care.

**TABLE 4.9 Influence of violence on work performance**

	Frequency	Made me consider leaving nursing	Caused me to call in absent	Negatively affected my standard of patient care
Intimidation, bullying or verbal abuse	Never	343 (70.5%)	355 (84.3%)	326 (77.4%)
	Occasionally	61 (14.5%)	47 (11.1%)	78 (18.5%)
Physical abuse	Never	385 (91.5%)	388 (92.2%)	381 (90.5%)
	Occasionally	18 (4.3%)	15 (3.6%)	22 (5.2%)
Sexual abuse	Never	383 (91.5%)	384 (91.2%)	373 (88.6%)
	Occasionally	21 (4.9%)	19 (4.5%)	30 (7.2%)

**4.8.1.1 MADE ME CONSIDER LEAVING NURSING**

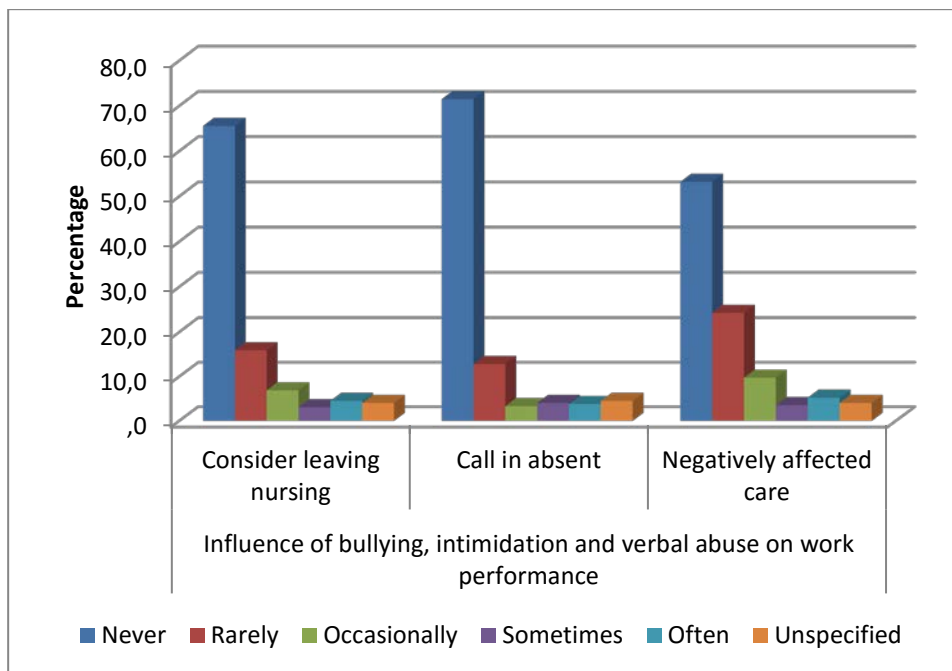
Regarding the intention to leave nursing, 70.5 % (n=343) of the respondents indicated that intimidation, bullying or verbal abuse did not lead them to consider leaving nursing.

**4.8.1.2 CAUSED ME TO CALL IN ABSENT**

Intimidation, bullying or verbal abuse did not lead student nurses to call in absent (n=355, 84.3 %), however, there were a few respondents, 11.1 % (n=47), who reported having occasionally, sometimes or often been intimidated, bullied and verbally abused which had led them to call in absent.

**4.8.1.3 NEGATIVELY AFFECTED MY STANDARD OF PATIENT CARE**

The majority (n=326, 77.4 %) of the respondents reported that intimidation, bullying or verbal abuse had never or rarely ever negatively affected their standard of patient care. A few of the respondents, 18.5 % (n=78), reported that they had occasionally, sometimes or often been intimidated, bullied or verbally abused which affected their standard of patient care as shown in figure 4.12 below.



**FIGURE 4.12 Influence of bullying, intimidation and verbal abuse on work performance**

#### 4.8.2 PHYSICAL ABUSE

The students were asked to indicate the influence of violence on work performance with regards to physical abuse. The following options were available: made me consider leaving nursing, caused me to call in absent and negatively affected my standard of patient care.

##### 4.8.2.1 MADE ME CONSIDER LEAVING NURSING

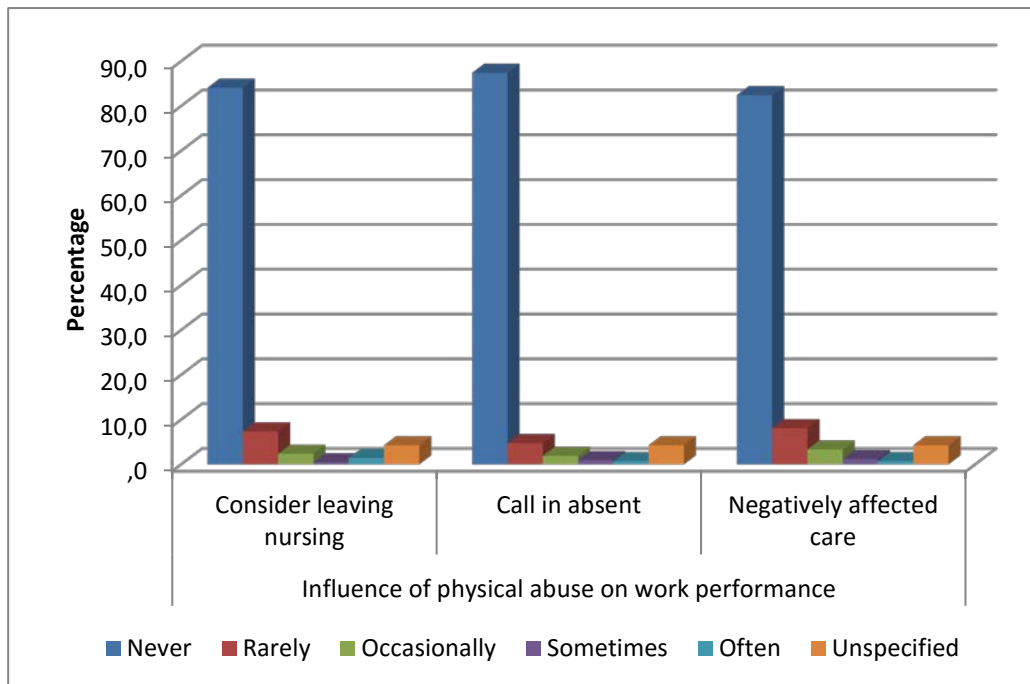
The majority (n=385, 91.5 %) of those who participated reported never or rarely ever having considering leaving nursing because of physical abuse, however only a few, 4.3 % (n=18), reported that they had considered leaving nursing as a result of occasionally, sometimes or often being physically abused.

##### 4.8.2.2 CAUSED ME TO CALL IN ABSENT

The majority (n=388, 92.2 %) of the respondents indicated never or rarely ever having experienced physical abuse that made them call in absent. Fifteen respondents (3.6 %) reported that they had called in absent because they had occasionally, sometimes or often been physically abused.

#### 4.8.2.3 NEGATIVELY AFFECTED MY STANDARD OF PATIENT CARE

A large number (n=381, 90.5 %) of the respondents reported never or rarely ever being physically abused, therefore this did not negatively affect their standard of patient care. While a small number, 5.2 % (n=22), indicated that they had occasionally, sometimes or often been physically abused and that this had negatively affected their standard of patient care. See figure 4.13 below.



**FIGURE 4.13 Influence of physical abuse on work performance**

#### 4.8.3 SEXUAL ABUSE

The students were asked to indicate the influence of sexual abuse on work performance in the following options: made me consider leaving nursing, caused me to call in absent and negatively affected my standard of patient care.

##### 4.8.3.1 MADE ME CONSIDER LEAVING NURSING

The majority (n=383, 91.5 %) of the respondents reported that they had never or had rarely ever experienced sexual abuse which made them consider leaving nursing. A few respondents, 4.9 % (n=21), reported that they had occasionally, sometimes or often experienced sexual abuse which had made them consider leaving nursing.

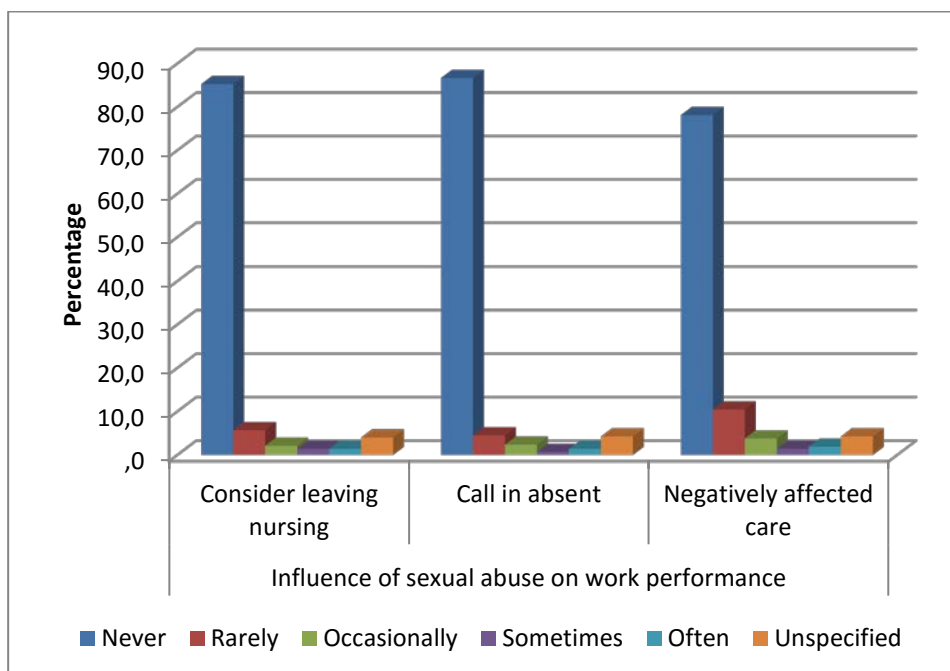


#### 4.8.3.2 CAUSED ME TO CALL IN ABSENT

In the sample, the majority (n=384, 91.2 %) of the respondents indicated that they had never or had rarely ever been sexually abused and so were not inclined to call in absent. A small number of respondents, 4.5 % (n=19), reported that they had occasionally, sometimes or often been sexually abused which had caused them to call in absent.

#### 4.8.3.3 NEGATIVELY AFFECTED MY STANDARD OF PATIENT CARE

The majority (n=373, 88.6 %) of respondents suggested that they had never or had rarely ever been sexually abused and so this had not negatively affected their standard of patient care. The few, 7.2 % (n=30), who reported that they had occasionally, sometimes or often been sexually abused, reported that this had negatively affected their standard of patient care. See figure 4.14 below.



**FIGURE 4.14 Influence of sexual abuse on work performance**

## **4.9 INFLUENCE OF VIOLENCE IN THE CLINICAL AREA ON PERSONALITY**

### **4.9.1 INTIMIDATION, BULLYING OR VERBAL ABUSE**

The students were asked to indicate the influence of violence on their personality with regards to intimidation, bullying and verbal abuse in the following areas: anger, depression, humiliation/embarrassment, anxiety/fear, and confusion, feelings of inadequacy, negative effect on personal relationships and standard of patient care.

#### **4.9.1.1 ANGER**

Significantly, the majority (n=285, 67.7 %) of those who participated reported never or rarely having been intimidated, bullied or verbally abused and so had not experienced anger. Almost a third of the respondents, 29.2% (n=123), reported that they had occasionally, sometimes or often experienced anger due to intimidation, bullying and verbal abuse in clinical area by patients and their relatives or friends.

#### **4.9.1.2 DEPRESSION**

The majority (n=337, 80.1 %) of the respondents indicated that they had never or had rarely ever been intimidated, bullied or verbally abused to cause depression. A few respondents, 15.7 % (n=66), reported occasionally, sometimes or often feeling depressed as a result of intimidation, bullying and verbal abuse.

#### **4.9.1.3 HUMILIATION/EMBARRASSMENT**

The majority (n=293, 69.6 %) of the respondents suggested that they had never or had rarely ever been intimidated, bullied or verbal abused which caused them to feel humiliation/embarrassment. A few, 26.1 % (n=110), had reported occasionally, sometimes or often feeling humiliation/embarrassment as a result of intimidation, bullying and verbal abuse.

