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Research paper

Support mechanisms that enable emergency nurses to cope with aggression and violence: Perspectives from New Zealand nurses

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A B S T R A C T

Background: Although efforts to reduce aggression and violence in emergency departments are important, it is also critical to minimise harm and support staff where this occurs. This research describes support mechanisms emergency nurses value when they experience occupational aggression and violence.
Methods: A mixed-methods design including thematic analysis of six interviews and descriptive analysis of fifty-one surveys, with experienced emergency nurse participants and respondents from a single large urban emergency department.
Results: Four key themes summarised coping with aggression and violence: Minimising exacerbating factors (mental health, lack of understanding of zero tolerance in practice, and wait times); Support before violence (use of huddles and having experienced nurses on each shift); Support during violence (education including restraint, self-defence, de-escalation and legalities); and Support after violence (debriefing, incident reporting and a sense of 'toughness')
Conclusion: Emergency nurses need preparation and support to competently manage complex mental health presentations, understand legal rights, communicate effectively with patients, families and colleagues and access event debriefing. Security staff are valued team members but also need adequate resourcing and preparation.
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1. Introduction

Nurses who work in Emergency Departments (EDs) are frequently exposed to aggression and violence [1–3]. Acts of violence in the ED are associated with long waiting times, dissatisfaction with service, a lack of understanding of the triage system, understaffing and overcrowding [4,5]. Emergency nurses can experience post-traumatic stress symptoms, including shame, guilt, anxiety and self-blame after these events [6]. Occupational aggression and violence are also associated with burnout, reduced work productivity, diminished quality of care, and increased costs to healthcare providers [2,7]. Research shows that aggression and violence in ED are often underreported [8], resulting in a lack of organisational recognition and failure to provide appropriate protection policies [9]. Despite low rates of reporting, the health sector has the highest rate of workplace violence in Aotearoa, New Zealand (NZ) [10]. There is a shortage of research into emergency nurses' coping before, during and after exposure to acts of aggression and violence [11]. This research aims to provide evidence to support nurses affected by workplace aggression and violence.

2. Methods

2.1. Mixed methods research design

A mixed-methods exploratory sequential design was used, with findings from an initial interview phase informing the design of a subsequent survey. Findings from both phases were triangulated and reported descriptively.

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Table 1
Semi-structured interview prompts.

Have you experienced aggression and or violence while working in ED? – describe situation(s) that come to mind.
What has worked well for you in terms of the support from colleagues and your organisation that you have received after experiencing aggression or violence?
If the support offered to you and your colleagues was perfect, what would it look like?
What is the first thing you would like to see improved?
What behaviour is acceptable from patients and family members?
What behaviour is not acceptable?

2.2. Semi-structured interviews

The Appreciative Inquiry approach [12] informed the collection of interview data that provided context, identified what is currently facilitating emergency nurses' coping with aggression and violence in the workplace, and identified areas to strengthen. A face-to-face semi-structured interview format was used, with key prompts outlined in Table 1.

2.2.1. Interview participant recruitment

Participants were recruited from a single urban emergency department – one of the busiest in NZ - and had to have at least 12 months of emergency nursing experience [13]. Purposive sampling was utilised as it enabled the researcher to recruit participants with a range of ED experience, thereby gaining perspectives from early-career through to highly-experienced nurses. Eligible participants (N = 315) received an email from a third-party Clinical Nurse Educator. Interested participants contacted the researcher directly to organise a suitable face-to-face interview time and place.

2.2.2. Interview data analysis

Interview audio recordings were transcribed verbatim, and NVivo Pro 12 [14] was utilised to facilitate analysis, data coding and thematic development using a general inductive thematic analysis approach. The first author led the analysis and met regularly with NA and SJ to discuss the analysis and encourage a reflexive approach that generated meaningful representations of the data.

2.3. The descriptive survey

Data from the interviews informed the development of a self-reported 30-item descriptive survey [Supplemental file: Survey questions]. Likert-type scale questions were formulated from themes identified in the interview data analysis, with open-ended questions to identify any important additional themes.

2.3.1. Survey respondent recruitment

A non-probability, volunteer sampling method was used to recruit nurses who had worked for at least one year at a single NZ level four ED. Eligible respondents (N = 315) received an email from a third party (not involved with this research project) with a link to the online survey in Qualtrics [15]. The survey was open from February to April 2020, with a reminder email sent two weeks after the first release date.

