How New Graduate Nurses Address Sexual Harassment from Patients in the Workplace: An Interpretive-Descriptive Study

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Abstract

International studies show that sexual harassment of nurses is a major concern and is more likely to occur with younger nurses. The first two years of nursing practice are a crucial phase for new graduate nurses to build confidence. They can experience transition shock as they move from the student nurse role to registered nursing responsibilities. This transition shock is unavoidable, but its effects can be mitigated in a supportive environment. A new graduate nurse faced with sexual harassment can experience psychological and physical effects. Therefore, the support they receive can be crucial in their decision to leave the profession or remain in nursing. Due to the worldwide nursing and staffing retention issues, appropriate support is vital to retain new graduate nurses if they experience any stressors, such as sexual harassment.

This qualitative study aimed to investigate how new graduate nurses addressed sexual harassment from patients during the first two years of their post-graduation practice. Another aim was to identify the types of sexual harassment new graduate nurses experienced, including whether they reported this harassment, if this sexual harassment affected their practice and whether this sexual harassment affected their decision to remain in nursing as a career. It also aimed to determine what education and support they have received or need after experiencing sexual harassment. This study focused only on the new graduate nurses' experience of sexual harassment by patients, and this specific focus allowed for coherent data analysis.

This study employed an interpretive-descriptive approach, underpinned by naturalistic inquiry, to explore how new graduate nurses in their first two years of practice addressed sexual harassment from patients. Five participants were recruited through extensive advertising. Questions were carefully scaffolded, encouraging respondents to share their experiences of sexual harassment from patients in their workplace. Using thematic analysis, five themes were identified. 1) “Did that just happen? It was a shock;” 2) “It’s taboo, not spoken about;” 3) “It changed my practice;” 4) Expecting respect but making allowances; 5) A culture of “silence” – the need for organisational change.

This study addressed a gap in the literature, as no prior studies had examined how new graduate nurses address sexual harassment from patients during their first two years of practice. This research identified a need for education on the definitions of sexual harassment and strategies for addressing this issue, both during nursing training and for all practising nurses. When these new graduate nurses experienced sexual harassment from patients, there was a demonstrated lack of intervention and support from colleagues and leadership. This study has shown that there needs to be changes in the organisational culture both within nursing education and workplaces. This will ensure any form of sexual harassment is recognised and seen as unacceptable. Incident reporting needs to be encouraged to decrease the organisational silence regarding sexual harassment, and follow-up support for those who experience sexual harassment must be mandatory. This research builds a platform for further research regarding sexual harassment in health organisations to help support the nursing workforce in Aotearoa New Zealand.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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Signature Date: 4/12/2025

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Ethics Approval

This study was approved by the Auckland University of Technology Ethics Committee on 02/02/2024 (ref no: **23/352**).

Chapter 1 Introduction

Overview

The purpose of this study is to examine how new graduate nurses (NGNs) address sexual harassment (SH) from patients during their first two years of nursing practice, to address gaps in the existing research. Sexual harassment is defined by the Human Rights Act 1993 s 62 as "any unwelcome or offensive sexual behaviour that is repeated or is serious enough to have a harmful effect". Sexual harassment occurs across a continuum from sexual remarks and fleeting touch to overt sexual approaches. Sexual harassment towards nurses is an important issue that has gained increasing attention alongside the broader international recognition of workplace sexual harassment. Sexual harassment has been identified throughout many industries and occupations, thus being endemic in wider society (Phillips et al., 2019; Ross et al., 2019; Scholcoff et al., 2020). Sexual harassment may have been normalised in the past; however, with the "Me Too" movement, which originated in the U.S.A. in 2006, publicity has shed light on the unacceptability of this behaviour (Ross et al., 2019). While there is generally a dearth of literature on SH in nursing, international studies indicate that SH among nurses is a significant problem worldwide. Sexual harassment can result in nurses experiencing increased stress, reduced job satisfaction, and detrimental effects on their physical and psychological health (Lu et al., 2020; Ross et al., 2019; World Health Organization [WHO], 2023). Nurses have been identified as being vulnerable to SH in many countries. This chapter provides the introduction and background to this study, including the aims and the key concepts.

Sexual harassment has been identified internationally as a problem in nursing for decades. Grieco (1987), as cited by Cogin and Fish (2009), noted that, as far back as the 1980s, SH in the health field was more prevalent than in other employment settings, but little data was available at the time. Earlier literature focused on bullying and harassment of nurses, often including SH (Spector et al., 2014). Spector et al. (2014) noted in their often-cited quantitative review of 136 articles from Anglo, Asian, European and Middle Eastern research that 25% of nurses reported sexual harassment, and patients were the most common perpetrators of this harassment. Spector et al. (2014) also identified that sexual harassment within nursing had not

been studied as much as other types of physical and nonphysical violence. Recent studies continue to note that sexual harassment in nursing may be underreported, and there is scant and dated research in this area (Bruschini et al., 2023; Kabat-Farr & Crumley, 2019; Parke et al., 2023; Ross et al., 2019). Therefore, research is needed to investigate SH in the nursing profession and the reasons for this under-reporting.

Nursing is a predominantly women-based profession, as women account for over 70% of the health workforce, and nursing can be seen as “women's work” (Lu et al., 2020; Ross et al., 2019; Smith et al., 2023; WHO, 2019). Ross et al. (2019) noted that females are more likely to experience SH than males and that SH has been identified as a problem of gender and power dynamics in society. Nursing being viewed as a female-dominated profession may contribute to decreased interest among males in pursuing this as a career, due to some gender stereotypes (WHO, 2019). Nurses also spend the most time with patients, caring for them closely, and are known to care for naked human bodies, which breaks some of the taboos about intimacy (Ross et al., 2019). Despite nursing generally being held in high regard as one of the most trustworthy professions, there are sexual overtones in some nursing media portrayals and pornography, which can lead to unsafe working conditions for nurses (Gill & Baker, 2021). These perceived negative stereotypes and the power imbalance as a female-dominated profession, where men are more likely to be in higher hierarchical positions, could explain why sexual harassment is under-reported (Parke et al., 2023; Ross et al., 2019; Smith et al., 2023). However, SH is increasingly being seen as unacceptable in workplaces, including healthcare organisations (Smith et al., 2023).

Sexual harassment is a concern, as all employees, including nurses, have a right to a safe workplace and to be treated respectfully (Health and Safety at Work Act 2015). In Aotearoa New Zealand, the Health and Safety at Work Act (2015) requires employers to provide a safe working environment by managing health and safety risks. A provision within this Act requires employers to provide information and training to protect all individuals from workplace risks. According to this Act, health encompasses both physical and mental well-being, and risks encompass both physical and psychological hazards (Health and Safety at Work Act 2015; Parke et al., 2023).

The physical and psychological effects of SH are significant occupational stressors for all nurses, especially new graduate nurses. Psychological effects such as lowered self-esteem, difficulty in interpersonal relations, increased stress, depression, frustration and anxiety have been reported by nurses experiencing SH in practice (Bruschini et al., 2023; Cogin & Fish, 2009; Grigorovich & Kontos, 2020; Lu et al., 2020). Nurses reported physical effects as a result of SH, including chest pain, numbness and tingling in extremities, nausea, gastrointestinal upsets, and shortness of breath (Draucker, 2019; Lu et al., 2020; Parke et al., 2023). These physical and psychological effects due to SH can impact nursing retention rates and increase absenteeism (Bruschini et al., 2023; Grigorovich & Kontos, 2019). Further exploration of SH is important, as the recruitment and retention of nurses is complex, and strategies to support and retain NGNs are necessary to sustain the future workforce.

An important issue to consider is the worldwide shortage of nurses, which underscores the need to promote positive job satisfaction and support nurses when they encounter workplace challenges, such as SH. Even before the COVID-19 pandemic, it was widely acknowledged that a global nursing shortage existed (Burgess et al., 2018; Parke et al., 2023). Gender inequality is apparent as many women are over-represented in part-time and casual employment, often due to family responsibilities and caring duties (Weatherall et al., 2021). These factors contribute towards nursing shortages (International Council of Nurses [ICN], 2021). The WHO report (2019) found that rising health needs will result in a global shortfall of 18 million health workers, a shortfall that the COVID-19 pandemic has since exacerbated (ICN, 2021; WHO, 2019). Other studies have noted this international shortage of nurses and identified contributing factors to nurses leaving the profession early in their career, such as excessive workloads, burnout, violence and sexual harassment (Draucker, 2019; Hawkins et al., 2019). Therefore, there is a need for further research to explore factors that contribute to nurses leaving, such as sexual harassment, so these can be addressed to encourage nurses to remain in nursing.

Relatively little research has been conducted on sexual harassment in the healthcare setting, possibly due to its sensitive nature (Grigorovich & Kontos, 2020; Hawkins et al., 2019; Minton et al., 2018). Recent studies have shown that SH towards nurses and nursing students in clinical settings is widespread and impacts their well-being (Lu et

al., 2020; Parke et al., 2023; Smith et al., 2023). Mammen et al. (2023) reported that NGNs may be more likely to leave the profession than experienced nurses when faced with increased stressors, thereby contributing to nursing shortages. Hawkins et al. (2019) noted that new graduate nurses often experienced emotional distress and anxiety due to negative workplace behaviours, and their leaving the nursing profession tends to be closely aligned with their experiences in their first year of nursing practice. Studies have shown that nursing students and younger registered nurses are also more likely to experience SH (Lu et al., 2020; Parke et al., 2023; Smith et al., 2023). Some stress is an inevitable part of NGNs taking on greater nursing responsibilities, but factors such as an NGN experiencing SH may result in increased physical and psychological stress, causing them to contemplate leaving nursing.

New graduate nurses are likely to experience transition shock when beginning work as registered nurses, especially as nursing practice has become increasingly complex. New graduate nurses often struggle to apply the ideals they have been taught during their training, particularly within the constraints of a system facing financial and staffing shortages (Bruschini et al., 2023; Smith et al., 2023). Transition shock was identified in Duchscher's (2009) stages of transition theory, which was built upon Kramer's concept of "reality shock" in their 1974 research (Akomeng Aryeequaye et al., 2025; Duchscher & Windey, 2018). Duchscher and Windey (2018) discussed the transition experience of NGNs as they endeavour to become autonomous practitioners within their new practice realities.

New graduate nurses are confronted with new responsibilities, expectations, knowledge, and relationships in their first years in the practice setting, a period that has long been recognised as a stressful time (Duchscher & Windey, 2018; Jamieson et al., 2023). They may experience emotional, physical, intellectual, and sociocultural challenges to their well-being (Duchscher & Windey, 2018; Jamieson et al., 2023; Mammen et al., 2023). This potential for transition shock is usually most acute in their first two months of practice, a stage which Duchscher and Windley (2018) called "Doing". The next four to five months are identified as "Being", which is marked by the NGNs rapidly gaining confidence in their roles and nursing responsibilities (Akomeng Aryeequaye et al., 2025; Duchscher & Windey, 2018). However, they may feel

exhausted, inadequate, and frustrated by the realities of the healthcare system (Duchscher & Windey, 2018).

The last stage NGNs experience is “Knowing”, in which they can organise, prioritise, and manage more complex patients. However, NGNs may be realising the realities of constant shift work, health system constraints, and their powerlessness to change their work environment (Duchscher & Windey, 2018). Factors identified as assisting with this transition for NGNs include supportive relationships with staff, constructive feedback, appropriate responsibilities, support with increasingly complex clinical presentations, reassurance about their progress, and support to improve quality care processes (Duchscher & Windey, 2018; Jamieson et al., 2023). As these NGNs are needed in these times of workplace shortages worldwide, a safe and supportive workplace is needed, free from stressors, including that of sexual harassment.

Although there are legal definitions of degrees of sexual assault, it is important to recognise that the felt experience of SH may not align with the legal definition of severity. Therefore, all cases of SH should be taken seriously, and those supporting the nurse must not speculate about whether the new nurses are justified in feeling distressed. Sexual harassment can range from verbal or non-verbal behaviours (Bruschini et al., 2023). Studies show that harassment towards nurses in the form of comments and propositions from patients is common, if not a “daily” occurrence (Hawkins et al., 2019; Smith et al., 2023). Many studies on this issue noted that, although students and nurses identified experiencing SH, most did not report these behaviours to their supervisors (Bruschini et al., 2023; Hawkins et al., 2019; Parke et al., 2023; Smith et al., 2023). Exploring the reasons why SH is underreported in care settings would help determine the cause of this reluctance.

Investigating reasons for the underreporting of SH is important, and semi-structured interviews are an appropriate method for hearing from the young nurses themselves. Thorne (2016) noted that subjective knowledge is gained through conversations with people about their experiences. However, those we interview may struggle to clearly describe and discuss their experiences, making it difficult to identify deeper, profound meanings (Thorne, 2016). Although some experiences of SH may be ignored, more serious instances can result in nurses feeling embarrassed and vulnerable and can

result in longer-term physical and psychological effects (Lu et al., 2020; Parke et al., 2023). Hence, there is a need to research nurses' experiences of SH from patients and identify barriers to their underreporting of these instances, so that support can be put in place.

Little is known to date about SH in healthcare in Aotearoa New Zealand, and research is scarce on the experiences of new graduate nurses in this context. A New Zealand study by Jamieson et al. (2023) found that most NGNs in their first year found nursing challenging, and that there was a dearth of research on NGNs' experiences during their first year of practice. Weatherall et al (2021) noted that Aotearoa New Zealand has high rates of sexual violence. A New Zealand Nurses Organisation [NZNO] (2019) survey found that 21.4% of registered nurses had experienced SH in the last 12 months from patients or their families. This SH ranged from sexual innuendos to abuse from patients, service users or relatives (NZNO, 2019). Parke et al.'s (2022) study of bullying, discrimination, and sexual harassment of Australian and New Zealand Intensive Care Unit (ICU) nurses found that 31.3% of respondents had experienced SH in their career, and 12.9% had experienced SH in the last 12 months. Only 24.7% had reported this harassment to management colleagues or those in charge, as most respondents did not feel their concerns would be addressed (Parke et al., 2023). Patients were the most cited perpetrators of sexual harassment (Parke et al., 2023). Further research is crucial to identify the types of SH occurring in Aotearoa New Zealand by encouraging reporting of any SH experienced.

Although this study does not explicitly target Māori, all research is of interest to Māori, as they are the Tangata Whenua of Aotearoa New Zealand. Te Tiriti o Waitangi provides a framework for identifying Māori ethics and how research may impact Māori (The Pūtaiora Writing Group, 2010). Chalmers (2020) noted that the number of Māori nurses in the health workforce in Aotearoa New Zealand is not proportionate to the Māori population, further exacerbating inequity in healthcare. Chalmers (2020) also identified that nursing leaders need to evaluate ways to increase the number of New Zealand-trained and Māori nurses to help achieve equity for Māori. The NZNO (2019) employment survey into violence and aggression in the workplace, which included SH, noted that Māori respondents were underrepresented, with only 5.9% of nurses identifying as Māori, compared to 7.3% of Māori in the total nursing workforce. It was

also noted that the number of Māori nurses represented a lower proportion than the NZ Māori population, which was 15.0% (NZNO, 2019). Māori nurses inherently understand the complexities of socio-economic contexts that adversely affect Māori and can show the wider health workforce how to care for Māori patients in a culturally safe manner (Hunter & Cook, 2020). Minton et al. (2018) found that Māori nursing students reported experiencing a higher proportion of bullying behaviours compared to Pākehā students. Bullying included physical, sexual and non-physical violence in this study (Minton et al., 2018). Although there is no specific data regarding SH for Māori nurses, research suggests that Māori nurses experience daily harassment (Minton et al., 2018). More research is necessary to see if Māori nurses experience SH, and to identify what kind of support is needed to ensure Māori nurses do not leave due to sexual harassment.

Research is also needed to explore the sexual harassment experiences of nurses who identify with an ethnic minority. The NZNO (2019) survey of nurses experiencing violence and aggression in the workplace showed 19.9 % of nursing respondents were Asian and 3.9% were Pacific. Members of ethnic minorities tend to be over-represented in general harassment statistics in NZ (Chalmers, 2020). Minton et al. (2018) noted that nursing students whose first language is not English may have difficulty identifying behaviours that constitute harassment, thereby contributing to under-reporting of these incidents. Further research is needed to establish a clearer picture of the SH nurses and NGNs from all ethnic minorities may experience, so that targeted support can be provided.

Background/ Researcher's interest in the study

I have been a nursing educator at a New Zealand university for the past 10 years, and my primary role involves visiting students during their clinical placements. I assist students with their clinical learning, support them, and guide them to think critically about their nursing practice. Over the years, there have been instances where nursing students have experienced distressing sexual harassment from patients and have needed ongoing support. This has led to my aim to investigate how new graduate nurses addressed sexual harassment from patients during the first two years of their post-graduation practice. Another aim was to identify the types of sexual harassment new graduate nurses experienced, including whether they reported this harassment, if

this sexual harassment affected their practice and whether this sexual harassment affected their decision to remain in nursing as a career. It also aimed to determine what education and support they have received or need after experiencing sexual harassment.

Overview of Chapters

This thesis is organised into five chapters. Chapter One, the introduction, sets the scene for the study and provides an overview of the researcher's pre-understandings. Chapter Two, the literature review, presents the context of this study in relation to previous literature on the topic. It presents an overview of the challenges that new nurses face due to sexual harassment in their workplaces and how support can be provided. Chapter Three presents the research design, considering the axiology, epistemology, ontology, methodology, and rationale that underpin this study. Ethical considerations will be explored in accordance with Te Tiriti o Waitangi, which provides a framework for understanding how research may impact Māori (The Pūtaiora Writing Group, 2010). Recruitment and participant selection are outlined, and ethical considerations are discussed. Efforts to ensure trustworthiness are identified, and an overview of the data collection and thematic analysis process is discussed. Chapter Four presents the research results, as themes generated from the data are explored. Chapter Five is the discussion chapter, presenting the findings and answering the research question: "How do new graduate nurses address sexual harassment from patients?" This chapter considers the strengths and limitations of the study. It concludes with suggestions for future research and recommendations to improve support for new graduate nurses.

Summary

This chapter has introduced the research topic for this study and highlighted the importance of investigating how NGNs address SH experienced by patients. Factors explaining why NGNs are vulnerable to SH have been explored, and the importance of supporting this group has been highlighted, as Aotearoa New Zealand needs to support its nurses due to the global nursing shortage. The background information regarding the researchers' interests in this area has been shown. The research question aims, and an exploration of key concepts has been supplied. Lastly, an overview of the

chapters has been summarised. Chapter two explores the literature to provide further context for the research question: “How do new graduate nurses address sexual harassment from patients?”