#### **4.9.1.4 ANXIETY/FEAR**

The majority (n=329, 78.2 %) of the respondents reported that they had never or had rarely ever been intimidated, bullied or verbally abused causing them to feel anxiety/fear. A few, 17.7 % (n=74), reported occasionally, sometimes or often feeling anxiety/fear as a result of intimidation, bullying and verbal abuse.

#### 4.9.1.5 CONFUSION

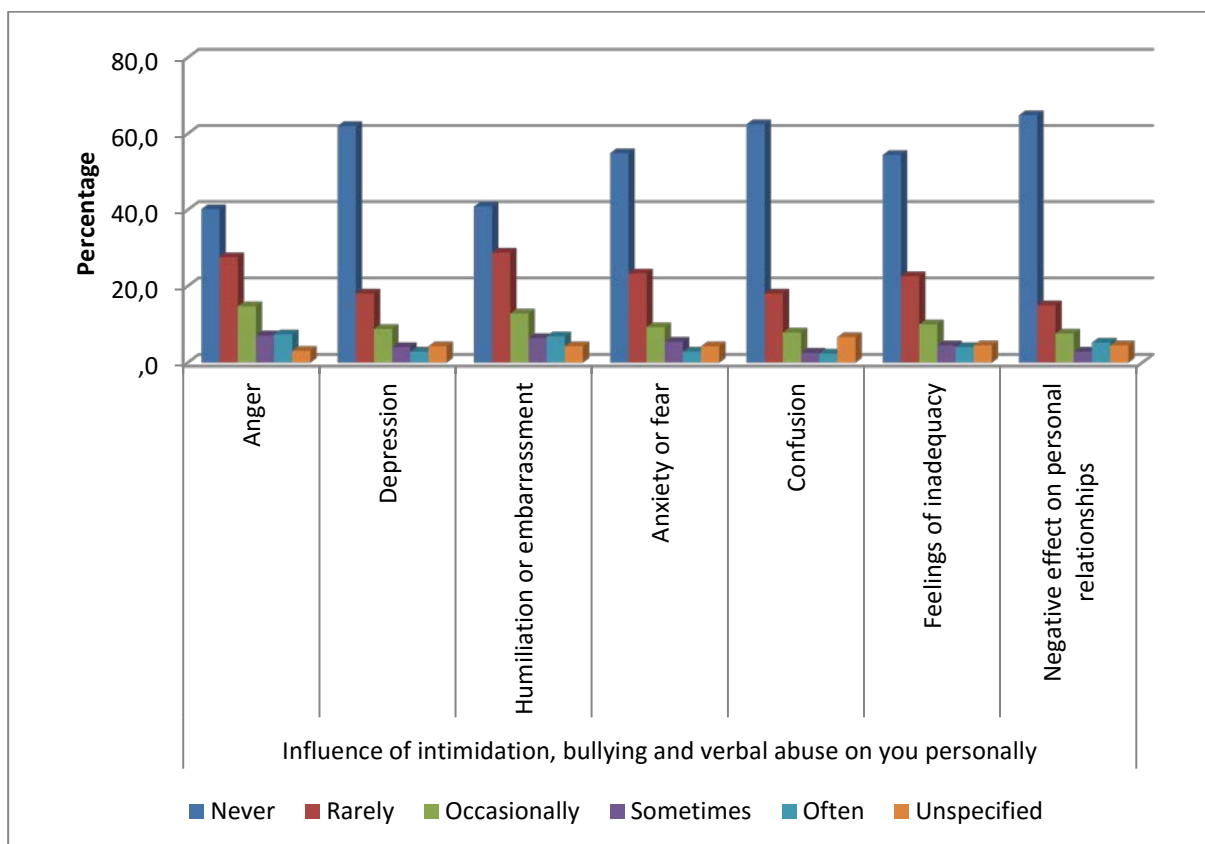
The majority (n=339, 80.6 %) of the respondents reported having never or having rarely ever been intimidated, bullied or verbal abused causing them to feel confusion. A few, 12.8 % (n=54), reported occasionally, sometimes or often feeling confused following intimidation, bullying and verbal abuse.

#### 4.9.1.6 FEELINGS OF INADEQUACY

The majority (n=324, 77 %) of those who participated indicated that they had never or had rarely ever been intimidated, bullied or verbally abused causing them to have feelings of inadequacy. A few, 21.9 % (n=92) did report occasionally, sometimes or often feeling inadequate as a result of intimidation, bullying and verbal abuse.

#### 4.9.1.7 NEGATIVE EFFECT ON PERSONAL RELATIONSHIPS

The majority (n=336, 79.8 %) of the respondents reported having never or rarely ever having been intimidated, bullied or verbally abused which led to any negative effects on personal relationships. A few, 15.7 % (n=66), reported occasionally, sometimes or often feeling a negative effect on their personal relationships as a result of intimidation, bullying and verbal abuse. See figure 4.15 below.



**FIGURE: 4.15 Influence of intimidation, bullying and verbal abuse on personality**

#### **4.9.2 PHYSICAL ABUSE**

The students were asked to indicate the influence of physical abuse on their personality regarding: anger, depression, humiliation/embarrassment, anxiety/fear, confusion, feelings of inadequacy, negative effect on personal relationships and standard of patient care.

##### **4.9.2.1 ANGER**

A significant number (n=373, 88.6 %) of respondents suggested that they had never or had rarely ever been physically abused and so did not experience anger as a result. Less than 10 %, 8.3 % (n=35), of those who participated reported that they had occasionally, sometimes or often experienced anger due to physical abuse in clinical areas by patients, their relatives or friends.

##### **4.9.2.2 DEPRESSION**

The majority (n=382, 90.7 %) of the respondents reported that they had never or had rarely ever been physically abused so did not report depression as a result. Very few, 5.2 % (n=22), reported occasionally, sometimes or often feeling depressed as a result of physical abuse.

##### **4.9.2.3 HUMILIATION/EMBARRASSMENT**

The majority (n=367, 87.2 %) of those who participated reported that they had never or rarely ever been physically abused so did not report that this had caused them humiliation/embarrassment. A few, 7.8 % (n=33), reported occasionally, sometimes or often feeling humiliation/embarrassment due to physical abuse.

##### **4.9.2.4 ANXIETY/FEAR**

The majority (n=374, 88.9 %) of the respondents reported having never or having rarely ever being physically abused so they had not experienced anxiety/fear because of physical abuse. A few respondents, 7.4 % (n=31), reported occasionally, sometimes or often feeling anxiety/fear because of physical abuse.

#### 4.9.2.5 CONFUSION

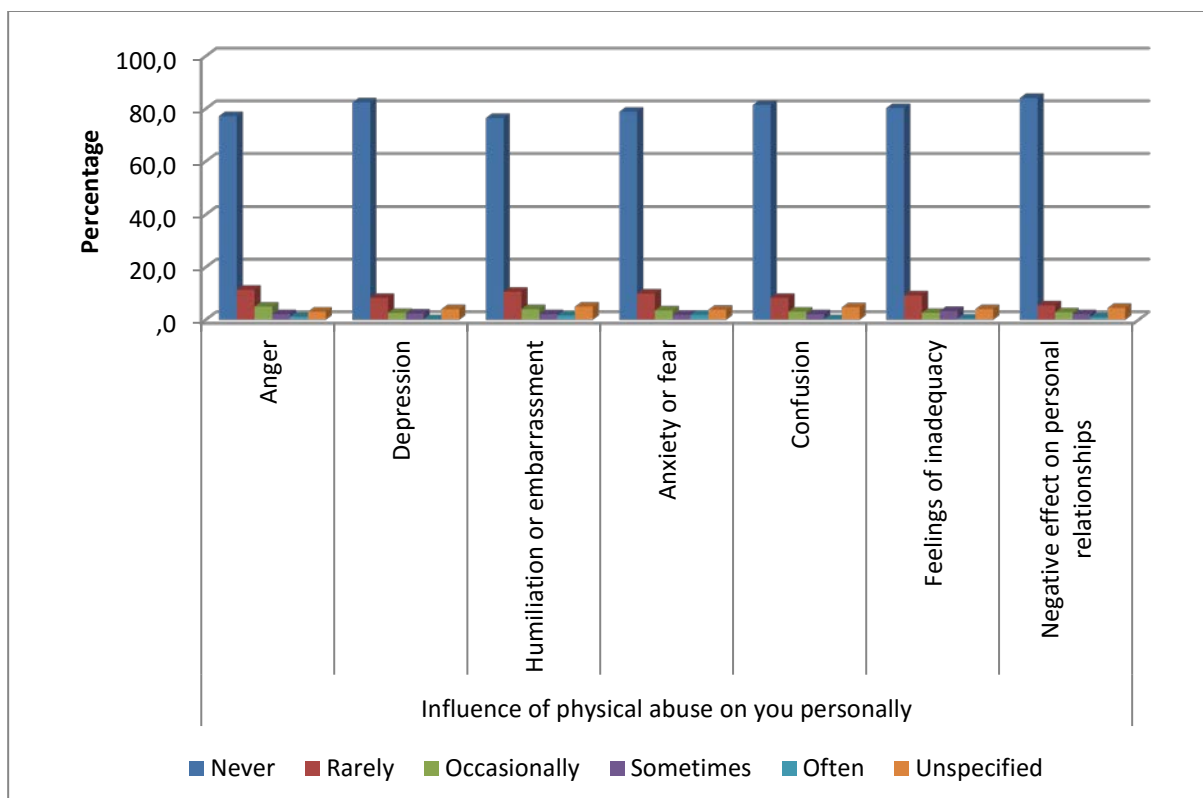
The majority (n=378, 89.8 %) of those who participated indicated that they had never or had rarely ever felt confused as a result of physical abuse. A few, 5.4 % (n=23), reported occasionally, sometimes or often feeling confused as a result of physical abuse.

#### 4.9.2.6 FEELINGS OF INADEQUACY

The majority (n=377, 89.6 %) of the respondents suggested that they had never or had rarely ever experienced feelings of inadequacy as a result of physical abuse. A few respondents, 6.4 % (n=27), reported occasionally, sometimes or often having feelings of inadequacy from physical abuse.

#### 4.9.2.7 NEGATIVE EFFECT ON PERSONAL RELATIONSHIPS

The majority (n=377, 89.6 %) of those who participated reported that they had never or had rarely ever been physically abused leading to negative effects on personal relationships. A few, six % (n=25), reported occasionally, sometimes or often feeling a negative effect on personal relationships due to physical abuse. See figure 4.16 below.



**FIGURE:4.16 Influence of physical abuse on personality**

### **4.9.3 SEXUAL ABUSE**

The students were asked to indicate the influence of sexual abuse on their personality with respect to the following areas: anger, depression, humiliation/embarrassment, anxiety/fear, confusion, feelings of inadequacy, negative effect on personal relationships and standard of patient care.

#### **4.9.3.1 ANGER**

Significantly, the majority (n=366, 86.9 %) of the respondents reported having never or having rarely ever been sexually abused thus causing them to feel anger. Some of the respondents, 10% (n=42), reported having occasionally, sometimes or often felt anger due to sexual abuse at clinical areas by patients, their relatives or friends.

#### **4.9.3.2 DEPRESSION**

The majority (n=380, 90.3 %) of the respondents indicated that they had never or had rarely ever been sexually abused resulting in depression. A few, 6.2 % (n=26), reported occasionally, sometimes or often experiencing feelings of depression from sexual abuse.

#### **4.9.3.3 HUMILIATION/EMBARRASSMENT**

The majority (n=362, 86 %) of the respondents reported that they had never or had rarely ever been sexually abused which caused them humiliation/embarrassment. A few, 9.8 % (n=41), reported occasionally, sometimes or often having feelings of humiliation/embarrassment from sexual abuse.

#### **4.9.3.4 ANXIETY/FEAR**

The majority (n=362, 86 %) of the respondents suggested that they had never or had rarely ever been sexually abused causing them to feel anxiety/fear. A few, 9.8 % (n=41), reported occasionally, sometimes or often feeling anxiety/fear as a result of sexual abuse.

#### **4.9.3.5 CONFUSION**

The majority (n=378, 89.8 %) of the respondents reported that they had never or had rarely ever been sexually abused which caused them confusion. A few, 5.4 % (n=23), reported occasionally, sometimes or often feeling confusion as a result of sexual abuse.

#### **4.9.3.6 FEELINGS OF INADEQUACY**

The majority (n=376, 91.5 %) of the respondents indicated that they had never or had rarely ever been sexually abused which caused them to have feelings of inadequacy. A few, 4.8 % (n=17), reported occasionally, sometimes or often having feelings of inadequacy as a result of sexual abuse.