2.3.2. Survey data analysis

Survey data were exported from Qualtrics to Microsoft Excel, which was utilised to calculate descriptive statistics. Respondent open responses within the comment-box sections were analysed through categorisation and frequency (quantitative content) analysis and did not reveal new major themes.

2.3.3. Integration of findings

As depicted in Fig. 1, findings from both phases of this study were thematically synthesised and are reported under four over-arching themes:

i) Factors exacerbating aggression or violence
ii) Support before aggression and violence
iii) Support during aggression and violence
iv) Support after aggression and violence

2.4. Ethical approval

Ethical approval was obtained by Auckland Health Research Ethics Committee (Ref: #AH1019) and locality approval was granted by the recruitment site (Ref: #1090).

3. Results

3.1. Interview participant and survey respondent demographics

Six nurses participated in the initial interview phase, and 51 nurses completed all items in the online survey. To protect the anonymity of participants and respondents, very few demographic details are reported. Grouped interview participant and survey respondent data are presented in Table 2.

3.2. Factors exacerbating aggression or violence

Key factors exacerbating aggression or violence identified by interview participants included issues with resourcing, including insufficient staffing, long patient wait times and environmental limitations. Many survey respondents (78%, n = 40) agreed (Somewhat Agree, Agree or Strongly Agree) that a lack of patient understanding of the emergency system and poor communication were major exacerbators of violence and aggression. As noted by one interview participant, these issues felt beyond the control of clinical staff:

> *"With the massive numbers of patients we have through those doors, the waiting times have increased, [and] we don't have a way of communicating that with patients. Patients and family get really angry at us about that. It is a political issue, and we have not been given the money to be able to appropriately staff the department to ensure patients receive timely access to healthcare." (Interview participant, Senior Nurse)*

Almost all survey respondents (96%, n = 49) agreed that aggression and violence took up a lot of their time, and all respondents agreed this adversely impacted the quality of care offered to other patients. Most (85%, n = 43) survey respondents agreed that involving students with aggressive or violent patients was unsafe.

3.3. Support before aggression or violence

Key supports before aggression or violence included formal education and mentoring around violence and aggression including de-escalation, restraint, duty of care and compulsory treatment orders. Interview participants identified education as the most important preparation for violence or aggression. Some suggested that education on restraint and de-escalation could be of benefit; others felt it was something that could only be gained through experience and observation of senior colleagues. The legalities surrounding aggression were highlighted as an area requiring education, particularly to establish a clearer understanding of duty of care and compulsory assessment and treatment orders.

> *"We need to know our legal responsibilities to have more powers*

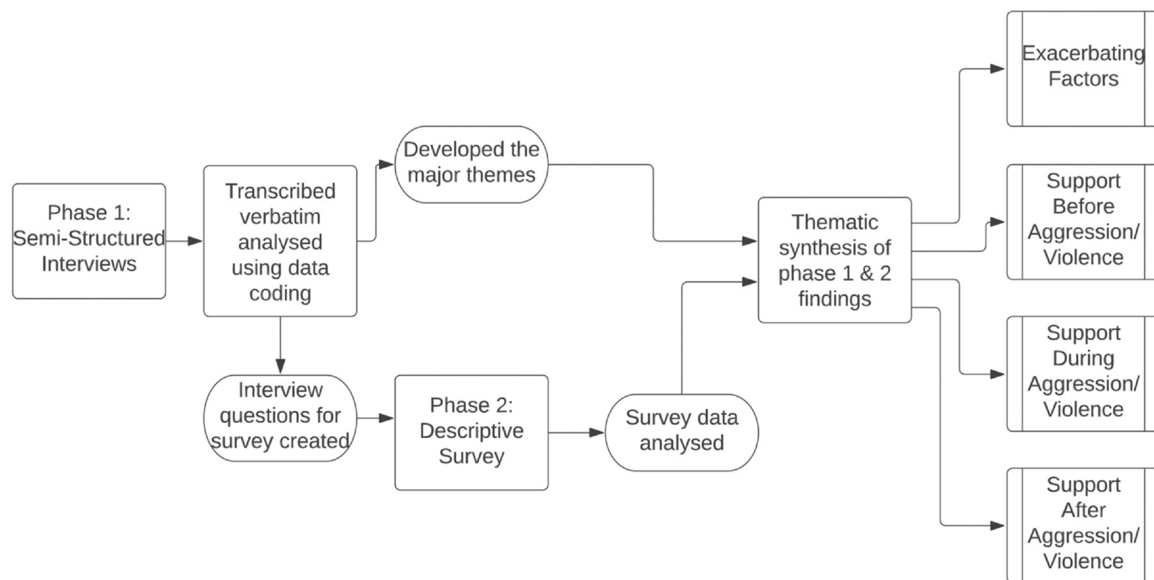

Fig. 1. Flow diagram of the integration of Phase 1 and 2.