Chapter 2 Literature Review

Introduction

This chapter explores the relevant literature related to the question: "How do new graduate nurses address sexual harassment from patients?" This study aimed to investigate how new graduate nurses addressed sexual harassment from patients during the first two years of their post-graduation practice. Another aim was to identify the types of sexual harassment new graduate nurses experienced, including whether they reported this harassment, if this sexual harassment affected their practice and whether this sexual harassment affected their decision to remain in nursing as a career. It also aimed to determine what education and support they have received or need after experiencing sexual harassment.

This literature review will explore the current research regarding the broader field of SH experienced by student nurses, NGNs and experienced nurses. Exploring the literature will identify gaps needing further research. This topic was selected because previous research has shown that SH is a common problem among nurses, but there is no research as to whether NGNs are particularly vulnerable to this harassment. New graduate nurses are transitioning from being students to registered nurses. They need to build confidence in patient care and decision-making, along with the responsibilities that accompany these roles. This period, as discussed in Chapter One, is known as "Transition shock" and typically lasts one to two years (Duchscher & Windey, 2018). As identified in the introduction, younger nurses are more likely to experience sexual harassment in the workplace, and NGNs are more likely to be younger in age (Bruschini et al., 2023). These factors make NGNs vulnerable to SH, and I am interested in understanding the types of SH that nurses, particularly NGNs, are experiencing.

It is necessary to research the effects of SH experienced by NGNs, including its impact on patient care and the effect of SH on NGNs' job satisfaction. This study also seeks to identify who the main perpetrators of SH towards NGNs in the healthcare settings are. It is necessary to determine what education NGNs received during their nursing training regarding SH, as well as any strategies taught to address it. Exploring whether NGNs experiencing stressors, such as SH, are more likely to leave nursing is a concern, given the global nursing shortage (ICN, 2021; WHO, 2019). This topic is also relevant to

nursing management, as support is needed to help NGNs remain in nursing. This is especially important, given the ageing New Zealand population, which will face increasing health complexities in the coming years (Minton et al., 2018). It is essential to determine if instances of SH experienced by NGNs are being reported and what support from senior staff and management is in place.

Despite an extensive database search, no English language studies were identified that specifically addressed the sexual harassment of new graduate nurses by patients. Therefore, a broader literature review was undertaken, incorporating literature about sexual harassment experienced by both student nurses and experienced nurses. Literature exploring SH experienced by caregivers and nurses working in aged residential care (ARC) facilities was also examined, as registered nurses supervise caregivers in these facilities and are responsible for the caregivers' practice and training.

This literature review explored what is already known about SH experienced by nursing students and nurses, both internationally and in Aotearoa New Zealand. The search strategy is described and identifies literature that I found meaningful and helpful for understanding the scope of previous research on SH and current understandings of this topic. Literature outlining the international and national contexts will be explored. The gendered nature of sexual harassment and stereotypes regarding how female and male nurses are portrayed in the media will be investigated. Links between power dynamics between nurses and perpetrators of SH, especially patients, will be considered. The different types of SH will be identified, as well as the physical and emotional effects of this harassment towards nurses. Underlying factors, such as the culture of silence around SH and its status as a taboo subject, will be examined. Ethical dilemmas, such as weighing the culpability of perpetrators of SH in cases of illness, will be explored, along with how nurses respond in these difficult situations. The need for education on what SH is and on strategies to address it during nursing training, as well as the organisational responsibility for keeping nurses safe once they are in the workplace, will be discussed. This literature review revealed important themes to explore further, drawing on past research, and identified gaps that warrant further investigation, particularly regarding how NGNs address SH from patients. New

graduate nurses are an important group that requires support during their initial years of nursing practice.

Search strategy

An initial search strategy for relevant literature was conducted to understand the prevalence of SH among new graduate nurses internationally and in Aotearoa, New Zealand. Multiple online database searches of EBSCO, Google Scholar, Sage, Scopus, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed were conducted to identify relevant publications using the following terms: “Nurs” AND “Sex” AND “harassment”. The search results yielded 234 articles and one media item.

The inclusion criteria were articles written in English, with full text available, that referred to sexual harassment of nurses in the title, abstract, or as part of their core findings. This criterion aimed to ensure studies had a significant focus on the SH of nurses, new graduate nurses, or nursing students. Grey literature, including opinion pieces and discussion papers, was included to facilitate a thorough exploration of issues related to SH and to help understand the social context.

Limitations included viewing only articles published between 2015 and 2025; however, given the dearth of literature on SH experienced by nurses, a few older studies were included for historical context. Research based in OECD countries that have similar democratic rights to Aotearoa, New Zealand, such as Australia, Canada, the United States, the United Kingdom, and other European countries, was preferred. Generally, articles that focused on students or professionals from other healthcare disciplines were excluded, though some literature was included that involved other healthcare workers, including nurses, to show how pervasive SH is in the general healthcare setting.

A search on the 25th of July 2025 was conducted in the above-mentioned databases with the keywords “new graduate” AND “nurses” AND “Sex” AND “harassment” AND” New Zealand”, and included search terms such as “incivility”, and “unwanted sexual behaviour” as these terms were also noted in the literature.

On the 12th of August 2025, another search was undertaken to check for any new literature using the keywords:

“New nurses” OR “New graduate nurse” OR “New graduate RN”

“sexual harassment” OR “unwanted sexual behaviours” OR “sexual impropriety”

“patients” OR “clients” OR “service users”

This search yielded 11 results, most of which I was already familiar with, but yielded a recent study regarding mental health nurses' experiences of violence, including sexual harassment.

The search strategy included reviewing the reference lists of relevant articles for additional useful literature. The literature search was updated throughout the study to include recently published studies from both international and New Zealand sources. The literature reviewed encompassed various methodologies, including questionnaire-based research, ethnographic research based on observations and interviews, systematic reviews, qualitative studies, integrative reviews, book chapters, and Aotearoa New Zealand legislation. Despite the wide reach of the keywords used, the searches showed there is a dearth of literature and research specifically investigating new-graduate nurses’ experience of sexual harassment from patients both internationally and in Aotearoa New Zealand.

Locating the extent of the problem: International and national contexts

Internationally, there has been an increasing body of research on SH experienced by healthcare workers, particularly among nurses, who comprise the most significant proportion of healthcare workers (WHO, 2019). Smith et al. (2023) note that although SH may have been tolerated in the past, due to the feminist movement and publicity from the “#MeToo” campaign, there is now a sense of international outrage recognising SH as unacceptable. Therefore, further research is necessary to investigate whether SH affects nurses in their workplaces and how they address this sexual harassment.

International context of workplace sexual harassment of nurses

Despite increasing awareness of the unacceptability of SH towards nurses, research indicates that SH continues to occur in healthcare organisations (Lu et al., 2020; Ross et al., 2019; Smith et al., 2023). Recent studies have focused solely on SH experienced

by nursing students, nurses, and caregivers, viewing it as a problem that needs to be urgently addressed. A British study found that 60% of nurses had experienced SH at work and noted that it had become a normalised part of the job (Dean, 2023). Lu et al. (2020) conducted a worldwide meta-analysis of observational studies, finding that 12% of nurses had experienced SH in the previous 6 months and 53% had experienced SH during their careers. Studies note that many systematic or integrative reviews are now based on outdated data, and that further research into SH would be beneficial (Draucker, 2019; Hawkins et al., 2019; Mammen et al., 2023; Ross et al., 2019; Smith et al., 2023). Kabat-Farr & Crumley (2019) also identified that a significant amount of research concerning SH is dated, and that the use of questionnaire design may limit the understanding of the issues if this method is employed. The point was made that questionnaires need to clearly define and categorise the different types of sexual harassment to ensure employees accurately label their experiences as such (Kabat-Farr & Crumley, 2019). Because some forms of SH are accepted, employees may not report certain behaviours as this harassment, which may be one factor contributing to the underreporting of SH at work and in research (Kabat-Farr & Crumley, 2019). However, sexual harassment is occurring towards nurses in health organisations, and further studies are needed to determine the extent and the effect of SH on the nursing workforce.

National context of workplace sexual harassment of nurses

There is a lack of research into how registered nurses experience SH in Aotearoa New Zealand, and none on how SH experiences affect new graduate nurses. In line with previous research overseas, a New Zealand study by Minton et al. (2018) found that nurses aged under the age of 30 were more likely to experience SH, which reflects international research noting that younger nurses are more likely to be sexually harassed (Kabat-Farr & Crumley, 2019; Parke et al., 2023). Some of the nursing students who participated in Minton et al's (2018) study indicated that they had experienced sexual remarks and inappropriate touching. This SH led students to feel anxious and unsafe, prompting some nursing students to call in sick and others to consider leaving their nursing training (Minton et al., 2018).

A more recent study of Australian and New Zealand nurses working in intensive care units, by Parke et al. (2023), researched bullying, discrimination and sexual harassment

experienced by these nurses in both countries. This cross-sectional online survey of Australian and New Zealand intensive care nurses found that 12.9% had experienced SH in the last year (Parke et al., 2023). This study found that most nurses did not report these behaviours because they believed no action would be taken (Parke et al., 2023). Nurses also reported feeling they had to accept some degree of SH as part of their work (Parke et al., 2023). An NZNO. (2019) survey revealed similar results, as 21.4% of nurses reported being exposed to sexual threats and harassment from patients or relatives in the last 12 months. The nurses identified that these types of abuse occurred often, and they believed this SH had to be tolerated (NZNO, 2019).

The gendered nature of sexual harassment

Previous research has highlighted the implications of SH for female nurses, as numerous studies have shown that a higher proportion of female nurses and nursing students experience SH than their male counterparts (Bruschini et al., 2023; Fitzgerald & Cortina, 2018; Kahsay et al., 2020). As nursing is a female-dominated profession, this can make nurses more vulnerable to being sexually harassed, as nursing has been traditionally seen as women's work (Bruschini et al., 2023; Hedlin & Klope, 2025; Smith et al., 2023). Other reasons identified in the literature for higher rates of sexual harassment towards female nurses were the public awareness that nurses care for patients' bodies in an intimate manner, and this could break down many of the societal taboos around intimacy and touch (Mao et al., 2024; Smith et al., 2023; WHO, 2019). Ross et al (2019) noted that nurses often are seen as caring and kind, so perpetrators of SH may think nurses are willing to be open to sexual suggestions. Mao et al (2024) make an interesting point from their research that nursing students de-sexualise intimate nursing care, but patients may not de-sexualise these interactions, so this could lead to SH. Further research is needed into the reasons female nurses are at a higher risk of SH and how their employment organisations can address this issue.

Stereotypes and the positioning of nurses

Stereotypically, nurses are often portrayed in the media as doctors' handmaidens, as "angels", or even as willing participants in pornography, lacking the power to make decisions and having little authority (Gill & Baker, 2021; Ross et al., 2019). Ross et al. (2019) identified that, as nurses are known to care for patients intimately and are

often portrayed in the media in a sexualised manner, this can result in nurses being at an increased risk of SH. Many studies identify patients as the main perpetrators of SH, although patients' families and coworkers are often implicated as well (Bruschini et al., 2023; Parke et al., 2023; Smith et al., 2023). Nurses and students are expected to be kind, caring, and nurturing, which creates the expectation that they are available and willing to please patients, with the possible implication for sexual availability (Bruschini et al., 2023; Draucker, 2019; Kahsay et al., 2020; Parke et al., 2023). Although nursing is viewed as a respected profession, and nurses often work autonomously as nurse practitioners, specialists and educators, media representations often fail to portray nurses in these positive professional roles (Bruschini et al., 2023; Smith et al., 2023). Sexual harassment enacted toward nurses, regardless of the underlying dynamics, needs further exploration through research.

Workplace sexual harassment of men in nursing and healthcare

Although most research indicates that female nurses are more likely to experience SH than male nurses, a few studies have examined SH among male nurses. One Korean study found that 65.2% of male nurses had experienced SH in the last 6 months of their work (Jeong & Hyoung, 2022). An American study by Jackson et al. (2021) found that, although a greater number (97%) of female healthcare providers experienced SH, 77% of male healthcare providers also experienced sexual harassment. Jackson et al. (2021) found that males reported high levels of verbal SH but less physical sexual harassment. Both female and male healthcare providers in this study identified physical SH as more problematic than verbal SH (Jackson et al., 2021). Female nurses, however, were more likely to experience all forms of SH, including physical (Jackson et al., 2021). Worman & Nimkar (2023) noted that although both male and female nursing students experienced aggressive behaviours, including SH, female nursing students reported higher rates of SH. Putting aside the problems associated with gender stereotypes and focusing on the problem of SH towards nurses, further studies would be useful in exploring the contributing factors of SH towards all nurses.

Links between power and sexual harassment.

Different theories exist in the literature regarding the reasons for SH, as some studies suggest that SH is rooted in power and beliefs about gender roles for men and women (Jackson et al., 2021). Smith et al (2023) identified that perpetrators of SH are mainly

male and patients in healthcare settings. Fitzgerald & Cortina (2018) explored why men harass others, particularly women, and identified that sexual harassers are from all social areas in society, occupations and ages. It was noted that people who sexually harass others generally do so due to beliefs about sexuality and gender roles; therefore, harassment is generally about power rather than desire (Fitzgerald & Cortina, 2018; Hedlin & Klope, 2025). The possible underlying belief that men have higher biological urges for sex could contribute to SH being tolerated (Hedlin & Klope, 2025; Smith et al., 2023). Further exploration of the contributing factors, such as gender and power in society, could help determine ways to address SH in healthcare towards nurses.

Despite nurses comprising most of the health workforce, this does not translate to greater power in decision-making or support (Ross et al., 2019). The female-dominated caring professions are often lower paid, thereby seen as having lower status than male-dominated, higher-paid professions (WHO, 2019). This perception of lower perceived worth has been identified as a contributing factor for nurses being vulnerable and more likely to experience sexual harassment (Gabay & Shafran Tikva, 2020; Jackson et al., 2021; Scholcoff et al., 2020). Over the years, media portrayals of female nurses have portrayed nurses as serving doctors' and patients' needs, and due to this perception, there seems to be a link made between nurses and availability for sex (Gill & Baker, 2021). Ross et al. (2019) identify that individuals or groups can be vulnerable to being easily hurt or attacked and that nurses as a group are at risk of SH due to inequalities and power imbalances. Kabat-Farr & Crumley (2019) identified that gender harassment, such as communication of insulting and degrading attitudes, is the most widely experienced harassment by women.

Another area of vulnerability for nurses was that, despite nurses often working in teams, they may become isolated in some situations. They may be working with patients behind closed doors or curtains, some areas of wards may have darkened areas far from workstations, and community nurses visit patients in their homes alone (Kabat-Farr & Crumley, 2019). Further exploration of the power dynamics between patients and nurses is necessary to understand how these dynamics may contribute towards sexual harassment of nurses.

Several studies have indicated that patients may have power over nursing students and nurses, as any complaints are taken seriously by management, who may side with the patient over the nurse (Fitzgerald & Cortina, 2018). Another study by Grigorovich & Kontos (2019) identifies that patients can be vulnerable yet also possess considerable power, which leads to the conundrum of what is more important – the rights of the patient or the carer? Smith et al. (2023) noted that nursing students felt powerless after experiencing SH from patients, and a contributing factor may be that nursing students are assessed on their ability to establish empathy and rapport with patients. Hence, there is an imbalance of power in the patient's favour, which may partly stem from nurses' desire to provide care and establish trust (Dean, 2023; Kabat-Farr & Crumley, 2019).

Another interesting consideration is that harassing nurses and joking in a sexual manner may be provoked by fear of loss of the patient's dignity and anxiety due to health problems (Smith et al., 2023). A study by Phillips et al. (2019) identified that female medical students were the predominant targets of SH, and most perpetrators were male, predominantly patients. What was interesting about this study was that none of the medical students identified having "power" in their profession, and none considered the possibility that SH from patients might be a way to regain perceived power lost as a patient (Phillips et al., 2019). Although this study focused on medical students, it could be argued that nurses have power over patients due to their knowledge and decision-making skills, but often unconsciously minimise this dynamic, focusing on relationship building and thereby ignoring the harasser.

Sexual harassment has numerous forms

There are wide-ranging behaviours that are included in the concept of sexual harassment. Of note, research consistently highlights that the intrusiveness of a behaviour does not correlate with the psychological impact of the SH. Several studies have noted the different types of SH to which nurses have been exposed. Examples of verbal SH noted in the literature range from attempts to initiate an unwanted romantic relationship, teasing, offensive jokes, showing nurses and students sexual material, sexual innuendo or compliments and even demands for intercourse (Bruschini et al., 2023; Fitzgerald & Cortina, 2018; Minton et al., 2018; Ross et al., 2019). Non-verbal

examples of SH identified were touching nurses' bodies without permission, staring at nurses' bodies, attempts to fondle or kiss, non-sexual or sexual touches, exposure to genitalia, and exposure to masturbation (Bruschini et al., 2023; Cook et al., 2022; Cranage & Foster, 2022; Fitzgerald & Cortina, 2018; Minton et al., 2018; Ross et al., 2019). Ross et al. (2019) noted that some SH is blatant, such as exposure to genitalia, but other SH, such as innuendo, can be harder to identify as SH. Ross et al. (2019) note that if the nurse does not perceive a certain behaviour as SH, then it is not considered harassment. However, another nurse may find the same behaviour to be SH, indicating some subjectivity in interpreting behaviours.

Studies, such as questionnaires, have aimed to explore the frequency and types of SH experienced by nurses and nursing students. Bruschini et al. (2023) found in their cross-sectional study that verbal SH was experienced by some nurses almost weekly, and almost all the participants had been sexually harassed by patients in the last 12 months. In this study, verbal SH was most common, followed by nonverbal, and then physical sexual harassment (Bruschini et al., 2023).