#### **4.9.3.7 NEGATIVE EFFECT ON PERSONAL RELATIONSHIPS**

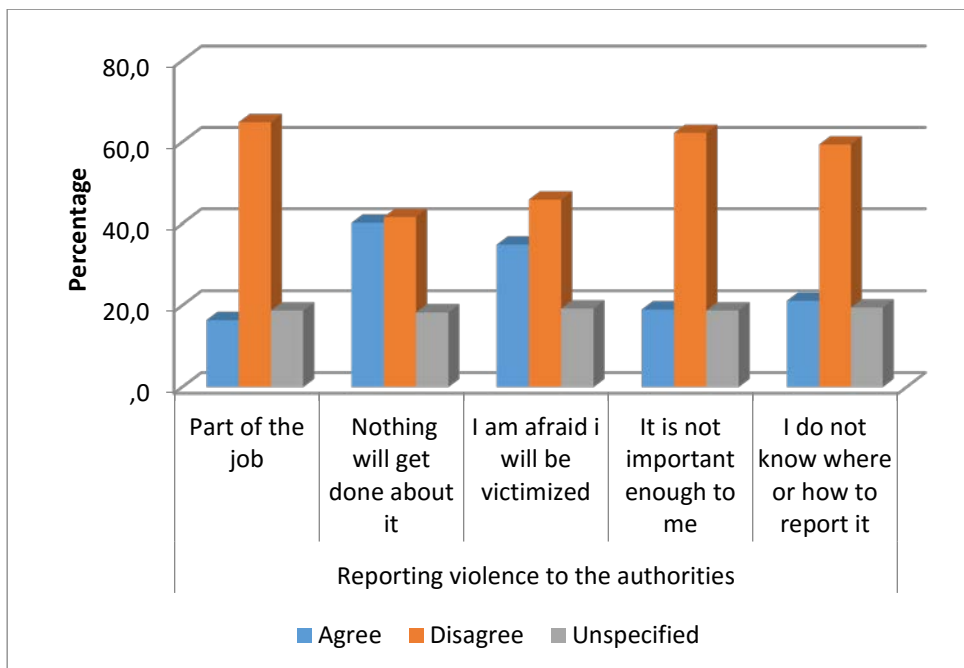
The majority of the respondents, (n=377, 89.3 %), indicated that they had never or had rarely ever been sexually abused resulting in a negative effect on their personal relationships. A few, 6.9 % (n=29), reported occasionally, sometimes or often feeling a negative effect on personal relationships from sexual abuse.

### **4.10 SECTION D: REPORTING OF WORKPLACE VIOLENCE**

Students were requested to respond with a 'yes' or a 'no' if they had reported an episode of any kind of workplace violence to the authorities. If 'yes' they had to proceed to the next question, but if 'no' they had to continue with the questions relating to 'why'. Under-reporting of workplace violence was found to be common among student nurses even in the literature.

#### **4.10.1 REPORTED AN EPISODE OF VIOLENCE TO THE AUTHORITIES**

Just under 88 %, 87.6 % (n = 369), of those who participated had not reported an episode of any kind of workplace violence. Less than 10 %, 9.3 % (n=39), had reported an episode of any kind of workplace violence to the authorities.



**FIGURE 4.17 Reasons for not reporting violence to the authorities**

#### **4.10.2 REASON FOR NOT REPORTING VIOLENCE TO THE AUTHORITIES**

For the reasons given, the student had to 'agree' or 'disagree' with the statement given.

Reasons for not reporting:

##### **4.10.2.1 IT IS PART OF THE JOB**

Nearly 65 %, 64.8 % (n=273), disagreed with the statement that the reason for not reporting any kind of workplace violence was because it was part of the job. Only 16.4 % (n=69) agreed with the statement. However, 18.8 % (n=79) did not answer the question.

##### **4.10.2.2 NOTHING WILL GET DONE ABOUT IT**

The respondents indicated a mixed perception towards reporting violence to the authorities, with 40.1 % (n=169) agreeing with the statement that nothing would be done about it if reported, to 41.6 % (n=175) disagreeing with the statement that nothing would be done about it if it was reported.

##### **4.10.2.3 I AM AFRAID I WILL BE VICTIMISED**

A little under half, 45.8 % (n=193), of those who participated disagreed that they were afraid that they would be victimised if they reported any violence, whereas 34.9 % (n=147) agreed that they were afraid of being victimised if they reported any workplace violence.



#### 4.10.2.4 IT IS NOT IMPORTANT ENOUGH TO ME

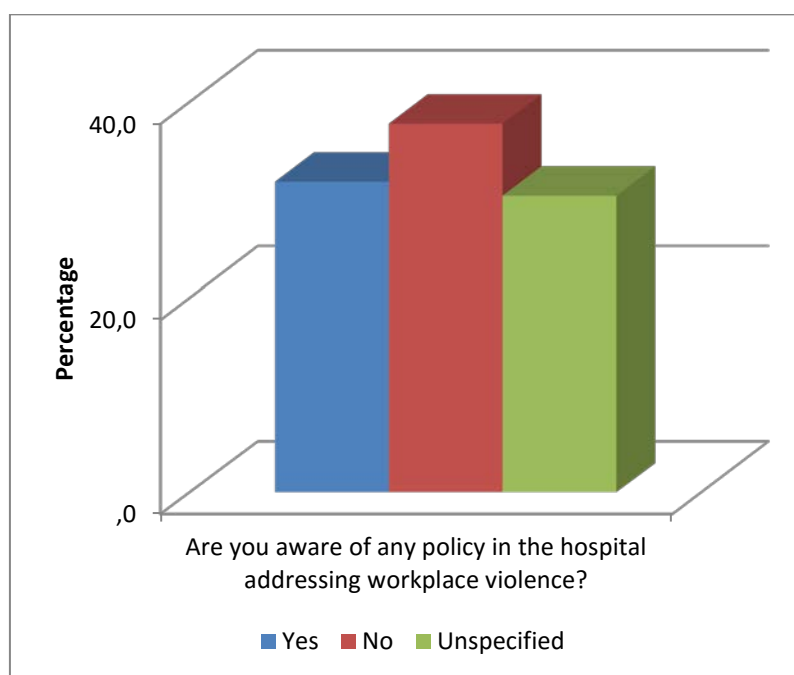
Over half, 62.2 % (n= 262), of those who participated disagreed that it was not important enough to them to report any workplace violence to the authorities. A few, (n=80, 19 %), agreed that it was not important enough to them to report any episode of workplace violence to the authorities.

#### 4.10.2.5 I DO NOT KNOW WHERE/HOW TO REPORT IT

Just under 60 %, 59.4 % (n=250), of those who participated disagreed with the statement that they did not know where or how to report it, whereas 21.1 % (n=89) agreed that they did not know where or how to report any workplace violence.

### 4.11 AWARENESS OF ANY POLICY IN THE HOSPITAL ADDRESSING WORKPLACE VIOLENCE

Students were requested to respond with a 'yes' or a 'no' if they were aware of any policy in the hospital addressing workplace violence.



**FIGURE 4.18 Awareness of any policy in the hospital addressing workplace violence**

#### 4.12 SECTION E: MANAGEMENT OF WORKPLACE VIOLENCE

In this section, the data was generated by the one open-ended question on the questionnaire. Respondents were asked:

*Do you have a suggestion regarding the management of workplace violence targeting student nurses in clinical areas?*

A total of (n=255) 60 % of the respondents answered this question. There were 17 % (n=72) of the respondents who did not report anything and left it blank. Others wrote 'nil' (n=54, 13 %) and some just said 'no suggestions/comments (n=40, 10 %). Therefore, in total, (n=166) 40 % of the respondents did not respond to the question.

The majority of the respondents reported that the people who abused them in the workplace were not patients or their relatives or friends, but staff. A majority of respondents from across all campuses requested that in future, a study on violence by staff be conducted, as these are the people responsible for most of the abuse experienced by student nurses. Respondents further reported that staff starting from the Enrolled Nursing Assistants up to the Management of the institution:

- Have a tendency to compare students' behaviour
- Undermine them, bullying and intimidating them
- Make them feel inferior in front of patients
- Schedule impossible off duties times
- Take sides when there is conflict
- Make them work on weekends and public holidays to cover the shortage of permanent staff
- They do not trust them in the work allocated
- Ignore them when they report violence
- Practise racism, have no respect for them, yell at them
- Do not compensate them for anything that happens to them in the workplace
- Make a mockery of them when they report issues and shout at them

In conclusion, they say that the profession, as a whole, oppresses student nurses in general.

**Table 4.10 Most common recommendations by respondents to manage workplace violence targeting student nurses in clinical areas**

<b>RECOMMENDATIONS</b>	<b>FREQUENCY (f)</b>
<ul style="list-style-type: none"> <li>• Formulation of clear policies regarding violence against student nurses and information on how to report it</li> </ul>	250
<ul style="list-style-type: none"> <li>• Provide protection protocol and increase security and make all aware of their existence in the community</li> </ul>	300
<ul style="list-style-type: none"> <li>• Community to be made aware of importance of student nurses, like all other employees who need mutual respect</li> </ul>	180
<ul style="list-style-type: none"> <li>• Need for preceptors and clinical lecturers to spend time with them to see how they are treated in clinical areas</li> </ul>	60
<ul style="list-style-type: none"> <li>• Encourage reporting without judgement, listen to such reports and matters to be dealt with promptly and effectively when reported</li> </ul>	280
<ul style="list-style-type: none"> <li>• Student nurses should not be made to work weekends and public holidays</li> </ul>	70
<ul style="list-style-type: none"> <li>• Staff not to reprimand student nurses in front of patients or visitors and to correct them constructively</li> </ul>	320

#### **4.13 BIVARIATE ANALYSIS - STATISTICAL RELATIONSHIPS BETWEEN DEMOGRAPHIC AND RESEARCH VARIABLES**

Further analysis was done as to whether gender, age, race, campus and the year of study had a significant effect on all measures in the questionnaire.

##### **4.13.1 Year of study:**

###### **4.13.1.1 Year of study and intimidation, bullying and non-verbal abuse**

In this study, the findings were that the higher the year of study, the greater the frequency of the abuse reported. The lower the year of study, the lower the reports of abuse. There was a significant positive correlation between the year of study and the experiencing of non-verbal abuse ( $\rho = .237, p < .0005$ ); being harshly judged or criticised ( $\rho = .174, p < .0005$ ); ignored or neglected ( $\rho = .130, p < .008$ ); ridiculed or humiliated ( $\rho = .108, p < .029$ ) and having a racist remark directed at them ( $\rho = .121, p < .014$ ).

###### **4.13.1.2 Year of study and physical abuse**

There was a significantly positive correlation between the year of study and being threatened with physical violence ( $\rho = .103, p < .035$ ).

###### **4.13.1.3 Year of study and sexual abuse**

There was a significantly positive correlation between the year of study and inappropriate touching (sp.  $\rho = .114, p = .020$ ); sexist remarks directed at students (sp.  $\rho = .126, p = .010$ ); and suggestive sexual gestures directed at them (sp.  $\rho = .181, p < .0005$ ).

###### **4.13.1.4 Year of study and the place that violence is likely to occur**

There was a significantly positive correlation between the year of study and the unit where the sexual abuse took place; wards (spearman's  $\rho = .130, p = .008$ ); OPD (spearman's  $\rho = .120, p = .015$ ); trauma (spearman's  $\rho = .208, p < .0005$ ); OT (spearman's  $\rho = .317, p = .0005$ ); and community settings (spearman's  $\rho = .221, p = .0005$ ). Analysis showed a significantly positive correlation between the year of study and reporting sexual abuse in the trauma unit (spearman's  $\rho = .154, p = .002$ ).

#### **4.13.1.5 Year of study and source of violence**

There was a significantly positive correlation between the year of study and who was responsible for the bullying, intimidation and verbal abuse; patients (spearman's  $\rho = .132$ ,  $p = .0007$ ); patients' relatives and friends (spearman's  $\rho = .127$ ,  $p = .010$ ).

#### **4.13.1.6 Year of study and work performance**

Results indicated a significantly positive correlation between the year of study and whether intimidation, bullying and verbal abuse affected work performance. Calling in absent was significant (sp. $\rho = .128$ ,  $p = .010$ ). There was no correlation between intimidation, bullying and verbal abuse and considering leaving nursing (sp.  $\rho = .019$ ,  $p = .705$ ).

