THE PERCEPTIONS OF NURSES REGARDING VIOLENCE, STRATEGIES AND SUPPORT IN A REGIONAL QUEENSLAND HOSPITAL

A thesis submitted by

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For the award of

Doctor of Philosophy
2016
ABSTRACT

Ironically, the most violent workplace in Australia today is the healthcare industry. Nurses encounter verbal and physical violence from patients and visitors in their workplace on a daily basis. Nurses who work in emergency and mental health departments are especially at risk of violence. The Australian media, such as television news reports and daily newspapers, frequently reports on incidents where violent patients attack nurses—leaving the nurses with physical and emotional scars.

Workplace violence is a significant cause of death and injury in many parts of the world, and in Australia alone the estimated cost of absenteeism and lost productivity as a result of workplace violence is over $AUD 13 billion per year (Farrell, Bobrowski, & Bobrowski, 2006). Workplace violence in the healthcare industry is increasing, and has significant long-term consequences on both individuals and our health system. Violence affects nurses’ personal lives, mental health, safety and professionalism by reducing their ability to offer effective patient care. Experienced nurses are leaving the healthcare industry due to patient violence.

There is a lack of qualitative Australian studies on nurses’ perceptions of workplace violence. In fact, there are no qualitative studies in Queensland, and only a few quantitative studies on workplace violence in Queensland hospitals and other healthcare sectors. However, no studies have been conducted on workplace violence in any of Queensland’s regional areas, or its prevalence within the Intensive Care Unit (ICU). My current research has investigated the issue of violence towards nurses in a regional public hospital of Queensland, and fills this gap in the literature. The Occupational Health Framework by Levin, Hewitt, and Misner (1998) assists in conceptualising the complex nature of workplace violence, and therefore was chosen to guide the investigation of my research questions, help with the data analyses and clarify the factors that contribute to assault injuries.

My current doctoral research has contributed to the overall body of knowledge on workplace violence within the healthcare sector, as it examines nurses’ perceptions of physical and verbal violence perpetrated by patients and visitors, and the ensuing impact on nurses—including their ability to care for patients. My research also investigates nurses’ perceptions of current workplace violence strategies and support services.
I collected data using mixed methodology studies: a qualitative study of three focus group interviews of N=23 nurses, and a quantitative survey of N=98 nurses who work in three ‘high risk’ units: the Emergency Department (ED), Intensive Care Unit (ICU) and Mental Health Department (MHD) in a Queensland regional public hospital, Australia.

My findings expose high levels of workplace violence in these hospital departments and the effect of workplace violence on nurses, witnesses and the interaction with patients. The findings describe the nurses’ perceptions and recommend improvements to manage violence and the support within the hospital, all of which aim to improve nurses’ work environments and quality of life. Implementing my research suggestions on hospital workplace safety and support services improvements would support nurse retention within the healthcare system, and ultimately, improve healthcare standards and patient wellbeing.

The research could be expanded to include all the hospital departments in a regional public hospital, to provide clearer comparison between departments. Further recommendations might be wider studies of other public and private hospitals in regional, rural and metropolitan areas to get a better understanding of the extent of violence in different locations.
CERTIFICATION OF THESIS

This thesis is entirely the work of Hila Ariela Dafny except where otherwise acknowledged. The work is original and has not previously been submitted for any other award, except where acknowledged.

Student and supervisors signatures of endorsement are held at USQ.
ACKNOWLEDGMENTS

This research could not have taken place without the 23 registered nurses who generously shared their experiences with me. Their willingness to share their stories in the hope that future nurses would benefit persuaded me to continue with the research, despite its challenging moments. I would also like to thank the 98 registered nurses who participated in the survey. Thank you for giving your time to be involved in this study. I sincerely thank the Emergency, ICU and Mental Health departments’ nurse unit managers who facilitated my research by permitting me to interview their staff members.

I would like to express my sincere gratitude to the Fellowships Fund Inc. and Graduate Women Queensland for sponsoring my PhD study with financial support through a Freda Bage three-year fellowship. Without their financial assistance, it would have been very difficult for me to successfully complete this higher degree study. Your invaluable help is greatly appreciated.