Nurses' initial physical and emotional reaction to sexual harassment

Few studies have explored the immediate effects of SH on nurses, although Draucker et al. (2019) noted nurses experiencing SH initially felt emotions such as shock, fear and anger. Qualitative studies exploring sexual harassment experienced by nurses and health professionals have been undertaken in recent years, which have provided a greater understanding of the lived experiences of nurses who have experienced sexual harassment (Cranage & Foster, 2022; Jackson et al., 2021). Scholcoff et al. (2020) identified that due to this initial shock, many staff feel stunned and, therefore, are consequently silent and do not respond to sexual harassment. Participants reported feeling unprepared when confronted by SH and often reacted awkwardly in the moment, such as ignoring the behaviours, laughing uneasily, or redirecting the conversation back to the clinical situation (Hedlin & Klope, 2025; Scholcoff et al., 2020). Studies identified that health workers struggled to identify a professional response to the SH, as they felt constrained by the need to maintain rapport with the patient (Hedlin & Klope, 2025; Scholcoff et al., 2020). This need to maintain rapport may contribute to SH being underreported by nurses (Scholcoff et al., 2020). Another significant finding was that many participants altered their appearance by dressing

differently or ceasing to wear makeup to appear less attractive (Scholcoff et al., 2020). Participants noted that they devised their own strategies to minimise the possibility of SH, such as leaving doors open or enlisting another staff member for assistance (Scholcoff et al., 2020). Furthermore, although the studies provide key insights into nurses' experiences of SH, they have not fully explored how to equip nurses with the knowledge to identify SH and strategies to help them deal with it. Identification of nurses' initial reactions to SH and the longer-term impacts of SH needs further exploration

The impact of sexual harassment

Considerable attention has been given to the physical and emotional stressors that affect nurses who experience sexual harassment. Nurses have reported both short-term and long-term physical and emotional effects (Scholcoff et al., 2020). Effects noted on physical health include insomnia, chest pain, numbness and tingling in extremities, nausea, headaches, and gastrointestinal discomfort (Cranage & Foster, 2022; Draucker, 2019; Parke et al., 2023). Emotional effects noted in the literature are lowered self-esteem, long-term post-traumatic stress disorder (PTSD), moral distress, burnout, depression, anxiety and loss of empathy. (Bruschini et al., 2023; Grigorovich & Kontos, 2020). Nurses also described feeling angry, helpless, threatened and alone in response to this sexual harassment (Draucker, 2019). These symptoms can lead to absenteeism, which in turn can place pressure on the Healthcare organisation's provision of care (Bruschini et al., 2023; Gabay & Shafran Tikva, 2020; Kabat-Farr & Crumley, 2019; Kahsay et al., 2020). In addition to time off work, nurses may consider resigning from nursing (Cranage & Foster, 2022; Kahsay et al., 2020; Parke et al., 2023; Smith et al., 2023). Hence, the physical and emotional effects on nurses must continue to be investigated, as well as the impacts the SH may have on patient care. (Bruschini et al., 2023; Grigorovich & Kontos, 2020; Lu et al., 2020).

Psychological and behavioural effects resulting from SH can affect nurses' work performance and compromise the quality of care provided to patients (Cranage & Foster, 2022; Gabay & Shafran Tikva, 2020; Parke et al., 2023). To cope with factors such as anxiety, nurses may avoid some patients or finish care too quickly, even at times accidentally omitting some tasks (Bruschini et al., 2023). Important and

meaningful data from studies showed that health providers, including nurses, found that SH encountered from patients disrupted the trusting relationship, and this could consequently impact patient care (Gabay & Shafran Tikva, 2020). The link between experiencing SH from patients and the effect on nurses' practice warrants further research, as nurses can experience moral distress when they become aware of poor-quality care provided to patients (Draucker, 2019).

Sexual harassment impacts the workplace climate. Kabat-Farr and Crumley (2019) identified in their study that ambient sexual harassment in the workplace, which is working in an environment where sexual harassment is occurring, affects the whole team, not just those who are targeted. This can impact the work environment by decreasing teamwork, leading to increased conflict and affecting patient care, which can result in mistakes (Gabay & Shafran Tikva, 2020; Scholcoff et al., 2020). The above research shows factors resulting from nurses' experiences of SH, which in turn have detrimental effects on the workplace and patient care. Further research is needed to explore ways to support nurses after they have experienced SH, thereby improving patient care and job satisfaction.

Why under-reporting, tolerating, and minimising occur

Studies have noted that nurses tend not to report instances of SH for a range of reasons, such as the belief that patients could not help with these behaviours and that nurses thought there would be no follow-up action (Parke et al., 2023). Nurses also did not think that reporting was needed if no physical injuries were caused (NZNO, 2019; Parke et al., 2023). Research has shown that, over time, experienced nurses may become desensitised to, or minimise, SH in practice, which may explain why they do not report this harassment (Bruschini et al., 2023; Grigorovich & Kontos, 2019; Lu et al., 2020). Despite nurses' tolerance of SH, studies of New Zealand nurses' working conditions have found that exposure to SH negatively affects nurses' physical, emotional, and psychological well-being (NZNO, 2019). The NZNO (2019) report noted that some nurses needed to take leave due to SH they experienced, and at times reports of SH experienced at work were made to the police. These factors show the seriousness of the SH and the abuse nurses experienced. Together, the above research provides a greater understanding of the importance of investigating the effects of SH of nursing students, NGNs and experienced nurses. Further research is needed to

explore the link between the detrimental effects of this SH on nurses' well-being and its contribution to nurses leaving the profession.

A Culture of Silence

Studies have identified a culture of silence regarding SH in the workplace, and the literature shows nurses who have encountered SH often develop their own strategies for dealing with this abuse. Research has noted that this is necessary, as little to no education is provided throughout their training or after commencing employment (Hawkins et al., 2019; Kabat-Farr & Crumley, 2019). Draucker et al. (2019) identified common coping responses among nurses, including denial, avoidance, informing peers, making formal complaints, and seeking support from friends. Denial of the incident being SH, or minimising its effects, was also used as a coping strategy (Cranage & Foster, 2022; Worman & Nimkar, 2023). Draucker (2019) noted that many nurses and healthcare workers became more alert and watchful in their practice following past experiences of SH, which could also affect the nurse-patient relationship due to this increased caution. Sexual harassment needs to be discussed openly within the workplace to encourage collegial support and sharing coping strategies.

Sexual harassment continues to be an 'invisible' problem

In particular, the literature consistently indicates that SH is not being discussed and is seen as a taboo subject. Wright et al. (2020) note that there may be a lack of awareness around what behaviours constitute sexual harassment. Even though nurses are used to caring intimately for patients, they still might not be comfortable discussing sexual matters with peers and management (Hedlin & Klope, 2025). Flynn (2020) noted that humour can be used to cope with embarrassment or discomfort regarding sexual matters in a nursing context. Some research has indicated that many nurses who experienced SH only mention it to their mentors or peers, with very few formally reporting incidents (Cranage & Foster, 2022). Another reason for the lack of reporting SH may be that some nurses feel shame (Bruschini & Schubert, 2025). Other studies note that SH is not reported, as nurses stated they did not expect any follow-up and that nothing would happen (Hallett et al., 2021; Kabat-Farr & Crumley, 2019). The lack of attention given to SH has done little to encourage nurses to report SH, which is necessary to identify the scope of this problem (Hallett et al., 2021; Kabat-Farr & Crumley, 2019). The literature has noted that managers are often unaware of the

problem of SH, and therefore rarely have policies or guidelines to manage sexual harassment (Kabat-Farr & Crumley, 2019). Therefore, further research is needed to encourage the identification and reporting of this SH, so that nurses do not feel they must deal with these experiences on their own.

The 'grey area' of nurses weighing up the harasser's culpability in the face of illness

Often, nurses make allowances for patients who sexually harass them, such as patients who are intoxicated, under stress, or experiencing mental health difficulties (Kabat-Farr & Crumley, 2019; Neilsen et al., 2017; Wright et al., 2022). Burgess et al. (2018) identify that staff often excuse, minimise or dismiss inappropriate behaviour from residents with cognitive difficulties such as dementia. Nurses tend to make allowances for these behaviours and show understanding of the diminished intent on the part of the perpetrator (Bruschini et al., 2023). An NZNO (2019) survey found that many nurses thought the SH they experienced was beyond the patient's control and happened frequently, so it had to be tolerated. Some studies also note that more experienced nurses can become desensitised and see SH as "normal" and just part of the job (Neilsen et al., 2017). Nevertheless, these allowances do not lessen the negative emotions and physical effects experienced by nurses due to this harassment (Burgess et al., 2018; Dean, 2023). Further research is needed to determine the support nurses need from their workplaces to address negative emotions they may experience because of SH, whether intentional or not.

Educational initiatives are needed

Nurses' ability to identify SH and develop strategies to address this harassment has emerged as a key issue in this area. According to Smith et al. (2023), many nursing training institutions lack a formal process for preparing students for possible SH from patients (or others) prior to clinical placements. Several studies have noted that education to prepare nursing students should begin during their nursing training, ideally before their first clinical placement (Smith et al., 2023). Bruschini et al. (2023) reported that fewer than 20% of nurses had any training in de-escalating SH and stated that there are rarely any consequences for perpetrators who engage in SH against staff. Scholcoff et al. (2020) noted that training lacked guidance on addressing SH, so

health providers had to develop their own strategies based on their personal experiences. Smith et al. (2023) found that nurse education is a strong protective factor against SH, as de-escalation skills and assertiveness training can promptly shut down inappropriate patient behaviours. Cranage & Foster note that all nurses need education to enhance their skills and to report concerns encountered in practice. Education also reinforces that SH from patients (and others) is unacceptable and empowers nurses not to minimise or ignore this, hence decreasing the physical and emotional detrimental effects experienced by this sexual harassment (Mammen et al., 2023). Studies have found that new graduate nurses are more likely to leave nursing due to experiences of workplace incivility than experienced nurses (Mammen et al., 2023; Walker & Clendon, 2018). Nurses are traditionally viewed as caring and kind, but education and skills that empower nurses to set boundaries when patients overstep with inappropriate behaviour could increase nurses' job satisfaction, improve their health, and decrease absenteeism and attrition.

Sexual harassment is an organisational responsibility

Although SH is legally a workplace issue, the international and national literature consistently indicates that, for the most part, nurses experiencing SH take responsibility for managing it themselves. Fitzgerald & Cortina (2018) identify that the amount of SH an organisation is willing to tolerate is the largest predictor in determining if SH will occur and how damaging this SH will be. Therefore, organisations that do not tolerate sexual offensiveness from patients or others will inhibit this harassment in the workplace (Fitzgerald & Cortina, 2018; Ross et al., 2019; Smith et al., 2023). How management and organisations can best communicate their intolerance of SH and convey it to patients, families, and healthcare workers remains to be investigated.

In particular, the need for both nursing educational, organisational responsibility, and support is a recurrent theme in most of the literature regarding sexual harassment towards nurses. Kabat-Farr and Crumley (2019) note that most health organisations rely on their staff to complete incident reports for adverse situations, including SH incidents. However, studies often report that nurses complain of a lack of follow-up from management, even when they formally raise concerns (Kabat-Farr & Crumley, 2019). In another study, nurses did not think it was worth formally reporting any

harassment unless it was physical or sexual (NZNO, 2019). Ross et al. (2019) noted that although it is challenging for organisations to address SH, especially in healthcare, organisations have an ethical obligation to provide a safe workplace, as research shows SH experienced by nurses leads to negative physical and psychological effects. Demonstrating organisational support by providing training on what SH is, strategies for dealing with it, and ensuring support for nursing students or nurses who experience SH is important (Bruschini & Schubert, 2025). This support could benefit organisations by increasing morale and job satisfaction and reducing attrition (Bruschini et al., 2023; Kabat-Farr & Crumley, 2019; Parke et al., 2023; Ross et al., 2019). This is especially important, as nurses make up the majority of the health workforce and a nursing shortage is predicted in the years to come (Tabakakis et al., 2024). Kabat-Farr and Crumley (2019) noted that organisations should address inappropriate verbal harassment, physical touching and harassment based on gender. Ross et al. (2019) identified that complaints should be taken seriously, including evidence such as texts, if available, and that the risk to the complainant should be reduced. Organisational support is needed, so if patients complain about nurses setting boundaries due to SH, employers will support the nurse and encourage reporting of these incidents (Kabat-Farr & Crumley, 2019). Therefore, research is necessary to determine the most effective way to educate and support staff on sexual harassment in the workplace.

Several studies have proposed methods to educate and support staff in identifying SH in healthcare settings. Firstly, it has been identified that the health settings need policies and guidelines regarding sexual harassment experienced by staff, as some studies have shown these are lacking in some areas (Scholcoff et al., 2020). Policies will help decrease the fear and stigma around reporting sexual harassment (Neilsen et al., 2017). Wright et al (2022) developed a self-directed e-learning tool aimed at aged care workers to assist them in identifying characteristics of unwanted sexual behaviours from residents and help them develop strategies to deal with these. Research has noted caregivers have a poor understanding of identifying SH behaviours and how to manage SH when it occurs (Ross et al., 2019). However, education that involves critical thinking and the development of complex understanding is shown to be more effective than simple online modules (Wright et al., 2022). Another study noted that online

training would not cover SH in sufficient depth or provide sufficient strategies for responding and advised that organisations needed to provide in-depth training with role-plays and discussions (Smith et al., 2023). Mammen et al. (2023) identified that healthcare organisations should develop strategies to communicate to the public that SH and uncivil behaviour are unacceptable towards staff, such as posters on walls stating a zero-tolerance policy for inappropriate behaviour. Transition programmes for new graduate nurses should have mentors trained to support new nurses in identifying and reporting any instances of SH experienced (Freyd & Smidt, 2019; Mammen et al., 2023). Viglianti et al. (2018) developed a simple one-page algorithm, which helps determine the best strategies if a patient is sexually inappropriate and the health worker feels unsafe. Though developed for physicians, algorithms such as this could be a useful resource for nursing students and nurses facing sexual harassment (Viglianti et al., 2018). Bruschini and Schubert (2025) are currently developing an evidence-based educational package to prevent SH against nurses from patients, thereby supporting nurses and minimising the adverse effects of this SH. With organisational and management backing, ongoing training and support for nurses will benefit the organisation, healthcare providers, and patients, utilising the resources outlined in the research above.

Summary

This literature review explores international and national contexts. There is scant literature on nurses' experiences of SH, and none specifically addressing how NGNs address SH. The literature noted the prevalence and past tolerance of sexual harassment towards nurses, particularly from patients. Despite this past tolerance, SH is increasingly seen as unacceptable. Nurses appear especially vulnerable as a profession due to being predominantly female dominated in numbers, though literature shows male nurses are not immune to sexual harassment. Other reasons identified in the literature for nurses to be sexually harassed may be due to the media portrayals of nurses as subservient, the knowledge that nurses deal with bodies intimately and the power dynamic relationship between the nurse-patient relationship.

Recent research has provided insights into the types and extent of SH, but it is evident that nurses perceive SH as an inherent part of their job that they must tolerate. However, despite this tolerance, the physical and emotional effects experienced by nurses remain, which can lead to increased sick leave, burnout, detrimental impacts on patient care and career departure. As the literature shows, younger nurses are more prone to experience SH; therefore, nursing students and new graduate nurses need education to identify SH, need strategies taught to deal with SH and encouragement to report all instances of sexual harassment. Unfortunately, studies reveal that educational and health organisations often do not have education or policies in place regarding sexual harassment in the workplace.

Research has shown that stressors, such as SH, experienced by nurses can contribute to their leaving the profession. Due to a global shortage of nurses, Aotearoa New Zealand is particularly vulnerable to nurses leaving the profession, leading to reliance on internationally trained nurses for many years to ensure safe staffing. The literature indicates that support is needed for new graduate nurses in Aotearoa New Zealand as they transition from students to registered nurses. This literature review has identified a gap requiring further investigation: to investigate how new graduate nurses address SH from patients during the first two years of their post-graduation practice. Another area to research is to identify the types of sexual harassment NGNs experience, including whether they report this harassment, if this SH affected their practice and whether this harassment affects their decision to remain in nursing as a career. Determining what education and support they receive or need after experiencing sexual harassment is also important to explore further.

Chapter 3 Methodology

Introduction

This research aimed to investigate how NGNs address sexual harassment from patients during the first two years of their post-graduation practice. This chapter describes the research process and design of this study. First, the research design and reasons for employing a qualitative methodology are considered, followed by a discussion of the epistemology and theoretical foundations that underpin this research. This is followed by a detailed account of the research methods, including participant recruitment and interview processes, an explanation of the data collection methods, and the process for analysing and interpreting the data. Next, the ethical issues are explored, including how consent was obtained and the measures used to minimise harm to interviewees. Measures to minimise harm were informing the NGNs that they could stop the interview at any time if they felt uncomfortable and carefully scaffolding the questions. Finally, steps used to ensure the validity of the study's findings will be discussed. This methodological process will help identify how NGNs address SH from patients during the first two years of their post-graduation practice. Based on the data collected, this research will identify the types of SH NGNs experienced, including whether they reported this harassment, if this SH affected their practice and whether this SH affected their decision to remain in nursing as a career.

Positionality

My Interest in this area developed during my 10 years as a nursing educator, as I have been aware of students experiencing sexual harassment from patients in their clinical placements. Whenever a student reported experiencing SH, I ensured that the events were investigated and that the students received counselling and support. However, based on the insights I gained from working with students, I realised that further investigation into new nurses' experience of SH from patients is needed so that they can be better prepared if this SH occurs. New graduate nurses in their first two years of practice were selected for interviewing because they are an at-risk group.

Qualitative methodology

This study uses a qualitative methodology, and one of the key reasons qualitative methodologies are useful is that they facilitate an understanding of certain questions that quantitative methodologies cannot (Thompson Burdine et al., 2021; Thorne, 2016). Qualitative research typically relies on inductive reasoning, whereas quantitative research generally employs deductive reasoning. A deductive approach often begins with a general concept and then becomes more specific with the results (Dingwall & Staniland, 2021). Qualitative research is inductive, as it explores people's experiences and identifies broader patterns from the data obtained (Thompson Burdine et al., 2021). Exploring these patterns seeks to identify areas that can pinpoint those aspects that need to be explored further using qualitative research (Dingwall & Staniland, 2021; Thorne, 2016). Qualitative research has its roots in the social sciences, drawing on approaches such as phenomenology, grounded theory, and ethnography (Thorne, 2016).

Phenomenological research philosophies, developed by major philosophers such as Husserl and Heidegger, focused on analysing constructive meaning from a person's subjective, lived experience (Thorne, 2016). Phenomenological philosophies hold that human truths are identified through striving to understand human experiences (Thorne, 2016). Thus, the ontology for interpretivist research concerns the nature of reality and acknowledges that multiple realities can exist (Thorne, 2016; Willis et al., 2016). Interpretive research also acknowledges that different people may interpret similar events differently, but their interpretations are subjective and their own truth (Pretorius, 2024). Thorne (2016) noted that traditional approaches, such as phenomenology, have not always met the research needs of health professions, which require greater flexibility to identify useful knowledge in practical areas, such as nursing. Qualitative analysis is appropriate to research how NGNs addressed SH from patients, as this explored the nurses' inner experiences resulting from these situations.

The epistemology, or nature of knowledge, of this study is constructionism, which posits that meaning is constructed by individuals based on their experiences in their socially constructed worlds (Thorne, 2016). Constructionism provides the basis for qualitative research, which acknowledges multiple realities (Pretorius, 2024).