#### **4.13.1.7 Year of study and personal consequences**

There was a significant positive correlation between year of study and personal consequences of humiliation or embarrassment (sp.  $\rho = .137$ ,  $p = .006$ ).

### **4.13.2 GENDER**

#### **4.13.2.1 Gender and intimidation, bullying and non-verbal abuse**

Female students, as expected, received significantly more non-verbal abuse than male students ( $z = -2.435$ ,  $p = .015$ ).

#### **4.13.2.2 Gender and sexual abuse**

Female students reported more sexual abuse than male students in the following ways:

Inappropriate touching ( $z = -4.152$ ,  $p < .0005$ ); threatened with sexual assault ( $z = -1.985$ ,  $p = .047$ ); sexist remarks directed at them ( $z = -4.898$ ,  $p < .0005$ ); suggestive sexual gestures directed at them ( $z = -4.435$ ,  $p < .0005$ ); requests for intimate physical contact ( $z = -4.272$ ,  $p < .0005$ ).

Only the female respondents reported incidences of sexual abuse in the workplace.

#### **4.13.2.3 Gender and the place the violence is likely to occur - physical abuse**

An interesting finding was that male students were more likely to have experienced physical abuse in the operating theatre than female students ( $z = -3.074$ ,  $p = .002$ ).

#### **4.13.2.4 Gender and the place violence is likely to occur - sexual abuse**

Female students experienced more sexual abuse in the wards ( $z = -4.272$ ,  $p = < .0005$ ); and trauma unit ( $z = -1.962$ ,  $p = .050$ ) than male students.

#### **4.13.2.5 Gender and the source of violence - sexual abuse**

Female students experienced more sexual abuse from patients than male students ( $z = -3.296$ ,  $p = .001$ ).

#### **4.13.2.6 Gender and work performance – sexual abuse**

Female students reported that sexual abuse negatively affected their standard of patient care ( $z = -2.646$ ,  $p = .008$ ) more than male students did.

#### **4.13.2.7 Gender and personal consequences - physical abuse**

Male students reported being more affected than female students by physical abuse which led to depression ( $z = -2.193$ ,  $p = .028$ ) and had a negative effect on personal relationships ( $z = -2.048$ ,  $p = .041$ ).

#### **4.13.2.8 Gender and personal consequences – sexual abuse**

Female students were more affected than male students by sexual abuse and reported higher levels of anger ( $z = -4.089$ ,  $p = < .0005$ ); depression ( $z = -1.972$ ,  $p = .049$ ); humiliation or embarrassment ( $z = -3.555$ ,  $p = < .0005$ ); anxiety or fear ( $z = -3.330$ ,  $p = .001$ ) and feelings of inadequacy ( $z = -2.213$ ,  $p = .027$ ).

#### **4.13.2.9 Gender and workplace violence as part of the job**

Significantly more than expected males agreed that workplace violence was part of the job ( $\chi^2 (1) = 4.640$ ,  $p = .031$ ).

#### **4.13.2.10 Gender and fear of being victimized**

Significantly more females agreed that they were afraid of being victimized if they reported the violence ( $\chi^2 (1) = 9.193$ ,  $p = .002$ ).

#### **4.13.2.11 Gender and stating it is not important**

Significantly more male students agreed that they do not report violence to the authorities because it is not important enough to the authorities ( $\chi^2 (1) = 12.769$ ,  $p = < .0005$ ).

#### **4.13.2.12 Gender and not knowing how to report**

Significantly more female students agreed that they did not report violence to the authorities because they did not know how to report it ( $\chi^2 (1) = 11.668, p = .001$ ).

#### **4.13.2.13 Gender and awareness of the hospital policy on workplace violence**

Female students were more likely to know about any policy in the hospital addressing workplace violence ( $\chi^2 (1) = 7.651, p = .006$ ) than male students.

### **4.13.3 CAMPUS**

#### **4.13.3.1 Intimidation, bullying or verbal abuse**

Intimidation, bullying and verbal abuse was more frequently experienced at Prince Mshiyeni and Port Shepstone than Greys campus, and more frequently at Port Shepstone than at Ngwelezane campus.

Student nurses at Prince Mshiyeni and Port Shepstone campuses were more often sworn at, shouted at and yelled at than those at Greys Campus. Student nurses at Prince Mshiyeni, Port Shepstone Ngwelezane experienced being more harshly judged and critiqued than those at Greys campus.

Being ignored or neglected was more often reported at Prince Mshiyeni, Port Shepstone and Ngwelezane than at Greys campus. Prince Mshiyeni and Port Shepstone reported more ridicule or humiliation than Greys campus. Racist remarks were experienced more often at Port Shepstone than at Ngwelezane campus.

#### **4.13.3.2 Sexual abuse**

Students at Ngwelezane Campus experienced more inappropriate touching ( $\chi^2 (3) = 10.155, p = .017$ ); sexist remarks directed at them ( $\chi^2 (3) = 11.653, p = .009$ ); and requests for intimate physical contact ( $\chi^2 (3) = 11.242, p = .010$ ) than students at Greys campus.

#### **4.13.3.3 Location of intimidation, bullying or verbal abuse**

Students at Ngwelezane and Port Shepstone Campuses reported that they experienced bullying, intimidation and verbal abuse in the wards and OPD, more than students at

Greys Campus ( $\chi^2 (3) = 15.144, p = .002$ ). Port Shepstone experienced more than Ngwelezane in the trauma unit. Greys reported more than the others in the OT. Ngwelezane reported more than Greys campus in community settings.

#### **4.13.3.4 Location of sexual abuse**

Students at Ngwelezane Campus reported that they experienced sexual abuse in the wards and OPD more than students from Greys Campus ( $\chi^2 (3) = 7.833 p = .050$ ). Port Shepstone experienced more in the trauma unit than Greys and Ngwelezane Campus.

#### **4.13.3.5 Source of intimidation, bullying or verbal abuse**

Prince Mshiyeni, Port Shepstone and Ngwelezane reported more abuse at the hands of patients than patients' relatives or friends than Greys campus. Patients' relatives or friends' abuse was reported more at Port Shepstone and Ngwelezane campuses than Greys campus. Ngwelezane experienced more than Prince Mshiyeni campus.

#### **4.13.3.6 Source of physical abuse**

Ngwelezane experienced more physical abuse from patients than Greys and Port Shepstone campuses.

#### **4.13.3.7 Source of sexual abuse**

Ngwelezane reported more sexual abuse from patients than Greys. Ngwelezane reported more sexual abuse from patients' relatives or friends than Greys and Port Shepstone campuses.

#### **4.13.3.8 Influence of intimidation, bullying or verbal abuse on work performance**

Port Shepstone experienced more of this treatment than all other campuses which made student nurses consider leaving nursing. All the other campuses experienced more feelings that negatively affected their standard of patient care than Greys campus.

#### **4.13.3.9 Influence of sexual abuse on work performance**

Ngwelezane reported more negative effects on their standard of patient care than Greys campus.



#### **4.13.3.10 Influence of intimidation, bullying or verbal abuse on personality**

Greys campus experienced less anger than other campuses. Port Shepstone and Ngwelezane reported more depression and humiliation/embarrassment than Greys campus. Prince Mshiyeni experienced more confusion than Greys campus. Port Shepstone reported more negative effects on personal relationships than Greys campus.

#### **4.13.3.11 Influence of physical abuse on personality**

Ngwelezane experienced more feelings of inadequacy than Greys campus.

#### **4.13.3.12 Influence of sexual abuse on personality**

Port Shepstone and Ngwelezane experienced more anger than Greys campus. Ngwelezane reported more humiliation/embarrassment than Greys. Ngwelezane reported anxiety/fear more than Greys campus.

Students at Port Shepstone Campus were more likely to consider leaving nursing because of bullying, intimidation and verbal abuse ( $\chi^2 (3) = 8.752, p = .033$ ) than students at all other campuses sampled.

### **4.13.4 RACE**

#### **4.13.4.1 Intimidation, bullying or verbal abuse**

Coloured student nurses reported more non-verbal abuse, such as raising of eyebrows and rolling of eyes, than Black student nurses and Indian student nurses. As far as racist remarks directed at the respondents are concerned, Coloured and Indians reported more than Blacks.

#### **4.13.4.2 Physical abuse**

Indian respondents experienced guns or knives being pulled on them more than Black respondents. White respondents reported more instances of something of theirs being deliberately damaged than the Black, Coloured and Indian respondents.

#### **4.13.4.3 Sexual abuse**

The white respondent experienced being threatened with sexual assault more than Black, Coloured and Indian respondents.

#### **4.13.4.4 Location of intimidation, bullying or verbal abuse**

Coloured reported more abuse in the OT than Black and Indian respondents. Indian respondents reported more abuse from the areas not mentioned in the study than the Black respondents.

#### **4.13.4.5 Source of intimidation, bullying or verbal abuse**

Coloured respondents experienced more abuse from patients than the Black respondents.

#### **4.13.4.6 Influence of intimidation, bullying or verbal abuse on person**

Coloured respondents reported more feelings of inadequacy than the Black respondents.

#### **4.13.4.7 Influence of sexual abuse**

The white respondent reported more anxiety /fear than the Black and Indian respondents. White respondent experienced more feelings of inadequacy than Black Respondents.

#### **4.13.5 AGE**

In this study, low age correlated with high frequency of intimidation, bullying and verbal abuse. The older respondents experienced more frequency of physical abuse by patients 'relatives or friends. Yet the influence of intimidation, bullying or verbal abuse experience of anger and humiliation/embarrassment showed no age difference.

#### **4.14 CONCLUSION**

In this chapter, the analysis of the results via a self-administered questionnaire was presented. Presentation of data was in the form of histograms and tables for each research variable. The results show more females being victims of workplace violence than males, though males also experience abuse in the workplace. Male patients and their relatives are reported as perpetrators of violence. Influence of abuse on people reported the effects of depression and a negative effect on personal relationships as being experienced by more males than females. Males felt that it was not important enough for them to report any workplace violence and more males see it as part of the job to be abused in the workplace than females.

The senior student nurses reported more abuse in the workplace than the junior student nurses. The Chi-square showed that there are no significant relationships between the

year of study and reporting of violence to the authorities and the awareness of any policy in the hospital addressing workplace violence.

Though the campuses that were used in the study are in urban areas, the response is not the same from the respondents regarding the violence they experienced. The same applies to the races that participated in the study; they had different feelings on violence as a whole.

Many respondents did not comment about awareness of the existing policy in the workplace. One worries about the orientation of new staff in the workplace and whether this is conducted, as these respondents constituted a large number, including those who reported that they were not aware.

In the following chapter, the discussion of findings and recommendations arising from the outcomes of this research will be presented.

## **CHAPTER 5**

### **DISCUSSION OF FINDINGS**

#### **5.1 INTRODUCTION**

The purpose of this study was to determine the types and extent of violence experienced by student nurses at the hands of patients and their relatives or friends in public hospitals in KZN, and whether this leads to the students' intention to leave the nursing profession. This was in response to the guiding research questions namely:

- What are the types of violence experienced by student nurses in public hospitals in KZN?
- Does the violence experienced by student nurses in workplace settings lead to an intention to leave nursing?

In the previous chapter, the data collected were analysed and presented. In this final chapter, the data findings are discussed critically. Limitations of this study and recommendations for further research will also be discussed.

Discussion is based on the 'Ecological occupational health model' to examine some factors hypothesised as contributing to workplace violence among the student nurses in KZN (Levin, Hewitt, Misner, & Reynolds, 2003) refer to figure 1.1 on page 9. Four concepts of this model were applied in this study: personal, workplace, community and environmental factors and the consequences of this violence on student nurses as victims. Personal factors included demographic details of student nurses such as gender, race, age, campus and level of training in years. Workplace factors used were: the location or departments where the violence that the student nurses were exposed to took place, such as wards, OPD, OT, trauma and community settings like clinics. Community and environmental factors used were the source of violence, namely the perpetrators: patients and patients' relatives or friends. Assault situations were the actual acts of violence used by perpetrators - intimidation, bullying and verbal abuse, physical, and sexual abuse. Consequences of assault included the influence of violence on the person, work performance and intention to leave nursing. See the details on page 6, 7 and 8 then figure 1.1 on page 9.