I give heartfelt thanks to my principal supervisor, Professor Don Gorman, for his guidance, wise advice and years of dedicated work with me. Don, I appreciate your time and commitment to my success by being my mentor and role model. I have special gratitude for my previous supervisor, Dr Delwar Hossain, who was invaluable as a guide, mentor and teacher at the beginning of this journey. My sincere thanks also goes to associate supervisor, Associate Professor Gavin Beccaria, for his wise suggestions, guidance and for his willingness to join my supervisory team during the final milestone of this study. It was a pleasure to work with great people like him.

I appreciate and thank my network of friends and family, my dear friends and colleagues from the Centre for Health Sciences Research (CHSR) at USQ. I appreciate their friendship, encouragement and practical help during this journey. I am most grateful for the assistance of USQ staff including Dr Rachel King, the statistics consultant and Ms Vivienne Armati, the librarian, for all their assistance and interest. I wish to thank my friend, Mrs Amanda Gearing, for her feedback and for proofreading my thesis. I also extend my thanks to Dr Juliette Lachemeier for her help in the final editing of my thesis.
Finally, I would like to thank my dear parents, Yehudit and Moshe, for their unfailing love and care. Most profoundly, to my husband Dr Elad Dafny, thank you for your great love, unfailing support, encouragement and patience that have enabled me to complete this study. Thanks also to our beloved and beautiful children: Omer, Adva, Noa and Amit who inspire me to do my best to create a better world. I have been very fortunate and blessed with many good friends and family who have supported me. I thank you my Almighty God, for protecting and guiding me wherever I go in my life.
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<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>HDU</td>
<td>High Dependency Unit</td>
</tr>
<tr>
<td>HN</td>
<td>Head Nurse</td>
</tr>
<tr>
<td>HREC</td>
<td>Human Research Ethics Committee</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Office</td>
</tr>
<tr>
<td>MHD</td>
<td>Mental Health Department</td>
</tr>
<tr>
<td>NUM</td>
<td>Nurse Unit Manager</td>
</tr>
<tr>
<td>QNU</td>
<td>Queensland Nurses’ Union</td>
</tr>
<tr>
<td>SSA</td>
<td>Site Specific Assessment</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WN</td>
<td>Ward Nurse</td>
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CHAPTER 1: INTRODUCTION

Overview

Violence towards nurses is a significant problem in the healthcare industry (Jackson, Clare, & Mannix, 2002). Nurses are at extremely high risk of experiencing workplace violence during their working lives (Hegney, Tuckett, Parker, & Eley, 2010; McPhaul & Lipscomb, 2004). Chapman and Styles (2006) described the everyday reality of nurses facing episodes of violence and aggression while working in the Australian healthcare system. Moreover, they reported that nurses face the distressing possibility of being victims of aggressive and violent incidents while caring for patients. Furthermore, Rosen (2013) identified workplace violence as a serious problem that can change a nurse from being a healthcare provider to a healthcare patient. The injuries caused to nurses when patients or visitors become violent have included fractures, lacerations, contusions and psychological trauma. However, there is debate over how to reduce workplace violence towards nurses, as very little is known about the interventions used by healthcare staff to manage workplace violence (Hahn et al., 2012).

The consequences of workplace violence include increased costs to the healthcare system, with an annual expense estimated over $AUD 13 billion due to absenteeism and lost productivity (Farrell et al., 2006); loss of experienced nurses from the workforce and difficulty in attracting nurses back into the healthcare system (Rosen, 2013). As a registered nurse in the ICU and Recovery Room, I have personally experienced verbal violence, as well as witnessed physical violence towards colleagues from both patients and their visitors or family members.

These facts motivated me to explore the issues related to violence towards nurses. ICU and other acute care nurses are considered to be frontline healthcare workers. However, little research concerning workplace violence has been conducted within the ICU, and there is a gap in the literature regarding Australian qualitative studies that discuss the nurse perceptions on violence, and its impact upon them.
This chapter covers six main sections: characteristics of violence, statement of the problem, focus of the study, significance of the study limitations and the structure of the thesis.

1.1. **Structure of the thesis**

The structure of this thesis consists of seven chapters:

Chapter 1, the introductory chapter, presents the overview of the research topic and includes the characteristics of violence and the statement of the problem, along with the research aims and questions and the significance of the study.