with regards to them." (Interview participant, Staff Nurse 10 + years' experience)

Team communication and support was also important, with survey respondents and interview participants identifying the importance of regular huddles (ad-hoc team discussions) to identify potentially violent situations early and get the support before things escalate. Many survey participants (72%, n = 37) agreed that there needed to be more education about managing an aggressive or violent individual. Areas identified as needing more support from the survey results included de-escalation (84%, n = 43), courses in self-defence/restraint (96%, n = 49), security presence before a situation escalates (98%, n = 50) and huddles (88%, n = 45).

3.4. Support during aggression or violence

Support during aggression and violence was often limited, and there was an expectation that staff would brush off the event and continue with their work. Hospital security staff and police were identified as key supports during incidents of aggression or violence. Security presence was mostly identified as being protective during aggressive episode, but effectiveness was dependent on security staff experience, confidence and availability. Emergency bells were problematic at escalating situations due to the additional stress the loud noise resulted in, and participants discussed the need for silent alarms. Calling a 'code' (internal prompting of an urgent security response) was considered an effective way of getting help when needed (98%, n = 50). The majority of the survey respondents (88%, n = 45) indicated that security staff are helpful during a situation involving aggression and violence. There was no consensus on the effectiveness of a 24-hour police presence in ED. Some survey respondents thought that police presence would improve patient behaviour, however there was doubt that a constant police presence in an ED is realistic. Other interview participants raised concerns that police presence may cause ED presentation hesitance, particularly if the presentation was related to illegal activities.

All survey respondents agreed it was common to feel shaken after exposure to aggression or violence and this made it hard to get straight back to work. Interview participants described feelings of self-blame and needing to be 'tough' and continue with work, even when events took an emotional toll:

> *"The one that affected me most… I actually just got into my car and just burst into tears, and I don't do that, I don't cry because most things just go over my head." (Interview participant, Staff Nurse 10 + years' experience)*

3.5. Support after aggression or violence

Most interview participants expressed a desire for routine debriefing after incidents of violence and aggression, to create an environment for reflection and change. However, the busy environment of ED was identified as a barrier to debriefing and nurses feared seeming 'incapable' at their job by seeking one. One interview participant had reservations about debriefing, feeling it was sometimes better to just move on from the traumatic situation. This reflected a sense of toughness expressed by interviewed nurses. Some described aggression as part of the job. It was important to keep going and avoid appear weak by concealing emotions, after a situation involving aggression or violence. The majority of survey respondents (98%, n = 50) indicated debriefing was or would be helpful after aggression and violence. A number of survey respondents (75%, n = 38) felt comfortable asking for a debrief, however the same proportion conceded that the tough and busy ED culture often prevents debriefs.

Table 2
Interview participant and survey respondent roles and years of emergency nursing experience.

	Phase 1 interview participants n (%)	Phase 2 survey respondents n (%)
Staff Nurse 10 + years' experience	2 (33%)	7 (14%)
Staff Nurse 6–10 years' experience	0 (0%)	9 (18%)
Staff Nurse 1–6 years' experience	3 (50%)	31 (61%)
Senior Nurse[a]	1 (17%)	4 (8%)
Total samples	**6 (100%)**	**51 (100%)**

[a] Nurses in leadership or educator roles

Interview participants felt formal incident reporting was time-consuming and complex, usually without apparent benefit. This was also reflected in the survey findings, with 67% of respondents (n = 64) agreeing they did not have enough time on a shift to complete an incident form.

> *"I think that there is this attitude in ED, that because we get exposed to a lot of verbal abuse, we just put our shoulders back and take it and put up with it" (Interview participant, Staff Nurse 10 + years' experience)*

4. Discussion & recommendations for practice

The emergency nurse participants and respondents in this research have identified what can be done to reduce the impact of violence and aggression in the ED setting. Key findings were organised under themes of exacerbating factors and supports before, during and after events. Significant research has described the problem of violence and aggression in emergency departments [3,16] and interventions to prevent or reduce these incidents [17]. Using an Appreciative Inquiry approach [12], this study has elicited support mechanisms emergency nurses value when they experience occupational aggression and violence. In keeping with this approach, this discussion is focused on implications for improving support and minimising harm.