In terms of work performance: 'was the victim of violence made to consider leaving nursing, caused to call in absent and did the violence negatively affect the standard of patient care factors used?'. In the influence on personality: 'did the victim of violence

experience anger, depression, humiliation/embarrassment, anxiety/fear, confusion, feelings of inadequacy and negative effects on personal relationships as a consequence of violence?'. Interventions like the design of policies and programs in the ecological occupational health model were not used in this study.

The recommendations for further research on education and management will be discussed.

## **5.2 PERSONAL STUDENT FACTORS**

### **5.2.1 GENDER**

This study reflects the predominance of females in the sample with a ratio of 2:1, but the perpetrators were more inclined to be males. Nursing remains a female-dominated profession as indicated by the national and international statistics (SANC 2015). The total number of student nurses in training at the South African Nursing Council (SANC) in 2015 was 20549, 15404 females and 5145 males (Stats SA, 2015:2). In the R425 program at the KZN CN, the number of students in training during 2015 was 3387, 2478 females and 909 males.

In KZN, the student gender ratio is similar to that of the national student population which is a ratio of 3:1. In the numerous studies reporting violence against women, there is no published work on the incidence of violence against student nurses in the province of KZN. Despite the gender distribution in SA being 51.3 per cent female and 48.7 per cent male, nursing remains a female-dominated occupation. There are fewer males than females due to the feminised nature of the profession (nursing). In this current study, the student nurses who were available and participated were mostly females. The Foundation for Professional Development (2015:24) stated that most perpetrators of violence are men.

The study's findings that more females were victims than males is consistent with other literature all over the world as in Ghana (Boafo, Hancock & Gringart, 2016:99; Turkey (Unal, Hisar and Gorgulu, 2012:11); Switzerland (Hahn *et al.*, 2012:98); Hong Kong (Kwok *et al.*, 2006:8) where females were found to be the majority of respondents in their study on workplace violence in the healthcare centres. Nurses are in the majority as victims of violence as they are at the frontline of the healthcare system (Kwok *et al.*, 2006).

### **5.2.2 AGE**

The age of the respondents ranged between 18 to 50 years, with a mean of 25 years. A large percentage of the respondents was over the age of 20 years. The younger student nurses reported more incidences of workplace violence than the older student nurses. Unal, Hisar and Gorgulu (2012:11) state that the young and less experienced student nurses are more likely to encounter violence in the workplace. It is consistent with other literature that says more experience and education in nursing is a protective factor against violence. Therefore, limited education and inexperience poses a risk of susceptibility to workplace violence among student nurses. Lin and Liu (2005:776) report that the novice nurses perceive workplace violence differently to the nurses who have been in the profession a long time. Hahn (2012:98) also stated that it is the younger staff who are reported most frequently as victims of patient and visitor violence in public hospitals.

### **5.2.3 RACE**

Most of the respondents in the current study were Black, followed by Indian, Coloured and White. This reflects the population of South Africa and the province of KwaZulu-Natal. Black students make up 70 per cent of enrolments and so this sample showed a greater enrolment of African students than in public hospitals (South African Nursing Council, 2015:23). This is possible as there are no fees paid but students receive a stipend for their tuition. The other reasons could be that the entrance requirements are lower than that of the Universities, and that there are greater job opportunities on completion of training (Mkhize and Nzimande, 2007:14-15).

There was no significance in the relationship with regard to race in the study. The fact that there were fewer Whites does not mean they were not interested in participating in the study, but was rather due to their lack of availability of in the nursing campuses. In almost many countries and cultures, the workplace violence exists and is the same against student nurses (Magnavita and Heponiemi, 2011:204).

### **5.2.4 CAMPUS**

Looking at the campuses that participated in the study, the abuse at PMMH and Port Shepstone was more frequent than at Greys, and at Port Shepstone it was more frequent than at Ngwelezane Campus. This was because the campus had the highest number of student nurses in the R425 program in KZN CN. So it was important to do the

study across different campuses throughout the whole of KZN for generalisation of the findings from the North, South, West and East of the province of KZN. The findings were the same in that workplace violence does exist among student nurses even in the province of KwaZulu-Natal.

### **5.2.5 YEAR OF STUDY**

A significant number of the respondents were in their third year of training at the different campuses. These categories of student nurses have not done their psychiatric nursing in order to be skilled enough to handle violent patients and their relatives. The year of study was statistically significantly associated with workplace violence. Few participants were in their first year of training which hypothesises that younger nurses take workplace violence as part of the job, and do not see the need to report it (Magnavita and Heponiemi, 2011:204). Lin and Liu (2005:776) states that young nurses perceive workplace violence differently to those with experience.

## **5.3 WORKPLACE FACTORS**

### **5.3.1 DEPARTMENTS WHERE VIOLENCE TOOK PLACE**

Workplace violence exists in all health care departments, but nurses are the ones who are affected the most as they are at the frontline of the healthcare system (Kwok *et al.*, 2006:6). Findings in this study revealed that student nurses are also at high risk of workplace violence like all other nurses. This is because nurses have the closest contact with patients and their relatives; hence they are at high risk of exposure to violence. The placement of student nurses in all these four campuses was in the wards, OPD, Trauma, OT, and community settings, e.g. clinics. Student nurses working in the medical and surgical wards were the most exposed to workplace violence. The next department with a high prevalence of workplace violence was the community settings such as clinics. The other departments were not uncommon for workplace violence. The department with the least incidence of violence was the OPD; surprisingly the OT showed a higher incidence than the OPD. The prevalence of violence in other countries is reported in emergency departments also known as trauma units (Lin and Liu, 2005:773; Levin, Hewitt and Misner, 1998:251). Since all settings have a potentially high risk for violence, it is therefore necessary for the management to improve security in all high risk areas so that the student nurses can remain safe.

The same applies to the areas of workplace violence; all these departments had incidences of violence, though intimidation, verbal abuse and bullying was more prevalent than physical and sexual abuse in community settings like clinics. More incidences of physical abuse were reported in the community settings such as clinics where student nurses were placed. Hence the sexual abuse was more marked in the wards (8.3 per cent, n=35).

## **5.4 COMMUNITY AND ENVIRONMENTAL FACTORS**

### **5.4.1 SOURCE OF VIOLENCE**

It was crucial that the main perpetrators were identified in order to be able to address the problem of workplace violence. The study examined the two possible perpetrators of workplace violence in the public hospitals of KZN namely patients and their relatives. Findings in this study are consistent with most of the literature which states that the majority of perpetrators of violence in the public hospitals are patients and their relatives or friends. Fouché and du Toit (2006:82) agreed that student nurses subject to abuse are mostly in acute phases with patients and they form the main link between patients and the hospital team, putting them at potential risk of abuse from patients and their relatives. Patients and their relatives are the perpetrators of workplace violence in this study.

In the source of violence, number of incidences perpetrated by the patients and relatives that were reported frequently, were almost the same in cases of intimidation, bullying and verbal, as also physical abuse. Surprisingly, patients were reported more frequently in instances of sexual abuse than the patients' relatives or friends. This study adds to the body of literature supporting the argument on workplace violence that student nurses are exposed to. It is consistent with the literature (Unal, Hisar and Gorgulu, 2012:11; Hahn, Muller, Needham, Dassan, Kok and Halfens, 2010:3546) that patients and their relatives or friends constituted the main perpetrators of workplace violence against student nurses. The hypothesis for the violence by patients is that patients and family have little control over the hospital environment and feel powerless, hence the violent acts.

With regard to intimidation, bullying, non-verbal abuse and physical abuse, an equal number of patients and their relatives or friends were reported as perpetrators of workplace violence, whereas in the case of sexual abuse, it was mostly the patients who abused the student nurses.



The majority of the respondents reported that the people who abuse them in the workplace are not patients or their relatives or friends, but staff, which is an avenue for further study. It was apparent from the responses that, for the vast majority of respondents, horizontal violence was the uppermost in their minds when they addressed this question.

## **5.5 ASSAULT SITUATION FACTORS**

Respondents experienced a different range of violence which covered verbal abuse, physical abuse and even sexual abuse by different perpetrators, which makes KZN similar to other provinces or countries with regards to workplace violence in the literature.

### **5.5.1 INTIMIDATION, BULLYING OR VERBAL ABUSE**

In all the types of violence reported, the highest incidence reported was intimidation, verbal abuse and bullying, which a number of students were exposed to. One of the remarkable findings in this study was that many students are victims of intimidation, bullying and verbal abuse. This is consistent with other research studies in Jordan (Al-Omari, 2015:116) which reported that more than half of respondents in their study were verbally abused.

Mostly, the student nurses had more to report on this type of violence than in cases of physical and sexual abuse. Even the consequences resulted mainly from intimidation, verbal abuse and bullying. However the student nurses were primarily concerned about their safety in the workplace. Student nurses also have a right to work in a healthy safe environment.

### **5.5.2 PHYSICAL ABUSE**

Though the majority indicated that they had never been attacked physically, there were isolated cases who had experienced all these types of physical abuse. The highest number of incidents involved the threat of physical violence, followed by those in which something personal was deliberately damaged. Nine student nurses were threatened with guns and knives and fourteen student nurses were actually hit with something. Others were pushed and kicked. This really calls for immediate intervention as it adds to the body of literature that student nurses are one of the victims of workplace violence at the hands of patients and their relatives or friends when in clinical areas.

In Victoria, the *Australian Nursing Journal* (O'Rourke, 2013:20) reported the different types of violence student nurses and midwives as being hit, punched, kicked, bitten and threatened with weapons and objects, even death threats. They had to launch a campaign calling the state to stop the violence and asking the community for their support following serious attacks in hospitals. Even the perpetrators are at risk of violence, in this case, if the nurse decides to hit back in defence. It is not easy to be quiet when a patient is losing it, as recommended by Navis (1987:52). Nurses from all categories need to report all incidents of violence to management and all the stakeholders so that they can intervene urgently before such cases become even worse.

### **5.5.3 SEXUAL ABUSE**

Respondents had to indicate the specific type of abuse related to sexual abuse such as 'inappropriate touching', 'threatened with sexual assault', 'sexist remarks directed at them', 'suggestive sexual gestures directed at them', 'a request for intimate physical contact'. Though all these types of sexual abuse had incidences reported, sexist remarks directed at respondents was found to be the most reported incidence of workplace violence across all the campuses in the study, followed by suggestive sexual gestures directed at victims of the study. A small number of student nurses were threatened with sexual assault.

The mere fact that there are victims of all these types of sexual abuse which occurred in the workplace, calls for development or improvement of policies, procedures and intervention strategies on zero tolerance of workplace violence.

## **5.6 EFFECTS OF WORKPLACE VIOLENCE**

### **5.6.1 INFLUENCE OF VIOLENCE ON WORK PERFORMANCE**

The student nurses were asked to indicate how workplace violence had affected their work performance regarding these types of abuse. They had to select between 'considering leaving nursing', 'calling in absent', or it 'affected patient care'. Fourteen per cent of the student nurses considered leaving the nursing profession due to exposure to workplace violence. This is a large number, especially when nurses are reported as short-staffed by researchers (Boafo, Hancock and Gringart, 2016:99).

Most of the consequences of workplace violence such as intimidation, bullying and non-verbal, physical and sexual abuse reported were that it affected nursing care rendered to patients, followed by student nurses considering leaving the nursing profession. Findings

are similar to Magnavita and Heponiemi (2011: 206) who state that nurses exposed to workplace violence consider changing their place of work or leave the profession. There was an increase in the number of nurses who were calling in sick following workplace violence. This is the reason why the community complains of poor nursing care received in public hospitals. This goes with the hypothesis that “there is a decreased interest in nursing” (Mkhize and Nzimande, 2007:24).

### **5.6.2 INFLUENCE OF VIOLENCE ON PERSONALITY**

The variables used were: anger, depression, humiliation, anxiety, confusion, inadequacy and personal relationships. The intimidation, bullying and verbal abuse reported caused anger in most of the respondents followed by humiliation. Findings were similar to other studies that indicated that the response to verbal abuse results in anger, fear and anxiety (Magnavita and Heponiemi, 2011: 204). In physical abuse, anger was the highest emotion indicated followed by humiliation. In sexual abuse it was anger followed by humiliation and anxiety in equal numbers. The result is that nurses are often sick or leave nursing as they fail to cope psychologically.

Unal, Hisar and Gorgulu (2012:14) revealed that the student nurses, who are subjected to workplace violence during training, are candidates to become abusive towards student nurses when they are trained. There is thus a need for the student nurses to be developed and equipped for the challenges they will encounter in the clinical setting in order to be professional nurses in their careers later on.