Chapter 2 reviews the literature relevant to the incidence of violence, consequences of violence, management strategies, workplace policies and support from coworkers and managers. Chapter 2 also presents the conceptual framework of this study.

Chapter 3 describes the methodology and research design that have been used for this study, and the ethical considerations. There are two sections: the qualitative study and the quantitative study, along with the data collection and data analysis.

Chapter 4 presents the findings of the three focus groups, discussing the themes that emerged during the data analysis.

Chapter 5 presents the survey findings of 98 nurses and their experience with verbal and physical violence in the workplace, and its management, strategies and support. Finding from the statistical $t$-tests and Analysis of Variance (ANOVA) are also presented.

Chapter 6 discusses the research findings. The research questions are answered using the findings of the qualitative and quantitative phases of the study in the context of the relevant literature and the conceptual framework of the study.

Chapter 7 draws the conclusions and discusses the contribution of this study. The implications and limitations of this research are presented, including recommendations for further research in this field.
1.2. Characteristics of violence

1.2.1. Workplace violence

Frequent reports of violence towards nurses appear in the media. The victims are all at work, going about their ordinary tasks, but they are exposed to attacks by patients, co-workers and even complete strangers (IPRC, 2001). Often, the causes of violence are foreseeable and preventable. However, there is no universal definition of workplace violence, making it impossible to develop an effective and unified solution to the problem.

Workplace violence is defined by the International Council of Nurses (ICN) as incidents where staff are abused, threatened or assaulted in circumstances related to their work (ICN, 2002). This possible definition includes workers who commute to and from work and identifies an explicit or implicit challenge to their safety, wellbeing or health. According to Jackson et al. (2002), workplace violence takes many forms, such as aggression, harassment, bullying, intimidation and assault. Other researchers categorise violence as verbal or physical. Verbal abuse refers to “any form of mistreatment, spoken or unspoken that leaves you feeling personally or professionally attacked, devalued or humiliated. It is communication through words, tone or manner that disparages, patronises, threatens, accuses, or is disrespectful towards another” (Farrell et al., 2006, p. 780). Verbal abuse also includes being yelled or shouted at; cursed or sworn at; being subjected to inappropriate, offensive, rude or hostile behaviour; having malicious rumours spread about you or being belittled and humiliated (Celik, Celik, Agrıbas, & Ugurluoglu, 2007, p. 363). Physical violence is defined as “the use of physical force against another person or group that results in physical, sexual or psychological harm. It includes beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching” (ICN, 2002, p. 4).

In many workplaces it is argued that there is a climate that encourages workplace violence (McPhaul, Lipscomb, & Johnson, 2010; Spector, Coulter, Stockwell, & Matz, 2007) and in many cases, our society has increasingly become more violent and more tolerant of violence (Hegney et al., 2010). In addition, the focus on workplace violence has raised nurses awareness and they are more likely to report workplace violence (Hegney, Eley, Plank, Buikstra, & Parker, 2006). For the purpose of this study
(despite the lack of a universal definition), workplace violence is described within the parameters of physical and verbal violence towards nurses. Violence and aggression are defined as any incident that puts a healthcare worker at risk, and includes verbal and physical abuse, threatening behaviour, assault by a patient, family member, friend or member of the public or any type of behaviour that may cause healthcare workers to fear for their safety (Ayranci, 2005).

### 1.2.2. Types of violence

Workplace violence is a complicated problem, because it has many sources. The University of Iowa Injury Prevention Research Centre (IPRC), (2001) divides workplace violence into four categories:

- **Criminal Intent (Type I):** the perpetrator has no legitimate relationship to the business or its employees, and is usually committing a crime in conjunction with the violence.
- **Customer/Client (Type II):** the perpetrator has a legitimate relationship with the business and becomes violent while being served by the business.
- **Worker-on-Worker (Type III):** the perpetrator is an employee or past employee of the business who attacks or threatens another employee(s) or past employee(s) in the workplace.
- **Personal Relationship (Type IV):** the perpetrator has a personal relationship with the intended victim but usually does not have a relationship with the business.