Liamputtong (2022) noted that a person's reality is constructed from their experiences, and there is no accurate way to measure this. However, a person's experiences can be interpreted by the researcher (Thorne, 2016). In practice disciplines such as nursing, it is beneficial to investigate human behaviours and experiences. Such investigations help to identify problems in nursing practice, leading to enhanced care and services (Liamputtong, 2022). In this study, NGNs explained their encounters with SH to the researcher, which reflected how they made sense of their experiences. The researcher then constructed themes from the data set based on their stories (Thorne, 2016). Thorne (2016) suggested that one of the criteria for ensuring the epistemological integrity of a research study is the alignment of the research question, the interpretation of data sources, and the strategies used to interpret the data.

Nursing questions often identify a "knowledge gap" or a problem, and since practice areas such as nursing deal with people, there are many complex factors to consider (Thorne, 2016). Reviewing the literature to establish what is and is not known about the question is vital to ensuring it is worth investigating further (Thorne, 2016). Then, the research question must be identified, which then informs the appropriate research methods, enhancing trustworthiness and minimising researcher bias (Johnson et al., 2020).

The methodology used for this study needed to explore the complexity of human interactions, as well as the thoughts and feelings subjects experienced when addressing SH in practice (Johnson et al., 2020). Interpretive description is a methodology developed for applied disciplines such as nursing, where the research meets the specific needs of practical areas (Thompson Burdine et al., 2021; Thorne, 2016). Interpretive description is post-positivist, as it seeks truth while recognising that interviewees have multiple experiences and realities (Thorne, 2016). The axiology of interpretive descriptive research refers to the role of values, ethics and morals in research (Thorne, 2016). Qualitative researchers must be aware of their own situatedness and acknowledge that their beliefs may influence data interpretation (Pretorius, 2024). However, it is also noted that the subjectivity of the research and values uncovered may be a strength of interpretive descriptive research (Pretorius, 2024). Researching how NGNs address SH from patients may help the researcher gain insights into whether NGNs report these incidents formally or informally in their

workplaces. Encouraging reporting of these incidents may help ensure ongoing support is available for these new graduate nurses. Increased support stemming from this research might help prevent NGNs from leaving the profession or moving overseas, thereby helping maintain the nursing workforce in Aotearoa New Zealand.

Methods

Research methods must be suitable for investigating the research question, including how data is collected and then analysed (Pretorius, 2024; Thorne, 2016; Tobin & Begley, 2004). Initial consent for this study was granted by the Auckland University of Technology Ethics Committee (AUTEC). Recruitment for this study was conducted through advertising in Kaitiaki, the magazine of the New Zealand Nursing Organisation (NZNO), and via one of the routine online noticeboard mailouts to members of the College of Nurses, Aotearoa (Appendix B). The inclusion criteria were for new graduate registered nurses in their first two years post-registration, who were working in a nursing-related area in Aotearoa New Zealand, with patients/residents/service users who were predominantly adults aged 18 years or older. The study focused solely on SH by patients, ensuring that the power differential between nurses and patients could be explored. It was beyond the scope of this study to investigate SH from colleagues or patients' significant others. Unfortunately, these advertisements resulted in only one potential candidate contacting me, who did not meet the criteria. A memo was sent to the AUTEC proposing that the search for candidates be widened to include two postgraduate courses with a high proportion of new graduate nurses. This application was granted, and the advertisement was posted on the university's official websites. The inclusion criteria were widened to include registered nurses in their first 10 years of practice who had experienced SH from patients in their first two years of practice post-graduation. This ethics application was granted (Appendix A), and the advertisement was posted on the university's official websites (Appendix B). Rigour was ensured through the participant selection process and the application of inclusion/ exclusion criteria. It was beneficial to ensure diversity in age, culture, gender, and other variables, but this depended on responses to the advertisements and the time frames (Tobin & Begley, 2004).

Once interested respondents saw the advertisements, they contacted me by phone or email, ensuring that this process was not coercive and that their participation was entirely voluntary. The respondents were sent an information letter (Appendix C) that clearly stated the inclusion criteria, and they were given four weeks to consider whether to continue with the interview process. They were given a consent form (Appendix D) to sign before the interview once they indicated they were interested in participating further. All participants were informed that they could withdraw all or portions of their data, up to a fortnight after the interview.

It was decided to conduct one-to-one interviews, as participants would be more likely to be comfortable discussing their experiences in this setting rather than in a group context, given the sensitive nature of the topic (Thompson Burdine et al., 2021; Thorne, 2016). Thorne (2016) noted that listening to interviewees discuss their participants' experiences helps interviewers gain a deeper understanding of their participants' experiences. However, words can never completely convey certain concepts or meanings, as they are often subject to the varying understandings of the participants (Dingwall & Staniland, 2021). The interviews were semi-structured, with carefully scaffolded open-ended questions serving as a guideline for the discussion (Appendix E). Participants were encouraged to share their own stories and express their feelings (Thorne, 2016). As an interviewer, it was essential that I built rapport with the participants in a neutral, supportive manner, encouraging them to share, while also avoiding steering the conversation in certain directions (Dingwall & Staniland, 2021). Participants were assured they could pause or stop the interview at any time if they were experiencing distress, given that SH is a sensitive topic and discussing their experiences could trigger uncomfortable emotions.

Participants were informed that all conversations would be recorded. Those living in the Auckland region were interviewed in person or online via Microsoft Teams, according to their preference. Participants outside of the Auckland region were interviewed via Microsoft Teams. Limited demographic data were collected to protect participants' identities. Demographic data included a broad description of their area of work and the number of months of their postgraduate practice. Gender and ethnicity data were collected to enable comparisons with previous research, which has highlighted that women and members of some ethnic groups were more commonly

the target of SH (Chalmers, 2020; Hunter & Cook, 2020; Ross et al., 2019; Thorne, 2016). However, in this study, all participants were Pākehā and female. All worked four or five days per week at the time of the harassment, across a variety of direct clinical care areas, including mental health, medical wards, and emergency departments.

Demographic data on age was collected using five-year age bands. All participants were aged 20-25 when they experienced SH within the first two years of their post-graduation practice. Participants were informed that their details would be kept confidential and that the transcripts would be anonymised with respect to their names and workplaces. Transcriptions of the interviews from audio or Microsoft Teams recordings were downloaded as each interview occurred, and I checked the data against the recordings, making corrections to the transcript as needed. Recordings were stored digitally on OneDrive and accessed using a designated, password-protected computer, in accordance with Auckland University of Technology Ethics Committee (AUTEC) guidelines. My supervisor was given the master list of participants' names, contact details, and the pseudonyms used, to be kept on a secure, password-protected computer, separate from my anonymised transcripts. Ongoing discussions with my supervisor included debriefing after interviews and reflections on my interviewing skills. This was necessary to identify any factors that could potentially affect or compromise the trustworthiness of the interview data

Data Analysis

The aim was to recruit eight to ten participants to gather rich data about their experiences of SH from patients through the interviewing process, thereby enhancing knowledge and understanding. However, there were challenges recruiting participants who met the criteria, with only a few responses to advertisements posted on the postgraduate university sites, the Kai Tiaki NZNO site, and the College of Nurses' routine mailout. I applied to one of the local hospitals that runs a new graduate nursing New Entry to Practice (NETP) programme for consent to send email advertisements to their recent graduates. Consent was granted to email these nurses who were in their first two years of post-graduation employment (Appendix F). Through these advertisements and word of mouth, five participants who met the criteria were willing to be interviewed, noting two others who were initially willing to be interviewed did not respond again after they initially contacted me. Another two

participants who initially responded decided not to be interviewed, as they stated that any sexual harassment they experienced was minimal. Four one-to-one interviews were transcribed from the Microsoft Teams visual and verbal recording, and one interview was transcribed from a taped verbal-only recording. Notes were made regarding body language and other observed behaviours, as interpretive-descriptive research is concerned not only with what is said but also with pauses, words, and gestures that may add depth to interpretation (Johnson et al., 2020). Familiarisation with the data through transcription enabled the initial identification of codes and patterns through inductive reasoning, which involved identifying parts of the data with similar meanings (Thorne, 2016). Semantic or descriptive codes are based on the surface meanings of the data, whereas latent codes examine the underlying meanings (Thorne, 2016). Colour was used to identify initial codes, which were then collated into tentative themes that were revised as more data became available through further interviews. Braun et al. (2018) identified themes built from smaller codes that capture and unite meanings explaining portions of the data. With the study's original purpose in mind, these themes were subsequently defined and named (Braun et al., 2018). Thorne (2016) noted that interpretation, achieved through sorting and identifying the interrelationships between pieces of data, is part of the inductive reasoning process that helps collate findings.

Qualitative researchers rely on accounts from multiple people on a subject, but reaching the saturation point or defining the ideal sample size is not necessarily possible (Thorne, 2016). When data are fitted into a general scheme that provides a rationale for answering the research question, it is accepted as valid and sound knowledge (Thorne, 2016). The researcher should provide a rationale for the sample size, which can be influenced by time and resources (Thorne, 2016). In this study, the sample size was determined by the difficulty of finding candidates who met the study criteria and were willing to participate in the interview within the given timeframe. However, since this study involved the collection of rich descriptive data, a lower number of participants could be acceptable (Thorne, 2016). Thorne (2016) noted that representative credibility increases when findings are based on in-depth rather than superficial data and when multiple perspectives on similar experiences are identified.

Using interpretive description as a basis for this study was appropriate, as rich data were yielded from the five interviews.

In addition to representative credibility, Thorne (2016) identified other evaluation criteria for interpretive descriptive research. Epistemological integrity involves ensuring that a research question aligns with the epistemology, data collection methods, and data interpretation strategies (Thorne, 2016). Following this analytic logic is important, as qualitative studies should demonstrate a clear process from the initial research design through to data analysis, and how these processes identify themes (Dingwall & Staniland, 2021; Thorne, 2016). Each step should be clearly defined so that another researcher can replicate the study process and obtain the same conclusions, thereby demonstrating reliability (Thorne, 2016).

However, drawing the same conclusions can be challenging in qualitative research due to the researcher's influence on interviews or the subjects' differing interpretations of similar experiences (Dingwall & Staniland, 2021). Trustworthiness, or what Thorne (2016) refers to as “Interpretive Authority,” is demonstrated by the researcher removing their own bias from the research while acknowledging that interpretation is still necessary to identify commonalities and differences in the data. Thorne (2016) proposed that moral defensibility is essential, especially when researching sensitive topics, because there must be a rationale for why gaining this knowledge will be useful. It is necessary to identify why interviewing new nurses about their experiences with SH helps to highlight this problem and the purpose to which this knowledge can be applied. Demonstrating the benefits of this research, such as enhanced education for nursing students and nurses on what SH is and strategies to manage it, is ethically important (Ross et al., 2019). Thorne (2016) further considered disciplinary relevance to be another important aspect that ensures the knowledge sought from research is beneficial to health disciplines. The relevance of the current study lies in highlighting to health organisations that support is needed for NGNs and all nurses who experience SH. However, the credibility of research in practical areas is not always clear due to the involvement of multiple individual realities on a topic, which may reduce generalisability. Thorne (2016) referred to the moral obligation of researching an area that can be used to improve practice as a pragmatic obligation. As discussed earlier, in interpretive-descriptive studies, both differences and similarities in the data can be

useful for exploring practical disciplines (Thorne, 2016). Contextual awareness is also essential for understanding participants' subjective experiences and for developing findings relevant to improving practice settings (Thorne, 2016). In this study, the context is investigating how NGNs address SH in the clinical setting, thereby identifying the support needed to help them remain in nursing as a career.

Ethics

Ethical approval was obtained from AUTEC prior to undertaking this research, and it was approved on 2 February 2024 under reference number 23/352 (Appendix A). Conducting research ethically and considering the impact of my actions and methods on my research were of extreme importance (Dingwall & Staniland, 2021; Thorne, 2016). Showing rigour in qualitative enquiry is important, as rigour is how the trustworthiness of qualitative research is evaluated (Liamputtong, 2022). The credibility of the findings was based on whether the multiple experiences discussed in the interviews had been transcribed accurately and whether the methodological standards had been applied to coding and theme development (Liamputtong, 2022; Thorne, 2016).

A consultation was held with a Māori nursing colleague prior to applying for ethics approval. The consultation was focused on cultural awareness and safety with any Māori participants I might interview. Research in Aotearoa New Zealand is of interest to Māori, and research including Māori is of great importance (The Pūtaiora Writing Group, 2010). Te Tiriti o Waitangi provides a framework for identifying Māori ethical issues arising from how research may impact Māori (The Pūtaiora Writing Group, 2010). It is known that the number of Māori nurses is not proportionate to the Māori population in the Aotearoa NZ health system, contributing to inequitable healthcare (Chalmers, 2020; NZNO; 2019). Cultural provision is needed to ensure Māori nurses are supported and do not leave due to sexual harassment. This research is grounded in manaakitanga, the social and cultural responsibility to support our new graduate nurses (The Pūtaiora Writing Group, 2010). I endeavoured to undertake my mahi as tangata te Tiriti by discussing the topic with my Māori colleague. No Māori NGNs came forward to be interviewed for this study; however, I was aware that any topic related to sexuality is tapu and would have ensured I addressed questions sensitively (Hunter & Cook, 2020). Although there is no data specifically about Māori nurses’ experiences

of sexual harassment, it is known that Māori nurses experience other forms of harassment, including institutional and casual racism (The Pūtaiora Writing Group, 2010). Therefore, if I had interviewed Māori NGNs, I would have been alert to the possibility that they might have reported overlapping forms of harassment.

My academic supervisor at Auckland University of Technology (AUT), Dr Catherine Cook, has a counselling background, which proved valuable given the sensitive nature of this topic. The AUT Code of Conduct for Research guided the process of addressing actual and potential ethical issues. Due to the sensitive nature of this research, the interviews might have caused distress for respondents. My workplace, Auckland University of Technology (AUT), had arranged counselling services for individuals participating in research who are eligible for counselling and support if anything in the interview process triggered the need for further assistance. Respondents were provided with details in the information sheet (Appendix C) regarding available counselling support services and helpful websites that outline the legal definitions of sexual harassment.

As a senior nurse, I have supported many colleagues and students who have disclosed sexual harassment in the clinical context. I consider that I have undertaken considerable reflection on this topic by documenting any past experiences I have had with sexual harassment and discussing these with my supervisor. My supervisor debriefed me as needed throughout the research process. I am a robust, competent professional with extensive clinical experience, and as a clinical educator, I mentor students. The Employee Assistance Programme (EAP) was available at my workplace in case I needed further emotional support.

Ample literature demonstrates that individuals engaged in sensitive research can feel empowered when discussing past experiences, and being listened to is beneficial (Dickson-Swift et al., 2008). With sensitive topics, participants can feel they are taking back control by being given a voice in research (Dickson-Swift et al., 2008). The subjective experiences of sexual harassment can be wide-ranging, as some can “brush off” the behaviours, while some may be significantly impacted (Draucker, 2019; Scholcoff et al., 2020). The level of SH may not equate with the felt experience of being harassed; for example, verbal SH can be experienced as impactful as physical

harassment (Draucker, 2019). The intention is that this research can aid NGNs and help employers address workplace issues related to SH by establishing workplace support and education programmes. This, in turn, could lead to increased nursing retention and job satisfaction.

Conclusion

Chapter Three presented the methodology for collecting data for this study, investigating how NGNs addressed SH from patients during the first two years of their post-graduation practice. Other aims were to identify the types of SH new graduate nurses experienced, including whether they reported this harassment, if this SH affected their practice and whether this SH affected their decision to remain in nursing as a career. This section has identified that using a qualitative methodology, specifically an interpretive-descriptive approach, was a suitable method for exploring the above questions. The rationale for using one-to-one interviews for data collection, given the sensitive nature of this topic, was explored. The use of thematic analysis to generate codes and identify themes was described, along with the rationale that even a small study, such as this one, can yield rich data to help answer the research questions. Chapter Four presents the research findings, and Chapter Five discusses the themes and metathemes identified in more detail, as well as defining the recommendations and limitations of this study

Chapter 4 Results

Introduction

This chapter presents the findings from one-to-one interviews with five new graduate nurses on how they addressed sexual harassment during their first two years of practice. The chapter discusses the themes identified from the data and uses word-for-word transcriptions of interview quotes to illustrate the findings. For clarity some parts of the verbatim quotes have been omitted as signified by the use of dots as shown: "….". Square brackets have been used to insert words or parts of words to increase clarity. Using Braun and Clarke's approach to thematic analysis, the following five themes were established: 1) "Did that just happen? It was a shock." 2) "It's taboo, not spoken about" 3) "It changed my practice 4) Expecting respect but making allowances 5) "A culture of silence" – the need for organisational change.

The five participants were Pākehā females, all aged 20-25 years. The participants worked four or five days per week at the time of the harassment, across a variety of areas, including mental health, medical wards, and emergency departments.

"Did that Just Happen? It Was a Shock!"

The NGNs often found it challenging to identify sexual harassment when it occurred. One of the nurses, Tanya, who was an NGN working in a medical ward at the time, noted that sexual harassment is endemic in society, and women are socialised into having high thresholds for naming a behaviour as sexual harassment. She suggested that women seem to accept sexual harassment as part of their everyday lives:

> *I think it's just the culture a little bit. I think it's just part of the job, everyone has sort of come to expect it almost. I mean in everyday life it happens to women. You get yelled out on the street and then at work; it's just an extension of that, right? You know, you're a nurse. You're going to have people being rude to you or being inappropriate. It's just sort of normalised* (Tanya).

The above quote highlighted the resignation of a nurse who experienced sexual harassment and rudeness to women in everyday life. Tanya used language to diminish the impact of sexual harassment, such as "a little bit" and seemed to accept SH as

"normalised". Another participant, Nicola, who had also experienced sexual harassment from patients, found that some harassment could seem quite insignificant at the time, but later would feel uncomfortable. She also noted these incidents are common, but more obvious forms of SH occur rarely:

> *It doesn't always seem big, but when you go away and think about it, it's like, wow, did someone just say that to me?.... it can be slight touching where it looks like it might be an accident, inappropriate conversations… You kind of try to laugh it off, so maybe the big incidents aren't as common, but little comments and little touches are quite common* (Nicola).