4.1. Minimising harm associated with violence

Frustrations arise from a lack of understanding of how ED works, and the long wait times highlight the need for more staff and better communication with patients and their families. Other researchers have reported that EDs tend to have the highest rates of aggression and violence due to long waiting times, dissatisfaction with the service and a lack of understanding of the triage system [2,4,5]. When ED systems are not well understood by consumers, they are more likely to become violent [4]. Aggressive and agitated mental health presentations were identified as being the most arduous for emergency nurses, made worse by nurses' lack of knowledge and confidence with legislation in place to keep these clients safe. This lack of confidence among emergency nurses in managing mental health emergencies, exacerbated by limited mental health knowledge and time constraints, is a common theme in the literature [18,19]. There is evidence that increased education tailored to emergency nurses effectively increases confidence caring for mental health presentations [19]. Room and department layout were identified as inadequate for nurse and patient safety, particularly for mental health presentations. Re-evaluation of where acute mental health presentations (without any medical concerns requiring medical clearance) has been identified as a priority for improving mental health care in EDs. International studies recommend specialised emergency centres for acute and crisis mental health assessment and care [20]. Although preventing escalation to violence wherever possible is an important goal, a 'zero tolerance' aim to eradicate violence was seen as unrealistic in the ED context, as other researchers have also noted [4,5,21]. Providing good training and support systems to minimise harm to staff, patients, and families is likely more feasible.

4.2. Support before aggression or violence has occurred

Although de-escalation was identified as an effective way of reducing aggression and violence in this study, this was considered best learnt through social modelling and clinical experience. Research supports this, with classroom teaching about how to de-escalate less effective than observing how a senior nurse manages it in practice, undertaking simulation and/or partaking in debriefing sessions [22,23]. Simulation-enhanced interprofessional intervention in conjunction with a short teaching session around de-escalation is much more effective at improving staff attitudes towards aggression and violence in emergency care than teaching alone [24].

Nurses need to have some education in restraint and self-defence, not only in terms of correct practice but also to enable compliance with the patients' rights, ethical responsibilities and surrounding legal obligations [25,26]. Legal issues associated with patients under compulsory treatment orders were highlighted as areas of uncertainty, and this is important and location-specific knowledge that may be new to internationally qualified nurses.

Informal staff huddles were described as a way of keeping patients and staff safe and enabling increased team support. Regular huddles have been shown to reduce the severity and number of violent incidents when conducted before aggression has occurred [25,26]. Senior nurses are assets in teaching and role-modelling the best ways to intervene in an acute episode of aggression [6]. A supportive social network and support from senior nurses have also been found to increase cognitive resilience, reduce post-traumatic stress symptoms and support a faster return to full work productivity [22,27]. Safety concerns of student nurse involvement with situations involving aggression were highlighted and frustrations were also expressed suggesting there is a need for preparation and guidelines to support students who experience aggression or violence [28].

4.3. Recommendations for nurses during times involving aggression or violence

Security presence is widely considered effective in reducing violent episodes in ED. A multidisciplinary de-escalation team involving security has been previously identified as effective in minimising harm from violent behaviour [29,30]. Little is known about optimising security staff numbers, deployment and training, but this is likely to benefit from further research and tailoring to each ED setting.

The support and care colleagues and senior nurses have for each other needs to be fostered as a priority, and measures should be taken to improve staff retention and create EDs with a strong senior nurse support team. Peer support and resilience contribute to one's ability to cope with aggression and violence [31]. A sense of collegial support among nurses in high-stress environments has been shown to reduce the severity of the impact of violent incidents [25,26].

4.4. Recommendations for support after violence

Threatening and aggressive behaviour is frequently encountered in emergency departments, but incident reporting systems are considered complex, onerous and pointless. Emergency departments should develop user-friendly reporting tools and transparent incident follow-up processes to ensure reported events reflect experienced rates of violence and aggression [7,32].

Informal debriefing has been shown to improve cognitive resilience and the ability to cope with the emotional consequences of violence [6,22]. A lack of skilled facilitators is one of the biggest barriers to regular debriefing occurring after a significant clinical event [33]. Introducing a clinical debriefing intervention tool may result in more regular debriefs and improved team management of unexpected clinical events. Further to this, trained nurse leaders may be best to conduct clinical debriefs because they have an understanding of team roles and expertise within the department, tend to oversee clinical events requiring debriefs, and do not have specific patient assignments themselves, allowing prioritisation of the clinical debrief [33].