Hahn et al. (2008) categorised violence into vertical or horizontal/lateral violence in the healthcare sector, emphasising the power differential between those who are the perpetrators of violence and those who are the targets of the violence. Vertical violence occurs between healthcare professionals and the care recipients, while horizontal or lateral violence occurs among healthcare professionals.

This study focuses specifically on vertical violence, or Type II violence according to the Iowa classifications, because Type II is the most prevalent type of workplace violence.
violence occurring in healthcare settings (Alexy & Hutchins, 2006). This category of violence includes perpetrators who are customers, clients, patients and visitors or any other group for which the organisation provides services (Alexy & Hutchins, 2006).

Lanza and Campbell (1991) established that assault by patients is a serious concern for clinicians and hospital administrators, and that both public and private hospitals have reported significant assault rates in United States. Assault rates had increased over a period of time by 32.9% from 1978 to 1980. Recent report from Queensland Health (2016) indicates significant increase in the reporting of occupational violence incidences and stated that in 2014-2015, about 3325 of 5030 reported incidents were from the nursing profession. “Interestingly, the number of reported incidents in the first three-quarters of 2015-2016 has increased significantly. If the trend continues, the projected number of incidents for the 2015-2016 year would be around 6700; an increase of over 30 per cent on the previous year. The reasons for this significant increase in the reporting of incidents requires further analysis”. (Queensland Health, 2016, p. 5).

There is an ongoing challenge in comparing rates of violence across time and place from various studies and therefore caution is required in making such a comparisons. There are many reasons for that challenge in making comparisons across studies’ findings such as different definitions of verbal and physical violence (Alexy & Hutchins, 2006), different statistical data, types and level of violence (Luck, Jackson, & Usher, 2006b), differing timeframes of experiencing of workplace violence varying from 3 months (Hegney et al., 2010), 5 months (Crilly, Chaboyer, & Creedy, 2004) or 12 months (AbuAlRub, Khalifa, & Habbib, 2007; Hahn et al., 2012; Talas, Kocaöz, & Akgüç, 2011). Differing locations of the hospitals nationally and internationally (Spector, Zhou, & Che, 2014), environmental settings and nurses individual differences (Chen, Ku, & Yang, 2013).

Both physical violence and verbal aggression are common occurrences in hospital settings and most violence is perpetrated by patients or their families (Spector et al., 2007; Spector et al., 2014). Magnavita and Heponiemi (2011) discovered that nurses were frequently exposed to “external” violence, that is, verbal or physical violence during the previous 12 months from patients (94%) or their relatives and friends
(71%). The same high incidence of violence was found by Pinar and Ucmak (2011) whereby nurses reported experiencing verbal and physical violence from patients (91.4%) and their families (74.9%) during the previous 12 months.

Even though this study focuses specifically on vertical violence, nurses who participated in this study also spoke about horizontal violence during the focus group interviews. Therefore questions were added to the survey to ask about horizontal violence and the survey tool used in this study as well as the findings reported includes horizontal violence. Horizontal violence, also described as lateral violence, or Type III violence according to the Iowa classifications, occurs among healthcare professionals.

The extent of horizontal violence found in various studies. For example, Farrell et al. (2006) study indicated that verbal violence perpetrated by nursing colleagues was reported by 28.7% of nurses and verbal violence by doctors was reported by 27.1% of nurses. Rates of physical violence were less, as physical violence committed by nurses reported by 3.6% of nurses and physical violence by medical doctors reported by 3.1% of nurses. The Granstra (2015) study found that violence between hospital staff is a growing problem with more than 50% of nurses experiencing horizontal violence. A recent study by Purpora and Blegen (2015) found that horizontal violence was higher among nurses with lower job satisfaction and less supportive peer relationships. National and international literature are lacking in definition of workplace violence and aggression as well as lacking in uniform standards of violence and aggression measurements (Jones & Lyneham, 2001). Similar, there is a lack of consensus and definition in the national and international literature regarding ‘severity’ of violence. The assessment of severity of violence has not received considerable attention such as which type of violence are more severe and which could be more punishable from a legal perspective (Escartín, Rodríguez-Carballeira, Zapf, Porrúa, & Martin-Pena, 2009).