As seen in the above comment, Nicola was unsure if SH had occurred until she reflected on the patient interaction afterwards. She highlighted that she often only realised the inappropriateness of a comment or touch later, hence the subversiveness of this SH. Nicola's discomfort was apparent from needing to "laugh this off" and seemingly tolerating the more common "comments and little touches". Even with insidious SH, there seems to be a degree of shock and uncertainty, which could contribute to these situations not being reported. Another aspect the nurses interviewed had in common was their youth. Most NGNs are accepted into their nursing training programs directly from school. This means that most will be in their early twenties when they first graduate, although older individuals also undertake their training. Youthfulness also seemed to be seen as attractive, as Tanya received many comments about her age and attractiveness in the below quote, often from older male patients:

> *I think being a younger nurse, I get a lot of comments, particularly from older gentlemen who I don't think necessarily mean harm by it. But you know, they make the classic like, "Oh lucky me, I've got the young pretty nurse," or that kind of thing* (Tanya).

The above quote suggests that patients and service users are more likely to notice youth and attractiveness than to show respect for nurses' roles and nursing skills. The quote highlighted the tension for Tanya, who had persuaded herself that the patient did not mean harm, resulting in the behaviour going unaddressed. Other forms of SH described were patients and service users glancing at nurses' bodies, brushing against nurses "accidentally", inappropriate comments, and use of innuendo. The example below illustrates that patients looking at a nurse's body sexually or making sexual

comments were more common than overt physical SH. Cathy emphasised that while some patients were mentally or cognitively unwell at the time the SH occurred, others were not:

> *I would say the most common thing I would experience, would be more comments or looks towards certain areas rather than the physical stuff;[but] I've had them like, grab my breasts or grab in my lower areas as well. I've had patients again in psychotic episodes, slapping my behind as well. Once or twice, I've had some male patients not particularly experiencing any [mental health] episode, but just making some inappropriate comments like "Come sit on my lap and warm me up", and those sort of things* (Cathy).

From the above extract, Cathy's use of the euphemism "certain areas" suggests she was uncomfortable discussing how patients or service users viewed her body. Patients looking at her body added to the difficulty of interpreting whether harassment had occurred. Cathy mentioned that some physical and sexual harassment that occurred was due to the patient's impaired mental state, but that this was not always the case. She mentioned another example of a service user speaking inappropriately to her who was not cognitively or mentally unwell at the time. The following excerpt features an account of SH that occurred when Nicola was trying to take a routine assessment:

> *…. he kept talking about wanting [me] to go to the bathroom with him. He wanted me to take him to the toilet and I said…. you're a 30-year-old man, I've seen you walk…..then … he said to me "If you won't go to the toilet with me, we can just do it here" and then proceeded to pull down his pants in front of me. One of the male nurses I was working with saw the situation unfold, and he came and grabbed [rescued] me* (Nicola).

This patient persisted despite Nicola's attempts to de-escalate the situation, including rational appeals and clear boundaries. Luckily, another staff member stepped in, but the situation could have been more serious if they had not intervened. While recalling the incident during the interview, Nicola was wringing her hands, which could have been a sign of distress. This was a situation in which the NGN's body language conveyed a different message from her spoken account, as Nicola's voice sounded calm as she recounted the event.

Another example of an incident experienced by a nurse is shown below. The quote features Tanya's description of how she felt after being confronted with nursing-based pornography:

> *…. one particular resident I went in to say goodbye to him and he [said], " I'm just going to show you something"…. and on his laptop he pulled up some nurse based pornography and I said "That's not appropriate." And then he got quite defensive going…."Why not?" …. and then saying, why had I not appreciated this? But it makes you feel very uncomfortable and unsafe in that particular moment. And you're not really sure how to react to something like that….definitely I was a bit shaken* (Tanya).

This example illustrates how a commonplace interaction not involving intimate care could deteriorate unexpectedly into an experience of harassment. The quote also illustrated that even when nurses tried to 'shut down' behaviours with professional politeness, they may not be able to do so. Across the dataset, there were examples of participants speaking up at the time, and others in which they could only formulate a fuller understanding and response to the event after it was over. In this example, Tanya informed the patient that she did not appreciate this view of nurses. The patient's defensive response to Tanya's objection to being shown pornographic material showed no remorse or insight as to the inappropriateness of this material. Unsaid in this interaction is the discomfort she felt as a professional being viewed in this sexual manner, and the power that patients possess to harass nurses sexually.

All the NGNs interviewed mentioned feeling shocked when they experienced SH from patients. They mentioned it was hard to respond when faced with these unfamiliar situations. In the quote below, Lucy noted how shocked she felt in the interaction she described when caring for a young paraplegic male patient:

> *He required a lot of assistance with personal cares…..he would have spontaneous erections. But in this particular instance he took great delight in, he seemed to get off on the impact it was having on me. And I remember trying to be intentional about not reacting because he was clearly trying to provoke a situation. But certainly there was like a reversal of power - it felt at that time that I became this vulnerable nurse who didn't know how to respond and he had the power in that instance. So I was quite shocked. I don't think I'd seen anything like it that I could recall as a nurse. So, it was a bit confronting* (Lucy).

Lucy noted she felt there was a reversal of power in the situation, and the patient seemed to be trying to provoke a reaction from her. Even though she tried not to respond, inwardly she felt confronted by his behaviour. She described feeling vulnerable and unsure how to respond. Lucy went on to explain that she found the situation very difficult to manage because the patient was both very vulnerable with his level of dependence, yet he was, in effect, harassing her:

> *……. and he would have only been probably about 19 himself. He was in a side room right down the very end, the furthest away. And he required obviously a lot of assistance with personal cares. He was dependent on nurses for everything. And in my naivety, I was learning the ropes, so to speak. The fact that I remember it suggests to me that it's had an impact. The fact that concerns me is that I didn't really know what sexual harassment was in the context of being a nurse* (Lucy).

Lucy noted that this situation had an impact on her, but she felt at the time that she did not understand what sexual harassment was. She showed insight as to his isolation, dependence and youth, but this understanding did not lessen the impact and confusion caused by this situation and her unpreparedness. Other NGNs gave examples of how they felt about providing fundamental care, including intimate care and managing people's naked bodies. They highlighted that managing these intimate cares was a big step and required them to learn to manage their discomfort. The below quote captures new nurse Jessica relating an ongoing situation with a patient who provoked a powerful emotional reaction from her:

> *….and he would start playing with himself [masturbating] while you're in the room and that kind of thing and I felt really disgusted. And he would request that you would help him put his penis in the bottle to pass urine, even though his hands are capable, he's not unable to use his hands or [had] anything wrong with his lower half. And I just found that disgusting, and I remember thinking, if this is what nursing is like, I just do not want to* (Jessica).

Jessica commented she felt disgusted by the situation, and, significantly, navigating this behaviour made her wonder whether she wanted to be a nurse at all. In addition to being confronted by someone masturbating while being expected to provide physical care, Jessica felt taken advantage of by being asked to perform tasks the patient was physically able to do himself. This is an example of another form of

insidious SH where a patient asks a nurse to do something intimate that they could do themselves. Some patients may pretend they cannot attend to their genital care or exaggerate their level of disability to ensure the nurse assists them, as in the above example. Nurses may realise later that this person has taken advantage of them, as the person could perform this care independently on further assessment

Experienced nurses and educators may not realise the impact caring for patients' personal and private care may have on young nurses and the possibility of SH they may face in these situations. This could be because experienced nurses may have become desensitised over time, as mentioned by Jessica in the following excerpt:

> *And like people kind of think, oh, you know, like we see hundreds of bodies, we see several patients a day, particularly in the emergency department and then always seeing them get them in the gown. And I guess that probably normalises bodies and talking about bodies (Jessica)*

As we can see from the above account, even a new nurse has become aware she has become used to seeing nakedness every time she is on duty, to the point where patients are just “bodies”, and it is normal to discuss bodies, including sexual/genital areas. There seems to be a tension between seeing “bodies” and nakedness being normalised when caring for people intimately, but also a resigned acceptance from nurses that this may lead to SH:

> *I've had many different types of experiences, you know, old men [patients]. Me: “Turn onto your side.” You know the accidentally grabbing onto parts of you that maybe they didn't mean to, or maybe [they did], but it still makes you feel quite caught, quite shocked, you know when they accidentally slip a feel* (Nicola).

In the excerpt above, Nicola noted that it was common for male patients to feel parts of her body, and she commented that she gave them the benefit of the doubt as to whether this was intentional. However, she also noted that even if this was not intentional, she still felt shocked when they “accidentally” felt parts of her body. There seemed to be a reluctance to discuss SH, which is explored further in the next section.

“It's Taboo”, Not Spoken About:

Across the dataset, the new graduate nurses described that although they noticed sexual harassment happened frequently, no one wanted to speak about this. As captured in the excerpt below, Tanya noted that SH seemed to be accepted as part of nursing, and there was no education about how to deal with any SH experienced:

> *It happens often but nobody ever does anything about it…. It's not spoken about, taboo, and seen as part of the job, culture and normalised…. no education to keep yourself safe* (Tanya).

As evident from the above statement, Tanya thought SH was happening frequently, but this was not discussed. She also explained it was seen as something nurses must put up with and ignore, and no education was given during nursing training or post-graduation regarding what sexual harassment is and how to navigate this. Lucy commented that she thought part of the reason nobody discussed sexual harassment was that they may feel embarrassed:

> *That's part of the reason you say nothing. It’s because no one talks about it and you think it's just you and you're young and you're naive and, and you're embarrassed. So why would you talk about it? So [I] absolutely 100% think that it's [SH} going on a lot more than we realize* (Lucy).

The quote above shows that Lucy felt new nurses like herself are young and naïve, and that they think they are the only ones experiencing SH. A consequence of SH not being discussed is that nurses, particularly new nurses, do not realise that the behaviours they are experiencing are SH and should not be tolerated. This results in SH being perpetuated as the NGNs are not confident to establish boundaries with patients, report incidents of SH and learn strategies to deal with SH. Cathy described colleagues' reactions to her account of experiencing SH below, and how she learned how to handle sexual harassment in the workplace:

> *Unfortunately, in those situations, when I talk to some colleagues, their initial reaction was to find it amusing and laugh…. When they saw later, I was actually a bit upset; they were more sympathetic…. Everything I learned regarding sexual harassment I just learned on the job…. experienced nurses would say, “Oh yes I had this…I just did X, Y, Z….” nothing formal”* (Cathy).

Again, Cathy minimised her experience ("I was actually a bit upset") and her nursing colleagues laughed. Even when they were helpful, the advice was "Just do this; I have had this happen to me, too." She noted above that she had to learn how to manage SH in the workplace herself without a senior nurse or organisational support. As shown below, nurses can feel shocked and confronted when they are SH by patients. Nicola described a situation below when a male patient dropped his pants and wanted to have sex with her. She noted that in the community, this would be a matter for the police:

> *And yet, it was quite a shocking situation. I was quite mortified by the whole incident….I must have been about 22, and I'd never really experienced anything like that. I was sheltered, very naïve. When I stop and think about it, cause it's not something that would usually happen in the community, and if it did, you know the police would be involved .It would be quite a big incident which the police [would] have to sort out, whereas in the hospital when this kind of thing happens, it's just brushed under the rug* (Nicola).

As this quote shows, Nicola was thoroughly unprepared for this type of behaviour, and the event was traumatic for her. Nicola was aware that if this incident had occurred in the community, the police would have been involved, so she understood the seriousness of the situation. Yet, in the clinical context, there seems to be a sense that the same rules do not apply. She also mentioned that there was no follow-up from the workplace, despite an incident report being filed. Because this incident was not followed up on, Nicola felt this episode was hidden and not dealt with. Similarly, Tanya noted that because it is not talked about, SH is not acknowledged as a problem:

> *People don't really talk about it that much at work…. It's sort of like you don't know what's a problem, so you don't do anything about the problem or people don't want to acknowledge it's a problem. So they don't do anything about the problem. ….later I actually found out it happened to another nurse…..nobody had done anything* (Tanya).

As Tanya mentioned above, if SH is not reported or discussed, then it will continue to be accepted as part of a nurse's role, and nothing will ever change. Even when nurses spoke up about experiencing SH, this may still be unreported, and new nurses need encouragement by senior nurses to fill out incident forms. The following incident occurred when Jessica was being orientated in her first two weeks in a new ward:

> *He placed both his hands right on my breast and fortunately I was very, very, lucky that the mature nurse had a voice and told him "that's really inappropriate. You're not to touch people like that, don't you ever touch females like that", And I'm so glad she was a seasoned nurse that had a voice. I'm so grateful to her. It's sad though, I also feel perhaps she should have said something to my colleagues. I haven't told any sort of management. I was quite new and I didn't want to make waves when I just literally entered the workplace. Maybe she didn't want to make a mountain out of a molehill* (Jessica).

From the situation described above, the experienced nurse role modelled an appropriate response to the inappropriate behaviour, which, according to the Human Rights Act 1993 s 62 would be classed as sexual assault. Jessica was grateful for the senior nurse's response, but she did not seem confident enough to report the incident herself, being so new. It seems she would have liked support in formally reporting the incident. Jessica used phrases like not wanting to "make waves" and thought the senior nurse did not want to make a "mountain out of a molehill", which minimised the severity of this event. However, this situation was serious and should have been reported. The lack of institutional support was also evident in Nicola's interview, where she mentioned the lack of guidance and debriefing after experiencing an incident of SH:

> *No one guided me or anything, just the male nurse assisted to diffuse the situation but then it wasn't really spoken about, to talk about. I know we're nurses and we look after people. We see body bits, all the body parts all the time, but to actually talk about someone pulling down their pants and masturbating in front of you, it's still quite a taboo subject to talk about and it's not something that you discuss in the nurses station with your colleagues to kind of have a debrief because it is a bit of an awkward conversation to have* (Nicola).

It can be noted from the above account that despite noting nurses being familiar with bodies and implied nakedness, Nicola was not comfortable discussing the fact that a patient was sexually inappropriate in front of her, and she felt awkward about this. The male nurse helped her in the situation, but then nothing more was said. Cathy mentioned below that when sexual harassment was discussed with senior nurses, the SH was minimised:

> *Just having talked to some nurses they'll just sort of casually mention like, oh, yeah, this happened to me and it's just brushed off as like, oh,*

> *it's part of the job and it's when you think about it, in any other workplace that would be completely unacceptable* (Cathy).

From the above quote, the seeming acceptance of SH was noted, but, as Cathy pointed out, in other workplaces outside nursing, this SH would be unacceptable. The NGNs seem to imply that nursing as a profession accepts a certain amount of SH, and this may be linked to nurses' familiarity with “bodies”. What is significant in the above examples is that, even when colleagues stepped in to support the new graduates, it was only in-the-moment support, without any follow-up to mitigate future harassment and/or ensure the perpetrator is held accountable.

“It Affected my Practice”

Most of the nurses interviewed noted how experiences of SH affected their practice. Jessica described below the physical and emotional symptoms she experienced because of SH she experienced in the area she worked in:

> *I don’t suffer from anxiety, but I get really nervous….. I have increase in my heart rate. I can’t concentrate. My eyes are like constantly sort of moving around assessing my area because I feel so unsafe….. and I lose my mind. There was one point where I was just like, honestly, I just want to go home. But I couldn't explain that to the charge nurse, obviously. So I feel like that's really affected me and my workplace. I’ve only been a nurse for about four years now. But I've really had a few incidences where I felt sexually harassed in different ways* (Jessica).

Jessica described how she felt because of different experiences of sexual harassment, detailing physical symptoms such as an increased heart rate and increased watchfulness in her surroundings due to feeling unsafe. Emotionally, she stated she felt unsafe and wanted to go home when she was at work. She identified that experiences of SH had affected her and how she felt in her workplace. Of concern, despite her sustained level of hyper-vigilance, Jessica did not consider it reasonable to talk to the charge nurse. These long-term impacts of SH were also noticeable in Nicola’s account of feeling upset for weeks after she experienced SH:

> *I did have to talk to my mum about it because I was quite upset for a few weeks and I didn't get any support from work about it. It's definitely stuck with me like this was four years ago and I still know what happened. I can still remember what he did* (Nicola).

The above quote illustrates, first, the lack of support from her workplace, even though this SH experience was reported. Neither of the nurses above felt they could talk to other senior nurses about their experiences. Second the above quote also shows the effects she felt for some time after the incident, as she said she was still upset "weeks later". It is significant that Nicola stated she "had" to talk to her mum, showing initial reluctance to discuss the SH. She minimised how she felt by using the words "quite upset". Finally, it is also noteworthy that four years later, the memory of the incident is still clear in her mind, which shows the long-term effects she experienced from this distressing incident. While these accounts of a lack of support from management were common in the data, there were also stories that feature management getting involved. In the below example, Cathy reported the physical SH she experienced to senior nurses, and they did take it seriously:

> *Those occasions where it was a physical interaction, I did tell my manager at the time; the charge nurse or the acting charge nurse. They did take it more seriously and they would have me do an incident report about it* (Cathy).

As described above, Cathy only seemed to report physical experiences of SH to senior staff, not verbal experiences, though those instances could also be reported formally. She noted that senior staff took physical instances of SH more seriously, suggesting that non-physical SH was not taken as seriously. She was encouraged to do an incident report, reinforcing the seriousness of the situation she experienced.

Nicola gave an example of how a previous instance of SH she experienced made her cautious in positioning herself in the room with patients:

> *The first situation where I got cornered in the room it definitely made me change the way I would stand in certain people's rooms or bed spaces and just to make sure I always kind of had an easy route out if I needed that. I also for a while was a bit anxious about looking after certain men that were detox [or]coming in with a mental health crisis because I didn't want to be put in a situation like that again* (Nicola).

As can be seen in Nicola's statement, she became careful about where she stood in patients' rooms or spaces, ensuring she could not be cornered, as this had happened in previous SH experiences. She also mentioned she felt anxiety looking after men who had mental health problems or who were detoxing with alcohol withdrawal, though

she diminished the anxiety by saying she was a “bit anxious”. She explained how she prevented herself from being put in a situation where she could experience SH again, to feel safer.

As mentioned previously, the NGNs appeared to have had to develop their own strategies to address SH based on past experience. Cathy mentioned she became more guarded in her nursing practice with patients due to past instances of SH experienced:

> *Just with the nature of the work you tend to give a lot of yourself. I think that with those experiences, I did tend to put up more of a guard with patients. I learned over time about keeping a certain distance and watching what I say. I actually never realized this. I used to wear makeup every day to nursing, but after I started getting those comments, I stopped because I didn't want to look a certain way I guess* (Cathy).