4.5. Strengths & limitations

This is the first study to use a mixed methods design to explore emergency nurses' coping with violence and aggression, and identify useful support mechanisms. Findings are derived from self-reported data provided by volunteer participants and respondents, and are therefore inherently subjective and susceptible to response and sampling biases. Analysis was undertaken by a team of researchers with existing and varying knowledge and experience of workplace aggression and emergency department settings. Voluntary convenience sampling from a single site may limit the transferability of findings to other contexts.

Data collection for this study coincided with the implementation of New Zealand's strict lockdowns to eliminate COVID-19 [34], which made recruitment challenging and may have contributed to the low response rate. Research also suggests that the pandemic may have further exacerbated workplace violence in EDs [35].

5. Conclusion

This mixed methods study describes some key support mechanisms identified by emergency nurse participants and respondents. Security staff should be adequately trained and available to support clinical staff. Nurses should receive education on peer debriefing strategies and the introduction of a more user-friendly reporting tool may help to increase incidence reporting of aggression and violence and improve organisational recognition. Debriefing and other offers of formal support should be accessible, and normalised whenever staff experience violence and aggression. Implementation and evaluation of educational interventions to improve emergency nurse confidence and competence in legal issues, including restraint and mental health emergencies is recommended, as well as the consideration of alternative suitable environments for the acute assessment of mental health emergencies.

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Declaration of Competing Interest

All authors were involved in the design, conduct, drafting, editing and checking of final manuscript. We have no conflicts of interest to declare.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.auec.2023.09.003.