According to Mayhew and Chappell (2007) it is essential to have a clear definition of workplace violence when considering the research data, including differentiate between incidence of violence and severity ratios. Kwok et al. (2006) states that recognition of the severity of violence is important and further investigation can benefit the whole profession.
The term severity of violence vary in the literature review and may refer to the severity of ‘dose’ of violence such as verbal versus physical violence, using of weapons and life-threatening assaults while others may implies to severity as violence that has been escalating over time within the same population. For example, Mayhew and Chappell (2007, p. 329) identify severity of violence as physical versus verbal violence (Farrell et al., 2006; Wilkes, Mohan, Luck, & Jackson, 2010) and therefore impress the important of having a clear definition of workplace violence, preferably with data categories broken down into divers form such as: assault, abuse, harassment etc. Others authors refer to the severity of violence as a degree of bullying such as emotional abuse, threaten to harm, insult or spread rumours (Escartín et al., 2009). On the other hand, some authors implies to severity as violence that has been escalating over time within the same population (Steadman, Cocozza, & Melick, 1978). The explanation of the increasing of rate of violence among mental patients within the same population may be related to the age, admitting diagnosis and prior assaults of patients that increased over the years (Steadman et al., 1978). In this study the definition of severity of violence, and the findings, refers to both approaches, verbal versus physical violence, degree of violence and the increase in violence over time within the same population.

1.3. **Statement of the problem**

High (and increasing) rates and the severity (verbal versus physical violence, degree of violence and the increase in violence over time within the same population) of workplace violence towards nurses are investigated in this study. Nevertheless, there is a lack of implemented strategies for reducing workplace violence. There is also a lack of support services for coping with workplace violence. This study explores both of these issues.
1.3.1. The research gaps

The extent of violence against nurses and the importance of this problem in the nursing workplace have been canvassed in the literature review, along with the strategies that are being trialled to address workplace violence against nurses. Several important gaps have been identified in the current literature relating to:

- The small amount of recent qualitative research on workplace violence towards nurses in Australia that provides the lived experience of nurses who have been subject to violence.
- The general lack of qualitative evidence of the lived experience of nurses who have been the victim of workplace violence in regional hospitals.
- The small amount of research to date on workplace violence in the acute ICU.
- Lack of Queensland studies enabling ward level analysis of public hospital workplace violence.
- Continuing controversy over how to address workplace violence against nurses.

This study addresses all of these research areas by gathering quantitative and qualitative data via survey and focus groups.

Violence towards nurses is a worldwide problem. While international longitudinal studies have been conducted (Arnetz & Arnetz, 2001), there is only one longitudinal study of workplace violence towards nurses in Australia (Hegney et al., 2006; Hegney, Plank, & Parker, 2003; Hegney et al., 2010). There is also a lack of research on violence towards nurses who work in the acute hospital settings of ICUs. This study focuses on one location in regional Queensland, Australia, where data were gathered. The majority of studies in Queensland to date were longitudinal quantitative survey studies conducted in 2001, 2004 and 2007 (Hegney et al., 2006; Hegney et al., 2003; Hegney et al., 2010). These significant longitudinal studies compared public, private and aged care workplaces and found that the incidence of violence towards nurses remains high, is highest in the public sector, and is increasing (Hegney et al., 2006).
The Hegney et al. longitudinal studies were unable to analyse the data at ward level, and therefore could not report on differences between wards in each sector of the private, public and aged care sectors of the healthcare system. The researchers suggested that greater attention to qualitative data is needed to provide a clearer picture of the incidence of workplace violence towards nurses, and that more needs to be done to address violence towards nurses.

A number of studies (Farrell et al., 2006; Hegney et al., 2010; Hodge & Marshall, 2007) have found that strategies addressing violence are controversial. This is because nurses who had experienced workplace violence were more likely to believe that their workplace policy was ineffective and insufficient, and that there needed to be a multifocal approach to successfully address workplace violence. For example, the multifocal approach for addressing violence included variety of strategies such as: monitoring and post-treatment of workplace violence (including training in violence prevention and management of violence) as well as providing sufficient resources for security, risk assessment and care for victims (Hahn et al., 2010). Furthermore, providing appropriate training programs in aggression management and communication skills for staff, along with managing situation and ward-type workplace violence was also recommended (Hahn et al., 2012). In addition, the need for streamlined organisational processes and improving individual skills in teamwork, clinical expertise and the ability to recognise and respond to patient agitation and behaviours was identified (Rosen, 2013). Intervention recommendations included educational sessions at orientation, a security incidence response team, extra debriefing and counselling services and mandatory reporting and analysing of incidents (O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000).