From the above observation, Cathy identified that nurses give a lot of themselves in their day-to-day practice. She noted that after experiencing SH, she “put up a guard” and became more careful with what she said, as if what she said could be misinterpreted as inviting sexual comments. She became more careful and learned to maintain a safe distance from the patients. She noted she became more conscious of the way she looked and stopped wearing makeup as she seemed to associate looking attractive with receiving unwanted comments of a sexual nature, which could seem to imply she felt she was to blame. The use of strategies to make her less attractive to avoid SH was also discussed by Jessica:

> *I certainly make sure there's other people in the room if I'm going to help a guy with toileting, where I feel like maybe [they’re] inappropriate. Like you've got use of your hands, you can do it. Yeah, I just sense it [past SH] has affected my care and I think it's sort of changed the way that I physically appear at work now as well. It may sound ridiculous, but I always wear my cardigan.I feel disgusting - I just feel like it's an extra layer. People aren't going to look at my body shape, and if there’s a row of shifts I'll never wash my hair a few days beforehand. So it's greasy. And I'll always wear my glasses-(when I'm out of work, I never wear my glasses)- just to try and make me not an attractive person, because I don't want that attention* (Jessica).

In the above statement, Jessica noted that she asked other staff for support if she felt unsafe with a patient during intimate care, and that she ensured patients who were

capable attended to their own needs. She also went out of her way to avoid appearing attractive, as she did not wish to attract inappropriate attention. This seemed to imply that she felt the way she looked could invite sexually inappropriate behaviour from patients. It seemed like she wore her cardigan like armour, concealing her body, and she also wore her glasses to protect her face and reduce her attractiveness to patients. She also noted that past SH affected how she cared for her patients, and her example of ensuring capable patients attended to their needs showed that she has learned to assert herself to protect herself. As shown in the quote below, Nicola noted she had grown in confidence and could inform patients that their behaviour was inappropriate as she gained more experience:

> *I also had an experience happen after that situation and I feel like I'm now in a place where I can actually say "I don't like the way you're talking to me" or "I think it's inappropriate and I don't think that you should do that".So my communication skills have gotten a little bit better and [I'm] more happy to stand up for myself. I don't know if that's to do with the situation in particular or if it's just that I feel more confident in my nursing practice and you know I'm no longer 22, I'm 26* (Nicola).

In the above example, Nicola commented that she had gained confidence from her past experiences and could now inform patients that their behaviour was inappropriate. She still did not sound completely confident, noting that her skills had become "a little bit better" and that she was "happier" to stand up for herself. Her youth was apparent, as she was still in her twenties. The excerpt below from another interview features Cathy, who had also developed coping strategies from her past experiences of SH:

> *I mean you've got whakawhanaungatanga, sharing[with] each other and that's very important in building the therapeutic relationship. That doesn't mean you have to give everything of yourself…. You're entitled to keep a piece of your privacy and your dignity. I feel a lot more confident in actually being able to stand up for myself in the moment as well as talking to people [in charge] afterwards. That's not something I was good at.As a new grad with the patients, say with comments, I'd sort of just laugh it off or say like, oh, no, we're not doing that,[Or] leave the situation rather than actually saying, no, that's not acceptable, you can't do that. So I feel a lot more confident putting a stop to it in the moment* (Cathy).

As her statement indicated, she experienced tension between developing a caring relationship and stopping inappropriate behaviours. She stated that she could maintain her dignity by setting appropriate boundaries. She described how she had developed the confidence to "stand up for herself" when faced with inappropriate patient behaviours, as well as seeking guidance from senior staff. She noted her way of dealing with SH when she was a new nurse was to "laugh it off", but with experience, she now can tell patients their behaviour is unacceptable and stop this. In the below comment, Tanya described conversations staff had about SH and strategies to deal with this:

> *In, like a joking context, you know, we all talk about our patients; "this room is a bit handsy sometimes" or "this patient can [be] inappropriate". When we sort of discuss it as colleagues, the oldest staff will tell you, "Make sure you're firm with them", and they sort of set boundaries, but then…. I think it's just so ingrained. We all just sort of go, "haha, that's a shame" or, "oh, well, better be careful with that patient" kind of thing. People don't treat it like it's a problem* (Tanya).

Tanya reported that senior staff offered some helpful strategies to younger staff when the topic of SH was discussed, such as "be firm" and "set boundaries". However, as already identified, the strategies typically focused on the individual nurse learning to manage the behaviour rather than on a wider organisational response. Furthermore, the quote suggested that humour was used when discussing situations in which SH was experienced by nurses, such as describing a patient as "handsy". From the above quote, it seems that Tanya considered humour dismissive of SH's impact, implying that SH was seen as funny. Lucy also discussed the use of humour in these situations:

> *You'd hear nurses make comments and use humour as a way of coping, so they would describe the individual or the individual's body parts or behavior so it [was] turned into some sort of joke. And it was kind of a way of defusing the situation* (Lucy).

Lucy mentioned that humour was used when nurses discussed SH, noting that it was a way of coping with these situations. She noted that humour was a way to defuse the situation when discussing an incident of SH with other nurses later regarding the individual and their behaviour. The use of humour seemed to make nurses more comfortable discussing SH, revealing possible underlying embarrassment.

Expecting Respect but Making Allowances

Most participants said they did not expect to experience SH from adult patients. Hence, these instances contributed to the shock they felt when they experienced these behaviours identified in earlier examples. Tanya noted below that she had expectations that patients would treat nurses with respect and should know not to treat them inappropriately:

> *In a general hospital setting, you know these people are all grown adults. Most of them have capacity to understand. You know when you tell them that that's not OK, they should know. And if they continue to ignore that, then you know, like that's not on them [the nurse] That's on the patient. I think a lot of times it's, you know, put back on us. What could we do differently? But actually it's not their [the nurses] fault* (Tanya).

As the above shows, Tanya identified her expectation that adult patients should treat nurses respectfully. She noted most patients had the capacity to understand, referring indirectly to some patients who may have cognitive problems or other conditions that reduced their understanding of what appropriate behaviour towards nurses should be. She also noted that it was not the nurses' fault if a patient was sexually inappropriate to them, and she felt that, at times, it was put back on the nurse to be "different" in their care to prevent SH. Nicola commented below that she also felt the need to keep herself safe was part of her responsibility, although she identified that nurses should be respected, as they are simply doing their job:

> *It's most important to keep yourself safe in situations like this but to also be aware that it can happen because, like I said to you earlier, you know when I was 22, fresh into the hospital, I didn't really know that these things happened. And you know, you're a nurse. We're supposed to be respected…..like you're doing your job? You're literally just there to do a job* (Nicola).

Inherent in the above quote was her realisation that the SH she experienced showed a lack of respect. She noted that, because she was so young when she was a new nurse, she had not experienced SH before or expected it. Contrastingly, in the quote below, Cathy showed understanding when she experienced SH from patients or service users experiencing mental health or cognitive problems. Cathy showed awareness that, due

to working in the mental health setting, she was aware that patients could be cognitively or mentally unwell, which could contribute to inappropriate behaviour:

> *Due to the nature of working in inpatient mental health with people with cognitive impairments, as well as people suffering from severe psychosis - I can understand what's happening….those patients weren't in their right state of mind and afterwards, when they had recovered, they didn't remember any of it, and one of them actually said " I'm sorry if I did anything when I was in that state, because I know I'm not the same person". I know that if I'd wanted to, I can actually press charges. In those situations, I didn't think it was appropriate because it's not really their fault* (Cathy).

In this excerpt, Cathy expressed understanding towards patients who had sexually harassed her, as she realised in those instances they were cognitively or mentally unwell and were not in control of their behaviour. However, Cathy pointed out the severity of the SH she experienced by noting that if they had demonstrated the same behaviour when mentally sound in mind, she could have pressed charges as the offending was a physical sexual assault. In the example below, Nicola described other reasons that may contribute to a patient sexually harassing a nurse

> *I had a patient in the monitored area who was in his mid-30's and he was coming in to hospital to detox from alcohol. He had ongoing issues at home with losing his mum and losing his long term girlfriend and he just started drinking a bottle of vodka every night….so coming in for medical management after his fall …..So I think does he have the capacity to really understand what he was doing?..... that was kind of the whole issue that came about [from] the situation as he was hallucinating with his detox* (Nicola).

Nicola acknowledged the patient's background and contributing factors causing him to drink heavily as a way of coping, resulting in his admission to the hospital. One of the effects of his detoxing from alcohol was hallucinations, which, as she noted, reduced his capacity to understand her refusal to go to the bathroom with him to have sex. However, whether he had reduced capacity mentally or not, this did not diminish the incident's effect on her, as she noted earlier that this SH bothered her for weeks, and she still remembered it vividly years later. Cathy explained below how she tried to help patients, but due to their altered cognition, they grabbed her inappropriately:

> *Sometimes when you're trying to do cares for them or just helping with mobilizing or things like that, they'll in retaliation - I can*

> *understand what's happening - they think you're an enemy of some sort and they don't understand you're there for them. I've had them like, grab my breasts or grab my lower areas as well. That's why we try as much as possible to form a therapeutic relationship and have a mutual respect* (Cathy).

In the interview, Cathy demonstrated empathy and understanding in her description of trying to help patients and was aware of their cognitive struggles. Despite the physical SH that occurred, she explained that she still tried to form a relationship with the patient and remained respectful. She remained professional and described how she attempted to maintain mutual respect despite the person sexually grabbing her body.

"A Culture of Silence" – The Need for Organisational Change

Most of the nurses interviewed mentioned their concern that other new graduate nurses could also experience SH. As shown in the example below, Nicola noted the complexity of the nurse's role and the difficult scenarios nurses face, which most people outside of nursing never have to deal with:

> *Because as a young nurse, you do deal with things that a lot of people never deal with in their entire lives. Now that I'm an educator and I'm educating young, not just young nurses, but I have a lot of young student nurses that are in their early 20s, my heart, kind of I feel for them. I'm like ohh it's just a scary world out there in the nursing world. And I know that it can take a toll on a lot of people, it definitely took a toll on me early on in my career* (Nicola).

In the excerpt, Nicola mentioned that she was now educating student nurses, many of whom were young, and that she felt for them, as, from her experience, the world of nursing was scary. She noted that some of the experiences she faced, such as the SH described earlier, took a toll on her emotionally when she was new to practice. Lucy also mentioned concerns for NGNs, most of whom are young:

> *I would say the majority of new graduates [nurses] are young. They're still highly female dominated, even though there's males [too] and males are not excluded from [SH] risk. Something about them being young and vulnerable and naive, I think makes them a target. I don't think that this instance [of SH] that I talked about would have happened with an older nurse. Because this clearly felt like [I was] a target. I was a target because I was young and naïve* (Lucy).

Lucy stated she thought new nurses were vulnerable to the risk of SH as they are often young, female and naïve. She pointed out that males are still at risk, but there are not as many of them nursing. She thought being young made new nurses a target for SH, and thought older nurses would be less likely to have these experiences. In the following example, Cathy summed up the possibility of SH and the advice she would give to new nurses:

> *I would say it [SH] does happen, and not to let anybody tell you that it has to be these major incidents like being grabbed or touched. It can be anything that you're not consenting to and is inappropriate, like comments and looks, and not to be afraid to actually tell your manager about so you can be protected. Also not to feel bad or guilty about putting a stop to it in the moment, and not to think that it won't ever happen to you, whether or not you think you're an attractive person or not, and even it could happen with a patient who you think you get along with or you really like* (Cathy).

Cathy said she would encourage nurses to report any SH they experienced, whether physical or verbal. She also suggested that NGNs should be assertive and stop SH as soon as it happens. She made the point that SH can happen to anyone and highlighted that it is not about what you look like. She also reinforced that it was not the nurse's fault if they experienced SH from anyone. As illustrated by the following excerpt, Jessica also felt strongly that she would support other nurses, especially new graduates, to discuss any SH they encountered and resist SH being described as“taboo”:

> *I would try and educate them .But if I were to give them just advice, I would say try not to make it so taboo. It's very common. To reach out and stand up against it. And you're definitely not alone .I'm here, I will back you 100% and we can go speak to the counselling services together and we can come up with a good plan, and speak to management. You're not alone and I'm here. Physically, I will be here and emotionally too* (Jessica).

The above comment shows that Jessica wanted to support new nurses in standing up against any SH they might experience. She also encouraged them to go to counselling to report SH to management and said she would go with them. She stated she would support NGNs emotionally and be present for them. Ironically, Jessica stated earlier in her interview that she did not feel she could attend counselling and wished senior staff had supported her in reporting the SH she experienced. However, she identified that

she wanted to help make changes and support nurses who experience SH. The earlier comments showed that most NGNs felt they had to keep themselves safe and deal with SH independently. Lucy commented below that all nurses should feel they have the space to be supported to discuss sensitive topics safely:

> *I don't think it should just be on us. I think that if people were provided the space to feel that they have a safe place to disclose sensitive topics, experiences, debriefing,[but] that doesn't happen for things that are not even related to sexual harassment. If there is a culture of silence, then people are more likely, I think, to take ownership. I don't think it is right. I think the responsibility should be from superiors, to ensure that new staff are equipped with the knowledge and to have options* (Lucy).

In the above excerpt, Lucy identified that "superiors", such as senior nurses, educators, and management, should be responsible for encouraging staff to discuss any distressing experiences, including SH. Otherwise, she noted that a culture of silence could develop, which is not supportive, as staff have a right to work in emotionally and physically safe workplaces. She also identified that when support at a management level was unavailable, nurses took ownership and felt responsible for either inviting or failing to manage SH instances. Jessica noted below that nurses should be educated on SH and how to respond to SH throughout their training:

> *I would really like it if at some point in nursing or student nursing or in your new grad[uate] year that you actually had not just a one-off class or a one-off talk but it would be integrated throughout what sexual harassment is, because there's so much, there's such a wide variety* (Jessica).

As seen above, Jessica stated that nurses should be educated on SH and how to respond to any SH during their nursing training. Some of the NGNs interviewed said that education on sexuality and SH should start in their first year of nursing, before students go on their first clinical placement. Participants considered that experienced nursing educators should be aware that students and other nurses could experience SH. However, as illustrated in Nicola's comment below, this may not be mentioned:

> *I feel like the hospital and maybe the university might not wanna highlight that it (SH) is a problem in the workforce…..it could be in a lecture to say before you go out to clinical, this is something you might face and how you could potentially work through it. It would*

> *be really useful to have an education day on how to manage situations like this. For example, we have education at the hospital for everything apart from how to manage sexual harassment in the workplace (Nicola).*

It seems from the above quote that nursing training institutions and workplaces are not educating nurses about the possibility of encountering SH, nor are they providing strategies to address it. There may also be the possibility that student nurses, young or more mature, have experienced SH or abuse before their training, as indicated in the quote below:

> *I've been sexually assaulted outside of work as well. And I think people don't realise that….. it can become a trigger for people. I'd like to think that would have affected me differently if I had proper talking [training] about it [SH] and not just a one off sort of lecture, like, make it normal to [discuss]* (Jessica).

As Jessica mentioned above, she thought it would be helpful for experienced nurses to be aware that any SH could adversely affect students and NGNs, as they may have experienced SH previously. This previous SH experience could have occurred in a professional or private setting and may trigger adverse emotions. She also stated that training could have helped her cope better with the SH she experienced in practice and may have empowered her to make a formal incident report despite not receiving any support from senior nurses.

From the dataset, it can be noted that many of the new graduate nurses felt unprepared and shocked at the sexual harassment they experienced from patients. From their accounts, there was very little support from senior staff, and even if these incidents were formally reported, there was little or no follow-up for emotional support. The nurses noted they felt disrespected by patients and surprised that they were not seen and respected as professionals.

Most of the NGNs noted reluctance from other staff members to discuss sexual harassment, and if SH was mentioned, it was in a dismissive way or humour was used to "laugh this off". The NGNs noted that their experiences of SH affected how they cared for their patients, as they became more aware of their own safety and some questioned whether they wanted to continue nursing as a career. Most of the NGNs noted they had not received any education about sexual harassment during their

nursing training or after they graduated. The NGNs identified that education on what SH is and on strategies to address it would be useful, along with encouragement and support to report it.

Summary

This chapter presented the findings of a qualitative study that explored how five new graduate nurses addressed sexual harassment by patients during the first two years of their post-graduation practice. It identified the types of SH the NGNs experienced, including whether they reported this harassment. It explored whether this SH affected their practice and their decision to remain in nursing as a career. It also explored the education and support they received, as well as the support they expressed they needed, after experiencing SH. The dataset highlighted that the new nurses felt unprepared for any sexual harassment that occurred from patients, and when this did occur, they were unsure whether to report this or not. This ambivalence regarding reporting SH was reinforced by limited, if any, responses from senior colleagues and the absence of clear pathways for making complaints. There was limited, if any, follow-up, even if incident forms were completed. The data showed there was a culture of silence and stigma surrounding SH, and no one felt comfortable discussing SH, even senior nurses. Significantly, the participants' experiences highlighted a detrimental impact on their desire to continue nursing, as they felt disillusioned by a lack of preparatory education and inadequate interventions by senior nurses.

The following themes highlight the complexities they faced in practice when confronted with SH behaviours from patients were identified through thematic analysis: 1) “Did that just happen? It was a shock,” 2) “It’s taboo, not spoken about,” 3) “It changed my practice,” 4) Expecting respect but making allowances, 5) “A culture of silence” – the need for organisational change.

Each theme was explored using verbatim quotes from the interviews. The dataset highlighted that the new nurses felt unprepared for any sexual harassment that occurred from patients, and when this did occur, they were unsure whether to report this or not. This ambivalence regarding reporting SH was reinforced by limited, if any, responses from senior colleagues and the absence of clear pathways for making complaints. There was limited, if any, follow-up, even if incident forms were

completed. The data showed there was a culture of silence and stigma surrounding SH, and no one felt comfortable discussing SH, even senior nurses. Significantly, the participants' experiences highlighted a detrimental impact on their desire to continue nursing, as they felt disillusioned by a lack of preparatory education and inadequate interventions by senior nurses.

Chapter 5 Discussion

Introduction

This chapter provides an overall synthesis of the study and further examines the meta-themes in more depth. It also discusses the study's limitations and identifies recommendations for further research and practice.

This qualitative study investigated the question: How do new graduate nurses address sexual harassment from patients during the first two years of their post-graduation practice? It has identified the types of SH five new graduate nurses experienced, including whether they reported this harassment, if this SH affected their practice and whether this SH affected their decision to remain in nursing as a career. It also explored what education and support they received or expressed they needed after experiencing sexual harassment.

Following individual face-to-face interviews, thematic analysis of the transcribed interviews identified five main themes: 1) “Did that just happen? It was a shock;”2) “It’s taboo, not spoken about;” 3) “It changed my practice;” 4) Expecting respect but making allowances; 5) A culture of silence” – the need for organisational change.