### **5.7 REPORTING VIOLENCE**

Incidences are under-reported in writing because of the absence of institutional reporting policies; there were those who reported abuse and those who did not. The reasons for not reporting were: ‘part of the job to be abused’, ‘nothing will be done’, ‘I will be victimised’, and ‘it was not important to report’. The majority indicated that it was the same because nothing would be done after reporting, followed by those who said it was not important to report. More than half of the respondents reported that they didn’t know how to report abuse.

This study thus adds to the body of literature indicating that there is also workplace violence by patients and their relatives against student nurses in KZN public hospitals. Most of the incidences are not reported to the authorities (Hinchberger, 2009:41; Magnavita and Heponiemi 2011:204; Unal, Hisar and Gorgulu 2012). It can be

concluded that the student nurses of KZN CN are reluctant to report incidences of workplace violence.

## **5.8 AWARENESS OF POLICY EXISTENCE ADDRESSING WORKPLACE VIOLENCE**

Respondents who said 'yes' and those who did not comment are equal in number, which totals are both less than those who said 'no'. This explains why most of the student nurses do not report episodes of workplace violence since the policy addressing the workplace violence is not known to them. The study is consistent with the findings of the study by Hewett (2010:109) that the majority of respondents had been unaware of policy existence. Those who are aware reported no need for reporting as 'nothing will be done by the authorities after reporting'.

## **5.9 SUMMARY**

A quantitative descriptive research study was conducted, investigating workplace violence against student nurses in the KZN Province of South Africa. The setting of the study was the KZN CN campuses across KZN namely Greys, Ngwelezane, Port Shepstone and Prince Mshiyeni Memorial. The population were student nurses in their first, second, third and midwives in their fourth year of training in the R425 programs. The psychiatric student nurses were not considered to avoid bias, due to their experience and knowledge in handling violent people during their module in psychiatric nursing.

The findings of the study revealed that student nurses, mostly females, of African origin, are also victims of workplace violence in the public hospitals of KZN perpetrated by patients and their relatives. As a result, they call in absent at work and they feel angry and depressed. Many of these victims do not report the incidences of abuse that take place during their clinical placement. They are not even aware of the policies that exist in their institutions.

## **5.10 LIMITATIONS**

- The study was conducted in a specific province being KZN, at public hospitals not private hospitals, and the student nurses in the R425 program. Therefore, the results cannot be generalised to other include population groups not in this program.

- The source of violence on the questionnaire, meaning perpetrators, was focused on patients and their relatives only, yet the respondents recounted many perpetrators of violence, including their lecturers. This is consistent with other literature that reports perpetrators as staff more often than patients and their relatives (Hinchberger, 2009:43; Hewett, 2010:107; Unal, Hisar and Gorgulu, 2012:13).
- The study failed to identify what the participant was engaged in or doing during an attack by the perpetrator of violent behaviour, nor what triggered the act of violence. These causes should be examined in studies to enable future prevention.

Therefore, this study recommends that student nurses be protected from all types of abuses which they are potentially subject to.

### **5.11 RECOMMENDATIONS**

This study has produced a number of recommendations to prevent workplace violence in public hospitals and so that student nurses can feel secure. The student nurses also deserve respect, like all other healthcare workers. It is hoped that these recommendations will benefit the Department of Health as well as institutions which provide training to student nurses. Based on the conclusion and results of the study, the following recommendations were made:

- Violence in the workplace should never be accepted nor tolerated as part of the job.
- Clear policies regarding violence against student nurses should be formulated as well as information on how to report its occurrence.
- Protection protocol should be provided, security increased and awareness of the existence of these aids in the community should be created.
- The community needs to be made aware of the importance of student nurses who, like all other employees, need mutual respect.
- Preceptors and clinical lecturers need to spend time with student nurses to see how they are treated in the clinical setting.
- Student nurses should be encouraged to report without judgement; they need to be listened to and their matters dealt with promptly and effectively when reported.

- Student nurses should not be compelled to work on weekends and public holidays.
- Staff should not reprimand student nurses in front of other staff, patients or visitors and if there is a need for them to be corrected, this should be done constructively.

Therefore, to succeed in the prevention of workplace violence intervention via a multidisciplinary approach is required. If student nurses are not willing to acknowledge the occurrences and report the workplace violence, the situation will not improve. I recommend these groups of students who participated in the study and explored their experience to limited extent workplace violence by patients and their family members. This phenomenon needs to be explored in future research.

#### **5.11.1 NURSING PRACTICE**

The managers of the institutions and nurse educators/lecturers need to be aware of the findings of this study regarding workplace violence against student nurses in KZN. They need to encourage and pursue corrective measures. Nurses need to know where to report workplace violence.

#### **5.11.2 NURSING EDUCATION**

The education and training provider management, that is KZN CN, DOH and campuses, should assume the responsibility of addressing workplace violence targeting student nurses in clinical areas. The lecturers need to educate student nurses to be able to recognise the signs of impending violence in patients, visitors or relatives, staff and their colleagues. They all need to be aware of hospital protocols if these exist and how to initiate them. Mentorship programs should be developed and implemented to reduce the high turnover rate.

All campuses should consider the proposed recommendations by the International Council of Nurses on the prevention of workplace violence (2007: 20). Finally, the recommendations of the researcher should be considered and implemented.

#### **5.11.3 MANAGEMENT OF INSTITUTIONS**

There is a need for the development and/or improvement of policies, procedures and intervention strategies. Managers have the responsibility to create and maintain a zero tolerance of workplace violence. Institutions should hire managers with higher educational qualifications to deal with workplace violence.

#### **5.11.4 RESEARCH FOR FUTURE STUDIES**

There is a need for qualitative research to provide more details on workplace violence and its precipitating causes.

#### **5.11.5 CONCLUSION**

According to the results of study, student nurses are at risk and are the targets of workplace violence in the clinical areas during practise, like all other healthcare personnel. There is a great need for them to be protected from the perpetrators of violence whether these are the recipients of healthcare or their co-workers. To promote an abuse-free environment, all the stakeholders involved are called upon to intervene. Future research needs to investigate successful measures to curb this workplace violence.

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# Annexures

ANNEXURE A –ADVERT

1ST YEAR,

2<sup>ND</sup> YEAR

3<sup>RD</sup> YEAR AND MIDWIVES

STUDENT NURSES

YOU ARE CORDIALLY INVITED TO  
TAKE PART IN A RESEARCH  
PROJECT SURVEY VOLUNTARILY

TOPIC

VIOLENCE AGAINST STUDENT  
NURSES BY PATIENTS AND THEIR  
RELATIVES IN PUBLIC HOSPITALS  
OF KWAZULU NATAL

DATE:

TIME:

VENUE: CAMPUS CLASSROOM



## ANNEXURE B- STUDENT QUESTIONNAIRE

### STUDENT QUESTIONNAIRE

No.

Please answer all questions. Title of the research project:

Violence against student nurses by patients and their relatives in the public hospitals in Kwa Zulu Natal.

Instructions:

Please complete the questionnaire.

Select your response by placing a tick (✓) at the appropriate spot next to each question.

There is one open-ended question at the end of the questionnaire where you are asked to formulate your own response to the question.

## SECTION A: DEMOGRAPHIC DATA

1. GENDER: Tick (✓) the appropriate answer:

MALE	
FEMALE	

2. AGE: Please fill in years:

--

3. RACE/ETHNIC GROUP: Select by placing a tick (✓) at the appropriate spot :

BLACK	COLOURED	INDIAN	WHITE

4. CAMPUS: Please fill in:

--

5. YEAR OF STUDY

1 <sup>ST</sup> YEAR	
2 <sup>ND</sup> YEAR	
3 <sup>RD</sup> YEAR	
MIDWIFE	

## SECTION B: DATA RELATED TO WORKPLACE VIOLENCE

6. Indicate your agreement with the following statements regarding intimidation, bullying and verbal abuse in the clinical areas:

Select by placing a tick (✓) at the appropriate spot :

In the past year in the clinical areas, I have been <u>bullied, intimidated or verbally abused</u> in the following ways:	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
6.1 Non-verbally, e.g. raised eyebrows, rolling eyes					
6.2 Sworn, shouted or yelled at					
6.3 Harshly judged/ criticized					
6.4 Ignored or neglected					
6.5 Ridiculed or humiliated					
6.6 Had a racist remark directed at me					
6.7 Other : please detail _____					

7. Indicate your agreement with the following statements regarding physical abuse in the clinical areas:

In the past year in the clinical areas, I have been <u>physically abused</u> in the following ways:	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
7.1 Pushed or shoved					
7.2 Kicked					
7.3 Hit with something					
7.4 Had a gun or knife pulled on me					
7.5 Been threatened with physical violence					
7.6 Had something of mine deliberately damaged					
7.7 Other : please detail _____					

8. Indicate your agreement with the following statements regarding sexual abuse in the clinical areas:

In the past year in the clinical areas, I have been <u>sexually abused</u> in the following ways:	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
8.1 Been inappropriately touched					
8.2 Been threatened with sexual assault					
8.3 Had sexist remarks directed at me					
8.4 Had suggestive sexual gestures directed at me					
8.5 Had a request for intimate physical contact					
8.6 Other : please detail _____					

SECTION C: SOURCE OF VIOLENCE INFLUENCE ON WORK+PERSONAL CONSEQUENCES.

9. Indicate your responses to the following statements regarding location of intimidation, bullying and verbal abuse in the clinical areas:

In the past year I experienced <u>bullying, intimidation or verbal abuse</u> , in the following clinical areas:	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
Hospital setting					
9.1 Wards					
9.2 OPD					
9.3 Trauma					
9.4 OT					
9.5 Community settings, e.g. clinics,					
9.6 Other : please detail _____					

10. Indicate your responses to the following statements regarding location of physical abuse in the clinical areas:

In the past year I experienced <u>physical abuse</u> , in the following clinical areas:	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
Hospital setting					
10.1 Wards					
10.2 OPD					
10.3 Trauma					
10.4 OT					
10.5 Community settings, e.g. clinics,					
10.6 Other : please detail _____					

11. Indicate your responses to the following statements regarding location of sexual abuse in the clinical areas:

In the past year I experienced <u>sexual abuse</u> , in the following clinical areas:	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
Hospital setting					
11.1 Wards					
11.2 OPD					
11.3 Trauma					
11.4 OT					
11.5 Community settings, e.g. clinics,					
11.6 Other : please detail _____					

12. Indicate your responses to the following statements regarding the source of intimidation, bullying and verbal abuse in the clinical areas:

In the past year I experienced <u>bullying, intimidation or verbal abuse</u> , in the clinical areas from the following sources:	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
12.1 Patients					
12.2 Patients' relatives or friends					

13. Indicate your responses to the following statements regarding the source of physical abuse in the clinical areas:

In the past year I experienced <u>physical abuse</u> , in the clinical areas from the following sources:	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
13.1 Patients					
13.2 Patients' relatives or friends					

14. Indicate your responses to the following statements regarding the source of sexual abuse in the clinical areas:

In the past year I experienced <u>sexual abuse</u> , in the clinical areas from the following sources:	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
14.1 Patients					
14.2 Patients' relatives or friends					

15. Indicate your responses to the following statements regarding the influence of intimidation, bullying or verbal abuse in the clinical areas on your work performance:

Intimidation, bullying or verbal abuse in the clinical areas has influenced my <u>work performance</u> in the following ways:	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
15.1 Made me consider leaving nursing					
15.2 Caused me to call in absent					
15.3 Negatively affected my standard of patient care					
15.4 Other : please detail: _____					

16. Indicate your responses to the following statements regarding the influence of physical abuse in the clinical areas on your work performance:

Physical abuse in the clinical areas has influenced my <u>work performance</u> in the following ways:	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
16.1 Made me consider leaving nursing					
16.2 Caused me to call in absent					
16.3 Negatively affected my standard of patient care					
16.4 Other : please detail: _____					

17. Indicate your responses to the following statements regarding the influence of sexual abuse in the clinical areas on your work performance:

Sexual abuse in the clinical areas has influenced my <u>work performance</u> in the following ways:	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
17.1 Made me consider leaving nursing					
17.2 Caused me to call in absent					
17.3 Negatively affected my standard of patient care					
17.4 Other : please detail: _____					

18. Indicate your responses to the following statements regarding the influence of intimidation, bullying or verbal abuse in the clinical areas on you personally:

Intimidation, bullying or verbal abuse in the clinical areas has resulted in me experiencing the following <u>personal</u> consequences	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
18.1 Anger					
18.2 Depression					
18.3 Humiliation / embarrassment					
18.3 Anxiety / fear					
18.4 Confusion					
18.6 Feelings of inadequacy					
18.7 Negative effect on personal relationships					
18.8 Other : please detail: _____					



19. Indicate your responses to the following statements regarding the influence of physical abuse in the clinical areas on you personally:

Physical abuse in the clinical areas has resulted in me experiencing the following <u>personal</u> consequences	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
19.1 Anger					
19.2 Depression					
19.3 Humiliation / embarrassment					
19.4 Anxiety / fear					
19.5 Confusion					
19.6 Feelings of inadequacy					
19.7 Negative effect on personal relationships					
19.8 Other : please detail: _____					

20. Indicate your responses to the following statements regarding the influence of sexual abuse in the clinical areas on you personally:

Sexual abuse in the clinical areas has resulted in me experiencing the following <u>personal</u> consequences	Never	Rarely (1-2 times)	Occasionally (3-5 times )	Sometimes (6-8 times)	Often (>8 times)
20.1 Anger					
20.2 Depression					
20.3 Humiliation / embarrassment					
20.4 Anxiety / fear					
20.5 Confusion					
20.6 Feelings of inadequacy					
20.7 Negative effect on personal relationships					

SECTION D: REPORTING OF WORKPLACE VIOLENCE

21. Have you ever reported an episode of any kind of workplace violence to the authorities?

YES	
NO	

If YES, proceed to question 23.