References

[1] Partridge B, Affleck J. Verbal abuse and physical assault in the emergency department: rates of violence, perceptions of safety, and attitudes towards security. Austral Emerg Nurs J 2017;20(3):139–45.
[2] Ashton RA, Morris L, Smith I. A qualitative meta-synthesis of emergency department staff experiences of violence and aggression. Int Emerg Nurs 2018;39:13–9.
[3] Nikathil S, Olaussen A, Gocentas RA, Symons E, Mitra B. Workplace violence in the emergency department: a systematic review and meta analysis. Emerg Med Austral 2017;29(3):265–75.
[4] Morphet J, Griffiths D, Plummer V, Innes K, Fairhall R, Beattie J. At the crossroads of violence and aggression in the emergency department: perspectives of Australian emergency nurses. Aust Health Rev 2014;38(2):194–201.
[5] Zampieron A, Galeazzo M, Turra S, Buja A. Perceived aggression towards nurses: study in two Italian health institutions. J Clin Nurs 2010;19(15–16):2329–41.
[6] Tan MF, Lopez V, Cleary M. Nursing management of aggression in a S ingapore emergency department: a qualitative study. Nurs Health Sci 2015;17(3):307–12.
[7] Anderson N, Pio F, Jones P, Selak V, Tan E, Beck S, et al. Facilitators, barriers and opportunities in workplace wellbeing: a national survey of emergency department staff. Int Emerg Nurs 2021;57.
[8] Tyler V, Aggar C, Grace S, Doran F. Nurses and midwives reporting of workplace violence and aggression: an integrative review. Contemp Nurse 2022;58(2–3):113–24.
[9] Richardson SK, Grainger PC, Ardagh MW, Morrison R. Violence and aggression in the emergency department is under-reported and under-appreciated. NZ Med J 2018;131(1476):50–8.
[10] Bentley TA, Catley BE, Forsyth D, Tappin DC. Understanding workplace violence and its prevention in New Zealand: the 2011 New Zealand workplace violence survey. J Manag Organ 2013;19(3):352–64.
[11] Elder EG, Johnston A, Wallis M, Crilly J. Work-based strategies/interventions to ameliorate stressors and foster coping for clinical staff working in emergency departments: a scoping review of the literature. Austral Emerg Care 2020;23(3):181–92.
[12] Cooperrider D, Whitney D, Stavros J. The Appreciative Inquiry Handbook: For Leaders of Change. Oakland: Berrett-Koehler Publishers; 2008.
[13] Australasian College for Emergency Medicine (ACEM). Statement on the delineation of emergency departments [Internet]. 2012. Available from: www.acem.org.au.
[14]. QSR International Pty Ltd. NVivo Qualitative Data Analysis Software 12 ed.
[15] Qualtrics. August 2021 ed. Utah, USA: Qualtrics.
[16] Aljohani B, Burkholder J, Tran QK, Chen C, Beisenova K, Pourmand A. Workplace violence in the emergency department: a systematic review and meta-analysis. Public Health 2021;196:186–97.
[17] Anderson L, FitzGerald M, Luck L. An integrative literature review of interventions to reduce violence against emergency department nurses. J Clin Nurs 2010;19(17–18):2520–30.
[18] Marynowski-Traczyk D, Broadbent M. What are the experiences of emergency department nurses in caring for clients with a mental illness in the emergency department? Austral Emerg Nurs J 2011;14(3):172–9.
[19] Stuhlmiller CM, Tolchard B, Thomas LJ, de Crespigny CF, King D. Increasing confidence of emergency department staff in responding to mental health issues: an educational initiative. Aust Emerg Nurs J 2004;7(1):9–17.
[20] Weiland TJ, Mackinlay C, Hill N, Gerdtz MF, Jelinek GA. Optimal management of mental health patients in Australian emergency departments: barriers and solutions. Emerg Med Austral 2011;23(6):677–88.
[21] Hogarth KM, Beattie J, Morphet J. Nurses' attitudes towards the reporting of violence in the emergency department. Austral Emerg Nurs J 2016;19(2):75–81.
[22] Gates DM, Gillespie GL, Succop P. Violence against nurses and its impact on stress and productivity. Nurs Econ 2011;29(2):59–66.
[23] Gerdtz MF, Daniel C, Dearie V, Prematunga R, Bamert M, Duxbury J. The outcome of a rapid training program on nurses' attitudes regarding the prevention of aggression in emergency departments: A multi-site evaluation. Int J Nurs Stud 2013;50(11):1434–45.
[24] Wong AH, Wing L, Weiss B, Gang M. Coordinating a team response to behavioral emergencies in the emergency department: a simulation-enhanced interprofessional curriculum. West J Emerg Med 2015;16(6):859.
[25] Buterakos R, Keiser MM, Littler S, Turkelson C. Report and prevent: a quality improvement project to protect nurses from violence in the emergency department. J Emerg Nurs 2020;46(3). 338-44. e7.
[26] Martin HA, Ciurzynski SM. Situation, background, assessment, and recommendation–Guided huddles improve communication and teamwork in the emergency department. J Emerg Nurs 2015;41(6):484–8.
[27] Lavoie S, Talbot LR, Mathieu L. Post-traumatic stress disorder symptoms among emergency nurses: their perspective and a 'tailor-made' solution. J Adv Nurs 2010;67(7):1514–22.
[28] Heckemann B, Zeller A, Hahn S, Dassen T, Schols J, Halfens R. The effect of aggression management training programmes for nursing staff and students working in an acute hospital setting. A narrative review of current literature. Nurse Educ Today 2015;35(1):212–9.
[29] Daniel C, Gerdtz M, Elsom S, Knott J, Prematunga R, Virtue E. Feasibility and need for violence risk screening at triage: an exploration of clinical processes and public perceptions in one Australian emergency department. Emerg Med J 2014;32(6):457–62.
[30] Ramacciati N, Ceccagnoli A, Addey B, Lumini E, Rasero L. Interventions to reduce the risk of violence toward emergency department staff: current approaches. Open Access Emerg Med 2016;8:17.
[31] Hsieh HF, Hung YT, Wang HH, Ma SC, Chang SC. Factors of resilience in emergency department nurses who have experienced workplace violence in Taiwan. J Nurs Sch 2016;48(1):23–30.
[32] Ashton RA, Morris L, Smith I. A qualitative meta-synthesis of emergency department staff experiences of violence and aggression. Int Emerg Nurs 2018;39:13–9.
[33] Rose S, Cheng A. Charge nurse facilitated clinical debriefing in the emergency department. CJEM 2018;20(5):781–5.
[34] Baker MG, Wilson N, Anglemyer A. Successful elimination of Covid-19 transmission in New Zealand. N Engl J Med 2020;383(8):e56.
[35] Byon HD, Sagherian K, Kim Y, Lipscomb J, Crandall M, Steege L. Nurses' experience with type II workplace violence and underreporting during the COVID-19 pandemic. Workplace Health Saf 2022;70(9):412–20.