Study Overview

This New Zealand study highlights that sexual harassment continues to be a commonplace part of the nursing experience. The findings illustrate the range of harassment that these NGNs experienced, some from relatively subtle behaviours including words, looks and possibly accidental touch. The NGNs often second-guessed their interpretation with these subtle behaviours. However, other SH behaviours ranged from verbal overtures to overt physical assault. Despite the consciousness-raising of the # MeToo movement internationally, the study concerningly indicates that there is a degree of organisational complacency and tolerance of sexual harassment as an inevitable part of nursing. The study findings highlight the limited education, leadership and formal response pathways when harassment occurs. Without guidance, participants expressed confusion about maintaining professionalism when responding to harassment from individuals deemed vulnerable. Of note,

recruiting for this study was a significantly prolonged process, with some potential participants considering that their experience was not “bad enough.” This point is significant because it indicates that nurses, as a feminised workforce, may have developed a tolerance for harassment in their earlier and broader life experiences. These points are explored in detail in the discussion of the meta-themes below, drawing on the broader literature. The chapter then addresses the study’s limitations, provides practice recommendations, and offers suggestions for further research.

Transition Shock and Sexual Harassment Implications

This research found that NGNs began their careers with enthusiasm for patient care and relationship-building but faced challenges when the realities of practice clashed with the ideals they had been taught. Their experience of these challenges aligns with Duchscher and Windey’s (2018) concept of transition shock, where NGNs move through stages of doing, being, and knowing, often experiencing emotional, intellectual, and physical discomfort as they adjust to the realities of clinical practice. However, nurses in this study who experienced sexual harassment experienced further stress and questioned their nursing career choice. This finding supports previous research, which suggests that if nurses experience SH, it can significantly increase distress, reduce job satisfaction, and impair performance (Lu et al., 2020; Minton et al., 2018; Worman & Nimkar, 2023). The interpretation of these findings suggests that SH is not just a personal issue but a systemic barrier to workforce retention, particularly for NGNs navigating the vulnerable early stages of their careers. These compounded pressures may contribute to early attrition or NGNs shifting to other nursing roles, as noted in the literature (Draucker, 2019; Hawkins et al., 2019; Ross et al., 2019).

Findings from this study indicate that nurses experiencing SH may question whether they wish to remain in nursing and are at a greater risk of leaving the profession. Despite NGN’s potential to alleviate nursing shortages, early nursing attrition is well documented (Hawkins et al., 2019; Mammen et al., 2023; Wakefield et al., 2023). However, the impact of SH on this decision has not been fully explored. A New Zealand study by Walker and Clendon (2018) found that workplace concerns—particularly the absence of managerial support—were among the most common reasons nurses left the profession. These findings highlight the need to support New Zealand-trained NGNs by creating safe environments where SH can be discussed openly. Interpreting

these results suggests that addressing SH is not only a matter of individual well-being but also a strategic priority for national workforce sustainability. The current study's findings identify the need to support New Zealand-trained new graduate nurses by encouraging them to report instances of SH. Ensuring they have the training and support to manage SH could help address factors that lead to early attrition.

Silence and Normalisation of Sexual Harassment

This study shows that SH is rarely discussed in the workplace, and the subject is often perceived as taboo. This silence has not been widely acknowledged in previous literature, which has focused more on the long-term emotional and physical effects of SH (Grigorovich & Kontos, 2019; Hawkins et al., 2019; Jamieson et al., 2023; Mammen et al., 2023). This silence seems to occur despite SH being endemic within nursing for decades (Lu et al., 2020; Parke et al., 2023). Participants in this study suggested that SH is normalised within nursing culture, possibly due to persistent gender bias and the predominance of women in nursing, a finding that aligns with previous research (Parke et al., 2023; Smith et al., 2023). Despite broad recruitment efforts for this study, only women participated, and some of those who did participate expressed embarrassment and fear of being perceived as "not coping" at work, which discouraged them from reporting SH. The finding of SH being "taboo" suggests that the normalisation and dismissal of SH contribute to a culture of silence, reinforcing the need for leadership and education that empower NGNs to speak up and be supported.

The findings show that when NGNs discussed SH, their concerns were often downplayed by senior nurses, sometimes accompanied by laughter. These responses diminished the seriousness of their experiences and contributed to feelings of isolation. Research has shown that younger nurses are more vulnerable to SH (Mammen et al., 2023; NZNO, 2019; Smith et al., 2023). Humour, while sometimes used as a coping mechanism (Bruschini et al., 2023; Minton et al., 2018; NZNO, 2019; Parke et al., 2023; Smith et al., 2023), can also invalidate distress. The paradox of nurses regularly providing intimate care yet avoiding discussions of SH reflects a deeper cultural issue. These findings suggest that experienced nurses may still be embarrassed to discuss SH or may become desensitised to this over time, leading to a lack of transparency and support (Bruschini et al., 2023; Flynn, 2019; Neilsen et al., 2017). By noting this, it becomes clear that nursing leadership must foster open

dialogue and model appropriate responses to SH to support both NGNs and experienced nurses effectively.

Nurses Internalising Culpability

A significant finding from this study showed that experiences of SH led some NGNs to change their appearance and the way they interacted with patients to prevent further harassment. Some avoided wearing makeup or styled their appearance to seem less attractive, reflecting a misplaced sense of blame. This aligns with the literature, which notes that victims of SH often internalise blame (Bruschini et al., 2023; Grigorovich & Kontos, 2020). Another reason some NGNs changed their appearance to seem less attractive could be due to the ongoing gendered nature of objectifying women, which may be a contributing factor to sexual harassment of the predominantly feminised nursing workforce. Nurses continue to be portrayed in the media as doctors' handmaidens, as "angels" or conversely as sexual objects, rather than as highly skilled professionals, and this issue has been discussed in the literature for decades (Gill & Baker, 2021; Ross et al., 2019; Smith et al., 2023; Stokes-Parish et al., 2020). The caring nature of nursing, which involves close physical contact and emotional support, may contribute to misperceptions of nurses as sexual objects, increasing their vulnerability to SH (Gill & Baker, 2021; Ross et al., 2019). Nurses also care for patients and whānau during times of physical, cognitive, and emotional distress, which further heightens the risk of inappropriate behaviour as altered cognitive and mental health decreases inhibitions (Parke et al., 2023; Smith et al., 2023). Despite patients being the primary perpetrators, there are often no consequences for their actions, and nurses are expected to tolerate such behaviour (Bruschini et al., 2023). The wider literature emphasises the importance of enforcing consequences and ensuring nurses are treated with respect (Cranage & Foster, 2022; Ross et al., 2019; Smith et al., 2023). These findings suggest that, without organisational support from employers, NGNs may be responsible for ensuring their own safety at work.

The Paradox of Professionalism

This study offers new insights into the ethical tensions that NGNs encounter when responding to SH. While they maintained professionalism by using de-escalation language such as "that is inappropriate," these responses were not always effective in shutting down undesired behaviours from patients. Unlike social settings, where

stronger reactions might be acceptable, nurses, especially female staff, felt constrained by professional expectations (Burgess et al., 2018; Scholcoff et al., 2020). Delgado et al. (2017) identified the emotional labour of nursing practice, in which nurses must manage the physical, emotional, and psychological complexities of working with patients and their whānau. It was noted that managing difficult emotions in clinical settings and suppressing them while remaining professional can lead to emotional dissonance (Bruschini et al., 2023). Ongoing management of these varied stressors can lead to stress and burnout (Delgado et al., 2017; Hogan & Drentea, 2023). In this study, the NGNs described learning to keep themselves safe by enlisting help from colleagues when they anticipated risky situations based on prior traumatic experiences of SH. Hogan and Drentea (2023) found that nurses' well-being has been affected by increasing workloads and the organisational emphasis on patient satisfaction. These findings regarding increasing workplace stressors further underscore the need for formal training before new nurses are exposed to the extra stress of SH, as well as for effective reporting and support systems to be in place. NGNs require both ethical guidance and practical strategies to navigate SH, thereby maintaining their professional integrity and decreasing stress and burnout.

The study showed that NGNs who experienced SH often made allowances for patients who were cognitively or mentally impaired. This pattern was also noted by Grigorovich and Kontos (2019) in their ethnographic study of how care providers and supervisors responded to SH from residents. Grigorovich and Kontos noted the paradox that patients with mental health and cognitive conditions are vulnerable, but at times have unpredictable power due to aggression or inappropriateness (Grigorovich & Kontos, 2019). In a sense, these patients cannot be held accountable, but at the same time nurses have the right to be physically and emotionally safe in practice (Grigorovich & Kontos, 2019). Additionally, the NGNs in this study felt uncertain about how to respond when SH was experienced by patients with no clinical justification for this behaviour. This tension has also been noted in previous literature, which highlights the complexity of interpreting intent and managing SH in healthcare settings (Grigorovich & Kontos, 2019; Scholcoff et al., 2020). Interestingly, participants described SH occurring not only during intimate care but also in routine interactions, suggesting that harassment is not confined to specific clinical contexts. Despite the shock and

discomfort, NGNs frequently minimised these incidents, prioritising patient needs over their own safety and emotional well-being, a pattern also observed in earlier studies (Grigorovich & Kontos, 2019; Mammen et al., 2023; Scholcoff et al., 2020). These findings suggest that the ingrained culture of self-sacrifice in nursing may contribute to underreporting and the internalisation of SH, reinforcing the need for clearer guidelines and support systems that validate nurses' experiences and promote respectful care environments.

Patient Rights Eclipse Those of Nurses

This research identified that the NGNs interviewed for this study were committed to delivering safe, professional, and therapeutic care and expected to be treated with respect by patients in return. When SH occurred, particularly in cases where patients did not have cognitive or mental impairments, participants felt deeply disrespected. This tension between professional expectations and patient behaviour reflects a broader issue in nursing, where relational care is central, yet education on managing relational abuse remains limited. Nurses in Aotearoa New Zealand are trained to uphold the Code of Health and Disability Services Consumers' Rights, outlining health consumers' 10 rights, one of which mandates that all patients be treated with dignity and respect (Health and Disability Commissioner [Code of Health and Disability Services Consumers' Rights] Regulations 1996). While this principle promotes patient-centred care, it may inadvertently obscure the power dynamics nurses navigate, especially when facing inappropriate behaviour. Phillips et al. (2019) found that Canadian medical students did not perceive themselves as holding power in clinical interactions, suggesting that health workers minimise power imbalances. There was also a suggestion that SH may sometimes be an unconscious attempt by patients to rebalance perceived power imbalances in their favour (Phillips et al., 2019). As noted in the literature review, SH can often be about a male patient asserting their power, and younger females seem to be vulnerable to this type of SH (Phillips et al., 2019). These findings underscore the importance of nursing education in providing clear guidance on identifying and managing SH, as well as reassuring NGNs that they will receive support when such incidents occur.

The Need for Systemic Change and Organisational responsibility

This investigation shows that NGNs identified a pressing need for organisational change in both nursing education and workplace culture to address the persistent silence surrounding SH. Participants expressed that education about what constitutes SH and how to manage it should begin before their first clinical placement during training. This finding aligns with Smith et al. (2023), who noted in their integrative review that students and senior staff believed education on strategies and de-escalation techniques was needed in situations where patients behaved inappropriately. Jamieson et al (2023) demonstrated that many NGNs reported that physical harassment was acknowledged by senior staff, while verbal and insidious behaviours were often dismissed. Research continues to show that many organisations lack clear policies and strategies to address SH effectively (Ross et al., 2019). This reflects broader challenges not only in nursing leadership but also for organisational leaders, where SH remains a pervasive issue across healthcare and other industries (Lu et al., 2020; Ross et al., 2019; Smith et al., 2023). These findings underscore the urgent need for comprehensive education, robust reporting systems, and an organisational leadership that actively supports nurses in confronting and managing SH.

The findings show that the NGNs in this study felt a significant lack of support after experiencing SH, both from senior colleagues and management, even when incidents were formally reported. This lack of follow-up and validation contributed to feelings of isolation and vulnerability. These findings align with international and New Zealand-based literature, which emphasises the legal and ethical responsibility of healthcare organisations to ensure the physical and emotional safety of nurses, including protection from SH (Bruschini et al., 2023; Lu et al., 2020; Parke et al., 2023; Ross et al., 2019). Although many organisations claim to uphold zero-tolerance policies for SH, Ross et al. (2019) argued that these policies are often not actively enforced and that reporting is not always encouraged. The gap between policy and practice was evident in this current study, where participants felt their concerns were not taken seriously. Parke et al. (2023) similarly noted that many nurses do not report SH because they believe no meaningful action will follow. Over time, this lack of response may foster a culture in which SH is seen as “normal” and tolerated, particularly by more experienced nurses (Burgess et al., 2018; Lu et al., 2020; Ross et al., 2019). Conversely,

other literature shows that nurses and NGNs who receive strong support through preceptorship, education, and structured graduate programs are more likely to succeed and less likely to experience the negative impacts of SH (Mammen et al., 2023; Tabakakis et al., 2024; Walker & Clendon, 2018). The findings contribute to the growing body of evidence that all SH incidents should be formally reported and followed up, not only to support individual nurses but also to inform organisational strategies for prevention and accountability.

Limitations

This study's findings are limited by the small, non-representative sample of new NGNs who experienced SH during their first two years of practice. Despite extensive advertising, only five participants responded and consented to being interviewed. All were Pākehā women aged between 21 and 25 years when the harassment occurred, working across various clinical settings, with most having transferred away from the area where the SH occurred. While this limits the generalisability of the findings, this study nonetheless contributes valuable insights to a relatively underexplored area of nursing research. This thesis examined SH only from patients, as the literature identified that patients were the most common perpetrators in practice. Sexual harassment from coworkers was not explored due to ethical and legal reasons. The body of literature and some participants referred to SH from coworkers (although this was not included in this study), suggesting that SH from coworkers warrants further exploration.

Sexual harassment towards nurses remains under-addressed in current research, possibly as nurses who are willing to discuss their experiences of SH are a hard-to-reach population. Questionnaires, such as the NZNO (2019) report, appear to have achieved higher response rates. However, given the scarcity of qualitative studies in this domain, the findings of this study offer an important perspective and underscore the need for further research with more diverse, larger samples to better understand the complexities of SH in nursing practice.

Practice Recommendations

This study has identified that there is a lack of education about what SH is, strategies to deal with it, such as assertiveness training and de-escalation techniques, and a lack of encouragement to report SH to senior management. Education detailing what SH is and that it can take many forms, both insidious and overt, should start at the beginning of nursing training, ideally before nursing students experience their first clinical placement. Education regarding SH and training in de-escalation techniques should continue once nurses are qualified.

It would be useful to further research this topic from the perspective of Māori nurses, as health organisations are responsible under Te Tiriti o Waitangi to address inequities. Research has shown that indigenous Māori experience increased levels of discrimination, even within nursing. There is a special need to support Māori nurses in Aotearoa New Zealand, in developing a representative workforce to promote cultural safety within the health system. Specific research into SH experienced by nurses from other ethnic backgrounds, in particular Pacific nurses, is also necessary, as research identified that they may be prone to harassment, but may be less likely to report this (Minton et al., 2018). Sexual harassment towards males would also be useful to research further, as there is literature that has identified that this occurs in practice.

Sharing the results of this study with the New Zealand Nurses Organisation and the College of Nurses is important, as these organisations provide education and support for nurses. This study builds on NZNO's 2019 Research Advisory Paper investigating violence and aggression against nurses (including SH) and provides further insight into the experiences of new graduate nurses. Consent was obtained from Te Whatu Ora Waitemata Health to advertise in their new graduate cohorts (Appendix F), and they will receive a report summarising the study, findings, and recommendations. The results should also be shared with tertiary education organisations that train nurses, so they can introduce purposeful SH training across their programmes, especially prior to the commencement of clinical placement.

The presentation of these study results at conferences will hopefully reach the management and senior nurses of health organisations and thereby encourage systemic change. Thus, management can implement processes that encourage nurses

to report all incidents of SH, thereby changing the culture of accepting SH as “just part of the job”. It is especially important to address SH in organisations as nursing is a female-dominated profession. Reporting incidents will help track the types of SH, how frequently they occur, and the patterns of perpetrators.

In the workplace, despite protective legislation prohibiting the acceptance of workplace hazards such as SH, a gap in practice has been identified through this study and in the wider literature. Organisational management must actively promote zero tolerance of all forms of sexual harassment towards nurses and establish education about the unacceptability of such behaviour in the workplace. Zero tolerance for violence is actively seen through posters being displayed in some hospital areas, and de-escalation skills for violence are taught in education sessions. It would be easy and appropriate to include sexual harassment in this training and signage.

Senior nurses must be educated to support new nurses and encourage formal incident reporting of any instances of SH in the workplace, no matter how “trivial” they may seem. Nurses who report these instances must have follow-up from charge nurses and occupational health nurses, who should encourage them to access free counselling available. Nurses should not be left to access counselling through employee assistance programmes, as they may feel that seeking help carries a stigma. Even though confidentiality is assured, some nurses may not trust that their confidentiality is maintained and feel worried that seeking counselling may indicate to management they are not coping.

Another area to explore is whether the chronic underfunding and stress that the health system in Aotearoa New Zealand experiences contributes to nursing leadership not addressing SH towards nurses. Addressing this problem will require time and resources, which are difficult to allocate if organisations are focused on managing chronic staffing shortages. However, if the SH problem is not addressed, nurses may leave the profession, further exacerbating staff shortages.

Many existing studies on this topic rely on quantitative methods such as systematic reviews, which, although useful for capturing broader trends, may lack the depth and nuance of qualitative research into individual experiences. However, in the broader literature, some qualitative studies on this topic have employed methods such as

interviews, surveys, and questionnaires. This study contributes to the literature by providing rich, qualitative data that highlight the lived experiences of NGNs facing SH from patients.

Conclusion

This thesis explored the question: "How do new graduate nurses address sexual harassment from patients during the first two years of their post-graduation practice?" This qualitative research, conducted in Aotearoa New Zealand, aimed to explore, first, whether NGNs experienced SH from patients and, if so, the types of SH they experienced. This study also aimed to determine how these nurses were affected by SH, assess whether these experiences impacted their practice, and investigate whether these situations influenced their decision to continue their nursing career.

Based on the thematic analysis of one-to-one interviews with five nurses, this research identified five main themes: 1) "Did that just happen? It was a shock;"2) "It's taboo, not spoken about;" 3) "It changed my practice;" 4) Expecting respect but making allowances; 5) A culture of silence" – the need for organisational change.

Although this study is small and qualitative, it has shown that NGNs believe SH in the nursing workplace is common but often unreported. They identified that it was a shock when they encountered sexual harassment, as they felt underprepared and disrespected. The NGNs also identified that SH seemed a taboo subject and was not widely discussed by colleagues, despite nurses being involved in intimate patient care every day. The NGNs described how their practice changed after experiencing SH from patients, such as becoming more cautious with certain patients and even changing how they presented themselves. They described the long-term effects they experienced and the lack of support from their peers and senior nurses, even after incidents were formally reported.