If NO, continue with question 22.

22. Indicate your agreement with the following statements regarding reporting violence to the authorities.

I have <u>never</u> reported an episode of physical or non-physical workplace violence to the authorities because:	Agree	Disagree
22.1 It is part of the job		
22.2 Nothing will get done about it		
22.3 I am afraid I will be victimized		
22.4 It is not important enough to me		
22.5 I do not know where / how to report it		
22.6 Other : please detail _____		

23. Are you aware of any policy in the hospital addressing workplace violence?

Yes	
No	

SECTION E: MANAGEMENT OF WORKPLACE VIOLENC

24. Do you have any suggestions regarding the management of workplace violence targeting student nurses in the clinical area?

Thank you for taking time on the questionnaire

Modified Hewett (2010:131-137).

## Annexure C-LETTER OF INFORMATION AND CONSENT



### LETTER OF INFORMATION

Title of the Research Study: Violence against student nurses by patients and their relatives in public hospitals in Kwa Zulu Natal

Principal Investigator/s/researcher: Mrs Bongi Majola (BA Honours in Health Studies)

Supervisor/s: Dr Penelope Margaret Orton (PhD in Nursing) and Dr Ayisha Razak

Invitation to participate: Dear Participant, You are kindly invited to participate in the above-mentioned research study.

Brief Introduction and Purpose of the Study: This study seeks to explore and describe the patient and visitor violence experienced by student nurses in clinical placement as to address the challenges that are faced within the workplace.

Outline of the Procedures: The study will be conducted at the following KwaZulu- Natal Colleges of Nursing Greys, Ngwelezana, Port Shepstone, and Prince Mshiyeni Memorial. Permission has been obtained from the college principal of each selected college for the study. Posters have been displayed, outlining the study, on the notice board for all the student nurses to see. The college principal has given permission for the study to take place on your campus. I invite you to participate in the study. You will be asked to complete the self-administered questionnaire which will be handed out to those who are interested in participating. I ask you to please complete the questionnaire today and post it into the sealed box which is in the room.

Risks or Discomforts to the Participant: I don't foresee any risks except that sharing experiences might alleviate emotional discomfort. If in answering the questionnaire you experience an emotional reaction please speak to the researcher who will help you with the referral to the Employee Assistance Practitioner.

Benefits: The benefits of this study will be an understanding of workplace violence that you experience in clinical placements and therefore strategies to assist you to deal with workplace violence.

Costs of the Study: The researcher will be liable for any costs and therefore you as a participant in this study will not incur any costs.

Confidentiality: The researcher will ensure that your confidentiality will be maintained throughout the study by using numbers instead of your name on the self-administered questionnaire. You will be given sufficient time to consider your participation before filling in the questionnaire. All data collected will remain confidential and that only the researcher and the statistician employed by the researcher will have access to it. The completed questionnaires will be kept in a sealed box when transported and will be locked in a steel cupboard for a period of 5 years and thereafter shredded by the researcher. A password protected computer will be used to store electronic data and this data will be deleted after 5 years by the researcher.

Research-related Injury: There will be no harm/ injury to you.

Persons to Contact in the Event of Any Problems or Queries:

Dr P.M. Orton (Supervisor)

Contact number: 031-373 2606

E-mail: [penny@dut.ac.za](mailto:penny@dut.ac.za)

Please contact the Researcher:

Mrs Majola

Contact number: 0834485854

E-mail: [bongi.majola@kznhealth.gov.za](mailto:bongi.majola@kznhealth.gov.za)

Or the Institutional Research Ethics administrator on:

031 373 2900



## CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Mrs Bongi Majola, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: 106/15
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant	Date	Time	Signature / Right Thumbprint

I, Mrs Bongi Majola herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

BONGI MAJOLA	_____	_____
Full Name of Researcher	Date	Signature

_____	_____	_____
Full Name of Witness (If applicable)	Date	Signature

## ANNEXURE D-REQUEST TO DOH

### ANNEXURE D

49 School Avenue

Extension 1

Chesterville

4091

15<sup>th</sup> September 2015

The Head of Department

KwaZulu-Natal Department of Health

Private Bag x9051

Pietermaritzburg

3200

Sir/Madam

#### **RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY**

I am a Lecturer at Addington nursing campus under KwaZulu-Natal College of Nursing and presently registered as a Masters of Technology: Nursing student at the Durban University of Technology in the Department of nursing. The proposed title of my research project is: *The violence against student nurses by patients and their relatives in public hospitals in KwaZulu-Natal*. The aim of the study is to describe violence against student nurses by patients and their relatives in public hospitals in KwaZulu-Natal. Data will be collected using self-administered questionnaires in student nurses in their first, second and third year of training.

I hereby request your permission to conduct the research project in the following four campuses of the KwaZulu-Natal College of Nursing: Greys, Ngwelezane, Port Shepstone, and Prince Mshiyeni Memorial. My research proposal has been attached for your perusal. Your permission to conduct the research project will be highly appreciated.

Yours obediently

.....  
B.A. Majola (Mrs)

MTech student

Contact number: 0834485854

E-mail: [bongi.majola@kznhealth.gov.za](mailto:bongi.majola@kznhealth.gov.za)

P.M. Orton (Dr)

Supervisor

Contact number: 031-3732 606

E-mail: [penny@dut.ac.za](mailto:penny@dut.ac.za)

## ANNEXURE E -PERMISSION FROM DOH

### ANNEXURE E



**health**  
Department:  
Health  
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langakhalile Street, Pietermaritzburg  
Postal Address: Private Bag X9051  
Tel: 033 395 2805/3180/3123 Fax: 033 394 3782  
Email:  
www.kznhealth.gov.za

#### DIRECTORATE:

Health Research & Knowledge  
Management

Reference: 276/15  
KZ\_2015RP43\_309

Date: 10 November 2015

Dear Mrs BA Majola  
Email: [bongi.Majola@kznhealth.gov.za](mailto:bongi.Majola@kznhealth.gov.za)

#### Approval of research

1. The research proposal titled 'Violence against student nurses by patients and their relatives in public hospitals in KwaZulu-Natal' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Grey's, Ngwelezana, Port Shepstone and Prince Mshiyeni KZN College of Nursing Campuses.

2. You are requested to take note of the following:
  - a. Make the necessary arrangement with the identified facility before commencing with your research project.
  - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to [hrkm@kznhealth.gov.za](mailto:hrkm@kznhealth.gov.za)

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

  
Dr E Lutge

Chairperson, Health Research Committee

Date: 10/11/15



**ANNEXURE F**

49 School Avenue

Extension 1

Chesterville

4091

29th September 2015

The Principal

KwaZulu-Natal College of Nursing

Private Bag x9089

Pietermaritzburg

3200

Dear Dr Mthembu

**RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY**

I am a Lecturer at Addington nursing campus under KwaZulu-Natal College of Nursing and presently registered as a Masters of Technology: Nursing student at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: *Violence by patients and their relatives against student nurses in public hospitals in Kwa Zulu Natal Province*. The aim of the study is to describe violence against student nurses by patients and their relatives in public hospitals in KwaZulu Natal. Data will be collected using self-administered questionnaires to student nurses in their first, second and third year of training.

I hereby request your permission to conduct the research project in the following four campuses under KwaZulu Natal College of Nursing: Greys, Ngwelezane, Port Shepstone, and Prince Mshiyeni Memorial. My research proposal has been attached for your perusal. Your permission to conduct the research project will be highly appreciated.

Yours obediently

.....

B.A. Majola (Mrs)

P.M. Orton (Dr)

MTech student

Supervisor

Contact number: 0834485854

Contact number: 031-3732 606

E-mail: [bongi.majola@kznhealth.gov.za](mailto:bongi.majola@kznhealth.gov.za)

E-mail: [penny@dut.ac.za](mailto:penny@dut.ac.za)

ANNEXURE G



**health**

Department:  
Health

PROVINCE OF KWAZULU-NATAL

Physical Address: 211 Pietermaritzburg Street, Pietermaritzburg 3200  
Postal Address: Private Bag X 9089 Pietermaritzburg 3200  
Tel: 033 264 7800 Fax: 033 394 7238 Email: sindizama.mthembu@kznhealth.gov.za  
www.kznhealth.gov.za

**DIRECTORATE:**

KwaZulu-Natal College of Nursing

Reference: Dr. S.Z. Mthembu  
Date: 05 November 2015

Principal Investigator: Mrs. Majola B.A.  
Student No: 21449549  
Durban University of Technology

RE: Permission to conduct research at the KZN College of Nursing.

TITLE: Violence against student nurses by patients and their relatives in public hospitals in KwaZulu-Natal

Dear Mrs. Majola


I have the pleasure in informing you that permission has been granted to you as per the above request by the Principal of the KZN College of Nursing.

Data Collection site(s): Prince Mshiyeni Memorial      Port Shepstone  
Ngwelezana      Greys

Please note the following:

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation of approval from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. Permission is therefore granted for you to conduct this research at the above identified campuses.
5. The KwaZulu-Natal College and its NEI's will not be providing you with any resources for this research.
6. You will be expected to provide feedback on your findings to the Principal of the KwaZulu-Natal College of Nursing.

Thank You

  
Dr. S.Z. Mthembu  
Principal: KZN College of Nursing

Fighting Disease, Fighting Poverty, Giving Hope

**ANNEXURE H**

49 School Avenue

Extension 1

Chesterville

4091

15<sup>th</sup> June 2015

**REQUEST FOR THE TOOL TO MEASURE**

Dear Ms Hewett

I am a master's student in Durban University of Technology in South Africa and conducting a study. My topic is "Violence against student nurses by patients and their relatives in public hospitals in Kwa Zulu Natal". I would like to use the tool that you have used on Workplace Violence against student nurses and nurses.

Kindly furnish me with all the relevant information in this regard. I will appreciate your assistance and will be glad to communicate with you the progress and the results of the study.

Regards

Bongi Majola

Mobile no: +27 834485854

Work telephone no: +27 31 3272075

Home telephone no: +27 31 2641064

ANNEXURE I

**Majola Bongi**

---

**From:** Deirdre Hewett <Deirdre.Hewett@westerncape.gov.za>  
**Sent:** 02 February 2015 03:07 PM  
**To:** Majola Bongi  
**Subject:** RE: ANNEXURE A

Dear Majola

You are welcome to utilize the tool I used, provided you also acknowledge the sources from which I drew ideas.

Best wishes for your studies.

Kind regards

Deirdre Hewett

---

**From:** Majola Bongi [<mailto:Bongi.Majola@kznhealth.gov.za>]  
**Sent:** Monday, February 02, 2015 2:29 PM  
**To:** Deirdre Hewett  
**Subject:** ANNEXURE A

Dear Deirdre

Kindly receive my request to use your tool for research.