The NGNs involved in this study were proud to be nurses and felt, as professionals, they should be respected. However, they made allowances for patients experiencing cognitive or mental health issues who sexually harassed them. Making these allowances did not lessen the emotional impact of SH experienced. However, they were initially unsure how to respond when encountering SH from patients without

neurological and mental health concerns. The NGNs were aware of the need to act and deal with SH professionally, but despite using de-escalation techniques, these did not always stop undesirable behaviour.

I have argued that NGNs are especially vulnerable to experiencing SH due to their youthfulness and nursing being a predominantly feminised workforce. Education regarding SH needs to start during nursing training to ensure students are prepared for possible SH experiences in their future practice. This workforce of NGNs needs to be supported and encouraged to remain in nursing as a career, given workplace shortages in Aotearoa New Zealand and the continued reliance on internationally qualified nurses. Although no Māori nurses participated in this study, any measures to support nurses in general will also support Māori nurses, who are in short supply in the workforce. The combined effects of the silence culture and career disruption due to SH point to a pressing need for systemic change. While individual coping strategies and peer support are valuable, they are insufficient without organisational commitment to addressing SH openly and effectively. This includes clear reporting pathways, education on professional boundaries, and leadership that models zero tolerance for SH. As the literature and this study suggest, fostering a culture of safety and respect is essential not only for nurse retention but also for the overall quality of patient care (NZNO, 2019; Ross et al., 2019). Future research should explore interventions that empower all nurses to speak out and ensure that their concerns are met with validation and action.

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Glossary

Term	Meaning
Mahi	A Māori term that means work, activity, occupation
Māori:	The indigenous Polynesian people of New Zealand
Manaakitanga	This Māori term encompasses the concepts of hospitality, care, respect and generosity towards others. It involves extending love and compassion to others
Pākehā	This term refers to a person who is not of Māori descent, commonly describing those of European descent living in Aotearoa New Zealand
Tangata Tiriti	A Māori term that translates to “people of the treaty” and refers to non-Māori people in Aotearoa New Zealand who are considered to belong by right of the Treaty of Waitangi. It involves an active right to understand and uphold the treaty by working alongside Māori.
Tangata Whenua	A Māori term that translates to “people of the land”. This refers to the indigenous people of Aotearoa New Zealand.
Tapu	A Māori term that means to be sacred, prohibited or restricted.
Te Tiriti o Waitangi	The Māori version of the historic agreement signed on February 6, 1840, between the British Crown and over 500 Māori chiefs.
Whakawhanaungatanga	The process of establishing relationships and building connections, particularly within Māori culture.

Appendices

Appendix A Ethics Approval

Auckland University of Technology Ethics Committee (AUTEC)

2 February 2024

Catherine Cook
Faculty of Health and Environmental Sciences

Dear Catherine

Re Ethics Application: **23/352 How New-Graduate nurses address sexual harassment from patients in the workplace: An interpretive-descriptive study.**

Thank you for your responses to AUTEC's conditions.

Your ethics application has been approved for three years until 2 February 2027.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC.
2. All public facing documents must have the AUTEC approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
3. Any amendments to the project must be approved by AUTEC prior to being implemented.
4. A progress report is due annually on the anniversary of the approval date.
5. A final report is due at the expiration of the approval period, or, upon completion of project.
6. Any serious or adverse events must be reported to AUTEC, this includes unforeseen issues that might affect continued ethical acceptability of the project.
7. AUTEC grants ethical approval only. You are responsible for obtaining management permission for access from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online http://www.aut.ac.nz/research/researchethics

For any enquiries, please contact ethics@aut.ac.nz
(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: jane.marshall@aut.ac.nz

Auckland University of Technology, D-88, Private Bag 92006, Auckland 1142, New Zealand.
T: +64 9 921 9999 ext. 8316: E: ethics@aut.ac.nz: www.aut.ac.nz/researchethics

Appendix B Advertisement for candidates

AUT

New graduate registered nurses needed for research:

Research title:
How New-Graduate nurses address sexual harassment from patients in the workplace:
Are you:

- A new graduate nurse practicing in your first ten years post registration?
- Working in a nursing-related field in Aotearoa, New Zealand?
- Working predominantly with patients/residents/service users aged over 18 years old?
- Have you experienced sexual harassment from patients in your first two years of practice as defined below:

Sexual harassment is defined by the Human Rights Act (1993) as "any unwelcome or offensive sexual behaviour that is repeated or is serious enough to have a harmful effect". Sexual harassment occurs across a continuum from sexual remarks and fleeting touch to overt sexual approaches.

As this is potentially sensitive research, please note the exclusion criteria:

- You had an admission to a mental health facility in the last six months
- You are currently under the care of a community mental health team or have been within the last six months.

Your involvement will help me:

- Explore new graduate nurses' experience of sexual harassment from patients
- Gain insight into your coping strategies
- Improve workplace support systems

When: Flexible dates/times for a face-to-face interview
Duration: 60 minutes
Place: At AUT North Campus or on the Zoom electronic platform
Please note a petrol voucher for petrol will be available for interviewees if they need to travel to an AUT campus.

To learn more please contact:
Jane Marshall
email: jane.marshall @aut.ac.nz
phone: 021 958 954 (w)

Interviews regarding sexual harassment may be a sensitive topic for people and may trigger distress. Research also indicates that participation can be experienced as empowering. Participation is voluntary and you may withdraw at any time.

This research has been approved by AUTEC,16/08/2024 Ethics approval no: **23/352**.
Under the supervision of Dr Catherine Cook

Appendix C Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

02/ 02/2024

Project Title

How new graduate nurses address sexual harassment from patients in the workplace:

An interpretive-descriptive study.

An Invitation

My name is Jane Marshall and I work at AUT as a nursing clinical educator. I have been employed in this role for over 9 years and enjoy working with students in their clinical placements. Before this role, I worked in the public hospital system for over 20 years in medical, surgical, orthopaedic, and emergency department areas.

I am interested in interviewing you if you have experienced any instances of sexual harassment in your workplace. From my own experience and when working with students, I am aware that many nurses experience sexual harassment but often this is unreported.

This research will be for my master's in nursing science qualification, and I hope it will help identify if this problem occurs, and result in increased support for students, new graduates, and registered nurses.

Participating in this research will not advantage or disadvantage you as your details and workplace details will be kept confidential.

What is the purpose of this research?

The purpose of this research is to explore new graduate nurses' experiences of sexual harassment from patients.

Sexual harassment is defined by the Human Rights Act (1993) as "any unwelcome or offensive sexual behaviour that is repeated or is serious enough to have a harmful effect". Sexual harassment occurs across a continuum from sexual remarks and fleeting touch to overt sexual approaches. Sexual harassment is illegal in the New Zealand context no matter the cognitive capacity of the offender. In Aotearoa, legislation (Employment Relations Act, 2000; Human Rights Act, 1993) protects employees from sexual and racial harassment.

I hope to gain insights as to how new graduates cope with these situations, to determine if this affects their decision to stay nursing or not and what support, education and processes are needed to assist them to thrive in their careers.

This topic is important as support is needed to retain our new graduate nurses in Aotearoa, New Zealand. This is due to the worldwide nursing shortage and staffing retention difficulties. International studies show sexual harassment of nurses is a major concern and nurses are reluctant to report this. Relatively little research has been conducted into sexual harassment in the healthcare setting, both internationally and in Aotearoa New Zealand, possibly as it is a sensitive subject.

If you would like to participate, I would like to interview you face to face, either in person at AUT or by Zoom meeting if more convenient, to discuss your experiences of sexual harassment from patients.

This research is for my Master of Health Science in nursing. The findings may result in publication in academic nursing journals and presentations at conferences.

How was I identified and why am I being invited to participate in this research?

You responded to the advertisement in either the Kai Tiaki, the magazine of the New Zealand Nursing Organisation (NZNO) members or to the online notice board mailouts to College of Nurses members.

You contacted me via email or phone to show your interest in participating in this research and that you meet the below criteria. You have been given two weeks before the interview, to have time to reflect on whether to participate.

Participation criteria:

Are you:

- A new graduate registered nurse practising in your first two years post-registration?
- Are you working in a nursing-related area in Aotearoa, New Zealand?
- Are you working with patients/residents/service users who are predominantly adults aged over 18?
- Have experienced sexual harassment from patients – Sexual harassment is defined by the Human Rights Act (1993) as "any unwelcome or offensive sexual behaviour that is repeated or is serious enough to have a harmful effect". Sexual harassment occurs across a continuum from sexual remarks and fleeting touch to overt sexual approaches.

Please note the exclusion criteria:

- Have you had an admission to a mental health facility in the last six months?
- Are you currently under the care of a community mental health team within the last six months?

If so, you are not eligible to participate in this research.

How do I participate in this research?

- Your participation in this research is voluntary (it is your choice). Whether or not you choose to participate will neither advantage nor disadvantage you.
- You can withdraw from the study at any time.
- If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.
- You will need to sign a consent form which will outline your right to withdraw from the study at any time.
- You have the right to stop the interview process at any time.
- If you can be interviewed face to face you can sign the consent form on paper but if you prefer to be interviewed by electronic platform such as "Zoom" or Microsoft Teams, there is an electronic consent form to sign.
-

Please note: a voucher for petrol will be available so you are not financially disadvantaged if you need to travel to an AUT campus for interviews.

What will happen in this research?

- You can be interviewed face-to-face in a neutral location at an AUT campus or via an electronic platform such as Zoom.
- Interviews will be recorded, and these will be transcribed by myself. I will be aiming to interview eight to ten participants to identify any common themes based on participants' shared experiences for my research.
- Once my research is finalised, I will contact participants to outline my findings.
- Please be reassured that all your contact information, recordings both audio and audio-

visual (such as "Zoom" or Microsoft Teams recordings) will be kept confidential under the Privacy Act 2020. AUTEC guidelines will be adhered to so all information both written and recorded will be kept confidential in a secure manner.

What are the discomforts and risks?

I am aware this is a sensitive topic, and you may feel uncomfortable and /or emotional discussing any sexual harassment you have experienced. This may also affect you physically as you could experience insomnia, stomach upsets and other physical or emotional symptoms. However, you may feel relief talking about experiences and may feel empowered after discussing these.

You can stop the interview at any time if you experience any discomfort.

How will these discomforts and risks be alleviated?

AUT Student Counselling and Mental Health can offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly because of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus
- email counselling@aut.ac.nz
- or call 921 9292.
- let the receptionist know that you are a research participant, and provide the title of my research, my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

Legal rights:

Please also be advised of your legal rights regarding sexual harassment in the links below:

Sexual harassment | WorkSafe

Sexual Harassment Guidelines (tikatangata.org.nz)

What are the benefits?

You may experience some positive emotions, as discussing your experiences and contributing to this research could have beneficial results for others.
You will be assisting my research for my MNSc (master's in health science degree). Any information gained as to how new graduate nurses address sexual harassment from patients in the workplace will also assist in identifying processes to help prepare students during their training. I am interested in discovering if new graduate nurses are reporting these situations.

This research may be used for journal articles and be presented at conferences to increase awareness about sexual harassment from patients in clinical practice. This research may identify what support, education and processes are needed to assist new graduate nurses to thrive in their careers. This topic is important as we need to support and retain our new graduate nurses in Aotearoa, New Zealand due to the worldwide nursing shortage and staffing retention difficulties.

I will ensure I provide you and all participants with a one- or two-page summary of the findings of this research.

How will my privacy be protected?

- Meetings can be face-to-face at an AUT location or be arranged and recorded on Microsoft Teams or Zoom electronic platforms. I will ensure I am interviewing from a private space where the meeting cannot be overheard.
- Limited demographic data will be collected to protect your identity.
- Demographic data will include a broad description of the area of your work and the months of your post-graduate practice.
- Your gender and ethnicity data will be collected as research highlights sexual harassment of women and some ethnic groups are over-represented in harassment.
- Demographic data on age will be collected using five-year age bands.
- All your details will be kept confidential, and the transcripts will be anonymized regarding your name and workplace.
- My supervisor will be given the master list of participants' names, contact details and the pseudonyms used, to be kept in a secure locked filing cabinet.
- Recordings will be kept safe digitally on OneDrive and accessed using a designated password-protected computer.

What are the costs of participating in this research?

You will ideally participate for 30-60 minutes of interview time plus travel time to the interview room at AUT (unless the interview is online). If you need to travel to an AUT premises for the interview a petrol voucher will be available, so you are not disadvantaged financially through travel expenses.

What opportunity do I have to consider this invitation?

You can consider whether to continue with this invitation to be interviewed for one month after responding to the advertisement.

Will I receive feedback on the results of this research?

I will provide you and other participants with a one-page summary of my findings.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor,

Dr Catherine Cook, email: catherine.cook@aut.ac.nz

phone: .09 921 9999 ext 6651

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Jane Marshall

jane.marshall@aut.ac.nz

021 958 954 (AUT work phone)

Project Supervisor Contact Details:

Dr Catherine Cook, email: catherine.cook@aut.ac.nz

Appendix D Consent Form

Auckland University of Technology
Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999
www.aut.ac.nz

Consent Form

For use when interviews are involved.

Project title:

How New-Graduate nurses address sexual harassment from patients in the workplace: An interpretive-descriptive study.

Research Question:

The aim is to explore new graduate nurses' experience of sexual harassment from patients, to gain insight into their coping strategies, workplace support systems and processes needed.

Project Supervisor: ***Dr Catherine Cook***

Researcher: ***Jane Marshall***

- I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- I agree to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes No

Participant's signature:
.....

Participant's name:
.....

Participant's Contact Details (if appropriate):

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 2nd February 2024 on which the final approval was granted AUTEC Reference number*23/352*

Note: The Participant should retain a copy of this form.

Oral Consent Protocol

For use when interviews are being conducted by videoconference.

Project title: How New-Graduate nurses address sexual harassment from patients in the workplace: An interpretive-descriptive study.

Project Supervisor: ***Dr Catherine Cook***

Researcher: ***Jane Marshall***

The participant joins the videoconference

Do you agree to my recording your consent to participate?

If they agree, then the record function will be activated and they will be asked the following:

Have you read and understood the information provided about this research project in the Information Sheet date 6/08 24?

Do you have any questions about the research?

Do you understand that notes will be taken during the interviews and that the interview will also be audio-recorded and transcribed?

Do you understand that taking part in this study is voluntary (your choice) and that you may withdraw from the study at any time without being disadvantaged in any way.?

Do you understand that if you withdraw from the study then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used? However, once the findings have been produced, removal of your data may not be possible.

Do you agree to take part in this research?

Do you wish to receive a summary of the research findings? (please tick one): Yes No

¡ Do you want me to send you a copy of the audio recording for this consent? Yes¡ No¡

¡ Please confirm you name and contact details

Participant's name: .....

Participant's Contact Details (if appropriate.....

I will now turn off the recording of the Consent and then will start a separate recording for the interview.

Approved by the Auckland University of Technology Ethics Committee on 2nd February 2024 on which the final approval was granted AUTEC Reference number*23/352*

Appendix E Indicative Questions

Indicative questions are as follows:

- Tell me a little about your role and the people you provide nursing care for.
- In general, how physically and emotionally safe do you feel in your workplace?
- Please can you tell me what interested you in participating in this study?
- Based on your experience, how would you define sexual harassment?
- Can you describe the situation?
- How did you manage this experience?
- Did you have any guidance and support to manage sexual harassment in the workplace?
- Have you reported sexual harassment, and did you know who to report to?
- How comfortable did you feel to report the situation?
- Has the experience had long term consequences for you personally and in your practice?
- Have you sought further support such as a counsellor regarding this situation you described?
- Have you developed skills to manage future instances of sexual harassment?
- Have you observed any colleagues who have role-modelled how to handle sexual harassment that you thought was helpful and appropriate?
- Have you ever received any education about managing workplace sexual harassment? If not, is this something of interest to you?
- If you were giving a new graduate advice about being aware of sexual harassment, what would you say?

Appendix F WAI20245 Waitemata Approval of Research

Application for Approval of Observational Research

Te Whatu Ora
Health New Zealand
Waitematā

WAI20245 How New-Graduate nurses address sexual harassment from patients in the workplace

Waitematā Contact: Victoria MacKay
Department: Nursing
Project Type: Observational research
Duration: 07.10.24 - 30.11.24

External CI: Jane Marshall, AUT

Description:
Aims:

- Explore whether new graduate nurses have experienced sexual harassment in their workplaces from patients and if they are reporting these situations
- To gain insights into how new graduates cope with these situations and to determine if this affects their decision to stay nursing or not
- To determine what support, education and processes are needed to assist them to thrive in their career if they experience sexual harassment from patients
- Provide recommendations to Health New Zealand - Te Whatu Ora on the ways to effectively support new graduate nurses and retain them in the workforce

Study design: Interpretive descriptive study.
Population: Eight to ten new graduate RNs in their first ten years post-graduation who have experienced sexual harassment from patients in their first two years post-graduation.
Method: Individual semi-structured one-to-one interviews, in-person and online, using open-ended questions will be used. This is a sensitive topic so individual interviews will be the safest way for nurses to talk about their experiences with sexual harassment.
Interviews will be transcribed from the audio or Zoom recording. Codes from the data of these recordings will be collated into tentative themes which will be revised as more data becomes available through further interviews (Clarke, et al., 2015). The findings from datasets will be compared to identify common themes and unique insights (Braun & Clarke, 2022).
Timeframe: 6 months

Locality Review

The undersigned agree to the following:
- The study protocol and methodology has merit and aligns with departmental/service area interests.
- The local lead investigator is suitably qualified, experienced, registered and indemnified.
- Resources, facilities and staff are available to conduct this study, including access to interpreters if requested.
- Conducting this study will have no adverse effect on the provision of publicly funded healthcare.
- There is a stated intent that results will be disseminated & the findings translated into evidence-based care (where appropriate).

Before this study is granted approval to commence, the Research & Knowledge Centre on behalf of Te Whatu Ora - Waitematā will check:
- there has been the appropriate level of ethical review eg ethics committee approval if required.
- cultural consultations have occurred or will be undertaken, as appropriate.
- appropriate confidentiality provisions have been planned for.

Dept/Org	Role	Name (Print Clearly)	Signature	Date
Hospital services	*Director of Nursing*	*Kate Gilmour*		21/10/24
Nursing Development Service	*Nurse Director for Workforce Development*	*Janine Quiding*		21/10/24

Return completed form to the Research & Knowledge Centre. Alternatively, emails from approvers are acceptable as electronic sign-off.
Enquires to research@waitematadhb.govt.nz