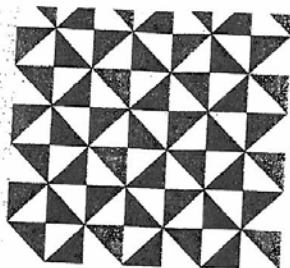
Regards

Bongi

"All views or opinions expressed in this electronic message and its attachments are the view of the sender and do not necessarily reflect the views and opinions of the Western Cape Government (the WCG). No employee of the WCG is entitled to conclude a binding contract on behalf of the WCG unless he/she is an accounting officer of the WCG, or his or her authorised representative. The information contained in this message and its attachments may be confidential or privileged and is for the use of the named recipient only, except where the sender specifically states otherwise. If you are not the intended recipient you may not copy or deliver this message to anyone."

ANNEXURE J-FULL APPROVAL FROM IREC (ETHICS COMMITTEE)

ANNEXURE J



Institutional Research Ethics Committee  
Faculty of Health Sciences  
Room MS 49, Mansfield School Site  
Gate 8, Ritson Campus  
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2900

Fax: 031 373 2407

Email: lavishad@dut.ac.za

[http://www.dut.ac.za/research/institutional\\_research\\_ethics](http://www.dut.ac.za/research/institutional_research_ethics)

[www.dut.ac.za](http://www.dut.ac.za)

26 November 2015

IREC Reference Number: **REC 106/15**

Mrs B A Majola  
49 School Avenue  
Extension 1  
Chesterville  
4091

Dear Mrs Majola

**Violence against student nurses by patients and their relatives in public hospitals in KwaZulu-Natal**

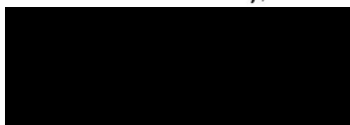
The Institutional Research Ethics Committee acknowledges receipt of your notification regarding the piloting of your data collection tool.

Kindly ensure that participants used for the pilot study are not part of the main study.

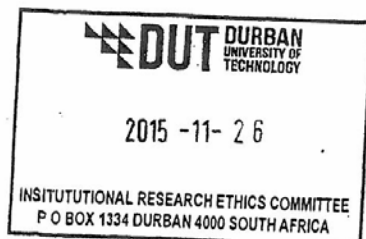
In addition, the IREC acknowledges receipt of your gatekeeper permission letters.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Yours Sincerely,



Professor J K Adam  
Chairperson: IREC



## ANNEXURE K-REQUEST AT CAMPUS 1

ANNEXURE K

49 School Avenue

Extension 1

Chesterville

4091

29<sup>th</sup> September 2015

The Principal

Greys

Private Bag x9001

Pietermaritzburg 3200

Dear Ms Hlongwa

### **RE- REQUEST FOR PERMISSION TO CONDUCT A STUDY**

I am a lecturer at Addington nursing campus under KwaZulu- Natal College of Nursing and presently registered for a Master of Technology: Nursing at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: *Violence against student nurses by patients and their relatives in public hospitals in KwaZulu-Natal*. The aim of the study is to describe violence against student nurses by patients and their relatives in public hospitals in KwaZulu Natal. Data collection will include self-administered questionnaire given to student nurses in their first, second and third year of training in the R425 (SANC) programme.

I hereby request your permission to conduct this research project in Greys Campus. My research proposal has been attached for your perusal. Your support and permission to conduct the research project will be highly appreciated.

Yours obediently

.....  
B.A. Majola (Mrs)

MTech student

Contact number: 0834485854

E-mail: [bongim393@gmail.com](mailto:bongim393@gmail.com)

.....  
P.M. Orton (Dr)

Supervisor

Contact number: 031-3732606

E-mail: [penny@dut.ac.za](mailto:penny@dut.ac.za)

ANNEXURE L



**health**

Department:  
Health  
PROVINCE OF KWAZULU-NATAL

**DIRECTORATE:**

Postal Address: Private Bag X 9001, Pietermaritzburg, 3200  
Physical Address: 201 Toonbush Road, Northern Park, Pietermaritzburg, 3200  
Tel: 033 897 3500 Fax: 033 897 3500 Email: esimen.hlongwa@kznhealth.gov.za  
www.kznhealth.gov.za

Kwazulu Natal College of  
Nursing:  
Grey's Campus

8<sup>th</sup> December 2015

Mrs. B.A. Majola

Dear Mrs. Majola


**Re: Request for permission to conduct study at Grey's Campus**

Permission is granted for you to conduct research at this Campus.

Kindly liaise with Mrs. M.S. Subhan- H.O.D. Community Nursing Science at Grey's Campus to make the necessary arrangements for you to conduct research at this Campus.

You are wished all the best with your studies.

Yours Faithfully

  
E.N. Hlongwa (Miss)  
Campus Principal

## ANNEXURE M-REQUEST AT CAMPUS 2

ANNEXURE M

49 School Avenue

Extension 1

Chesterville

4091

29<sup>th</sup> September 2015

The Principal

Ngwelezane

Private Bag x20021

Empangeni 3800

Dear Dr Matsane

### **RE- REQUEST FOR PERMISSION TO CONDUCT A STUDY**

I am a lecturer at Addington nursing campus under KwaZulu- Natal College of Nursing and presently registered for a Master of Technology: Nursing at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: *Violence against student nurses by patients and their relatives in public hospitals in KwaZulu-Natal*. The aim of the study is to describe violence against student nurses by patients and their relatives in public hospitals in KwaZulu Natal. Data collection will include self-administered questionnaire given to student nurses in their first, second and third year of training in the R425 (SANC) programme.

I hereby request your permission to conduct this research project in Ngwelezana Campus. My research proposal has been attached for your perusal. Your support and permission to conduct the research project will be highly appreciated.

Yours obediently

.....  
B.A. Majola (Mrs)

MTech student

Contact number: 0834485854

E-mail: [bongim393@gmail.com](mailto:bongim393@gmail.com)

.....  
P.M. Orton (Dr)

Supervisor

Contact number: 031-3732606

E-mail: [penny@dut.ac.za](mailto:penny@dut.ac.za)



## ANNEXURE N-REQUEST AT CAMPUS 3

ANNEXURE N

49 School Avenue

Extension 1

Chesterville

4091

29<sup>th</sup> September 2015

The Principal

Port Shepstone

Private Bag x719

Port Shepstone 4240

Dear Mr Gwala

### **RE- REQUEST FOR PERMISSION TO CONDUCT A STUDY**

I am a lecturer at Addington nursing campus under KwaZulu- Natal College of Nursing and presently registered for a Master of Technology: Nursing at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: *Violence against student nurses by patients and their relatives in public hospitals in KwaZulu-Natal*. The aim of the study is to describe violence against student nurses by patients and their relatives in public hospitals in KwaZulu Natal. Data collection will include self-administered questionnaire given to student nurses in their first, second and third year of training in the R425 (SANC) programme.

I hereby request your permission to conduct this research project in Port Shepstone Campus. My research proposal has been attached for your perusal. Your support and permission to conduct the research project will be highly appreciated.

Yours obediently

.....

.....

B.A. Majola (Mrs)

P.M. Orton (Dr)

MTech student

Supervisor

Contact number: 0834485854

Contact number: 031-3732606

E-mail: [bongim393@gmail.com](mailto:bongim393@gmail.com)

E-mail: [penny@dut.ac.za](mailto:penny@dut.ac.za)

## ANNEXURE O-PERMISSION FROM CAMPUS 3

### ANNEXURE O



**health**  
Department:  
Health  
PROVINCE OF KWAZULU-NATAL

**DIRECTORATE:**

107 Marine Drive, Shelly Beach 4265  
Private Bag X710, Port Shepstone 4240  
Tel: 039 3155322 Fax: 039 3155326 Email: nodirector@kznhealth.gov.za  
www.kznhealth.gov.za

KWAZULU NATAL COLLEGE OF NURSING  
PORT SHEPSTONE NURSING CAMPUS

Date: 17 November 2015

Attention: Mrs. B.A. Majola

49 School Avenue  
CHESTERVILLE  
4091

Dear Mrs. Majola

**RE: REQUEST FOR PERMISSION TO CONDUCT STUDY**

Your letter dated 29 September 2015 is hereby acknowledged and refers:

Permission is hereby granted for you to conduct your study at Port Shepstone Nursing Campus. Please take note of the conditions as stated by the Kwa-Zulu Natal College of Nursing. Please note that it may not be always possible to have students at your projected time due to the congested teaching timetables and other commitments.  
Please make arrangements well in advance to avoid disappointment.

Best wishes

✓  
MR N.B. GWALA  
CAMPUS PRINCIPAL  
PORT SHEPSTONE NURSING CAMPUS

## ANNEXURE P-REQUEST AT CAMPUS 4

ANNEXURE P

49 School Avenue

Extension 1

Chesterville

4091

29th September 2015

The Principal

Prince Mshiyeni Memorial

Private Bag x07

Mobeni 4060

Dear Madam/ Sir

### **RE- REQUEST FOR PERMISSION TO CONDUCT A STUDY**

I am a lecturer at Addington nursing campus under KwaZulu- Natal College of Nursing and presently registered for a Master of Technology: Nursing at the Durban University of Technology in the Department of Nursing. The proposed title of my research project is: *Violence against student nurses by patients and their relatives in public hospitals in KwaZulu-Natal*. The aim of the study is to describe violence against student nurses by patients and their relatives in public hospitals in KwaZulu Natal. Data collection will include self-administered questionnaire given to student nurses in their first, second and third year of training in the R425 (SANC) programme.

I hereby request your permission to conduct this research project in Prince Mshiyeni Memorial Campus. My research proposal has been attached for your perusal. Your support and permission to conduct the research project will be highly appreciated.

Yours obediently

.....  
B.A. Majola (Mrs)

MTech student

Contact number: 0834485854

E-mail: [bongim393@gmail.com](mailto:bongim393@gmail.com)

.....  
P.M. Orton (Dr)

Supervisor

Contact number: 031-373260

E-mail: [penny@dut.ac.za](mailto:penny@dut.ac.za)

ANNEXURE Q

For the love of Jesus Christ

---

**From:** Bridgemohan Rozana  
**Sent:** 17 November 2015 03:29 PM  
**To:** Majola Bongile  
**Subject:** RE: Permission to collect data

Good Afternoon Ms Majola

Permission is hereby granted to collect data from student nurses as requested. Please ensure that data collection does not interfere with teaching and learning activities of learners. Kindly adhere to the attached stipulations as laid down by KZN CN.

Kind Regards

Mrs Rozana Bridgemohan  
Campus Principal  
Prince Mshiyeni Memorial Campus  
Telephone : 031 9078314  
Fax : 031 9067772  
Email: [Rozana.Bridgemohan@kznhealth.gov.za](mailto:Rozana.Bridgemohan@kznhealth.gov.za)



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From: Majola Bongile

ANNEXURE R-LETTER FROM THE STATISTICIAN

**ANNEXURE:R**

**Gill Hendry** B.Sc. (Hons), M.Sc. (Wits), PhD (UKZN)

**Mathematical and Statistical Services**

Cell: 083 300 9896

email : hendryfam@telkomsa.net

31 January 2017

Re: Assistance with statistical analysis

Please be advised that I have assisted Bongsi Majola (student number 21449549), who is presently studying for an M Tech Nursing with the statistical analysis for her study.

Yours sincerely

Gill Hendry (Dr)

**ANNEXURE S**



7 Woodlands Rd  
GLENWOOD  
DURBAN  
4001  
083 415 2531

Reg. No. 2006/156780/23

25 January 2017

Bongi Majola


**EDITING OF RESEARCH DISSERTATION OF BONGI MAJOLA**

I have an MA in English from University of Natal (now UKZN) and have been performing editing services through my company for eleven years. My company regularly edits the research dissertations, articles and theses of the School of Nursing, Environmental Studies and various other schools and disciplines at the University of KwaZulu-Natal and other institutions, as well as editing for publishing firms and private individuals on contract.

I hereby confirm that Barbara Dupont edited the thesis of **Bongi Majola** titled "VIOLENCE AGAINST STUDENT NURSES BY PATIENTS AND THEIR RELATIVES IN PUBLIC HOSPITALS IN KWAZULU-NATAL" on behalf of WordWeavers cc and commented on the anomalies she was unable to rectify in the MS Word Track Changes and review mode by insertion of comment balloons prior to returning the document to the author. Corrections were made in respect of grammar, punctuation, spelling, syntax, tense and language usage as well as to sense and flow. Reference guidelines and additional comments were provided to assist with corrections.

I trust that the document will prove acceptable in terms of editing criteria.

Yours faithfully

  
**Catherine P. Eberle (MA: University of Natal)**