Hegney et al. (2006) suggested that it might not be the presence or absence of a policy on workplace violence that decreases violence, but rather the context of the workplace in which the policy operates. Due to this controversy, Spector et al. (2007) put forward that violence in the workplace requires further research attention.

The findings from Hegney et al. (2006) suggested in 2001 that male nurses might have more exposure to violent patients, as male nurses reported more workplace
violence in the public and aged care sectors than female nurses. The connection between gender and the incidence of violence was investigated in this study by examining whether there were any differences in the incidence or seriousness of violence by patients and visitors towards male or female nurses in three hospital departments: ICU, ED and MHD. The findings also identified possible preventative action.

Identifying trends and patterns of violence is necessary for better healthcare planning and service provision, so that effective preventative and safe strategies for nurses in the workplace can be implemented (Crilly et al., 2004). Most of the studies concerning violence towards nurses were limited to those who worked in MHDs and EDs with high incidences of violence. However, there might be other healthcare professions or departments with a higher risk of workplace violence (Fujita et al., 2012). Although there are many studies evaluating prevention and management strategies in MHDs and EDs (Gournay et al., 2002; Needham et al., 2005; Wright, Gray, Parkes, & Gournay, 2002) no recent studies were found that investigated patient aggression prevention and management strategies in ICUs.

Kynoch, Wu, and Chang (2011) noted that further studies were needed to investigate the effectiveness of interventions to prevent and manage aggressive patients in acute hospital settings. Kynoch et al. (2011) also suggested that more qualitative research in this area would assist in determining whether different interventions would minimise the frequency and severity of violence towards acute hospital staff.

My research study includes staff in the MHD and ED, but also includes ICU staff—underrepresented in studies to date. The inclusion of an ICU contributes to extending knowledge by canvassing current data on the extent of violence towards nurses in the public sector of three departments.

My study focuses on workplace violence in the public sector, because the highest incidence of violence towards nurses was found in the public sector in Australia, both in Tasmania (Farrell et al., 2006) and Queensland (Hegney et al., 2006). My research also fulfils the study recommendations to investigate violence at the ward level, especially in the ‘high risk’ units—ED, MHD and ICU—instead of focusing on the
employment level sectors. 'high risk’ units are defined by Farrell et al. (2006) as departments in which many staff experience and report high levels of aggression in the form of verbal and physical abuse.

My research furthers existing knowledge on workplace violence towards nurses by providing quantitative and detailed qualitative information on the incidence of violence at the ward level, perpetrated by patients and visitors in a public hospital. My research findings are used as the basis for recommendations that, if implemented, may mitigate the frequency and seriousness of violence against nurses, and lead to improvements in public hospital support services for nurses during and after an incident of workplace violence. This will ensure a safer workplace for nurses in the most at-risk departments in the regional public hospital system.

The mixed methodology design (i.e., survey and focus groups) was designed to yield both quantitative and qualitative data that together improve our understanding of gender-related violence perpetrated by patients and hospital visitors. The male and female nurses who participated in the qualitative study shared their lived experience of violence in the workplace, and their perceptions about the type of violence they experienced and how it impacted on them. This study, therefore, contributes to the body of nursing knowledge, providing a more thorough understanding of the impacts of violence on male and female nurses and how this affects their ability to care for patients.

As recently as the studies in Kynoch et al. (2011), researchers noted a lack of sufficient quality qualitative studies in acute care settings. The question of possible interventions is therefore explored in this study with a view to providing preliminary recommendations for mitigating violence and the risk of violence towards nurses. The use of one public hospital allows the research to explore the complexity of these issues through qualitative interviews, and links the data from the interviews with questions in a further quantitative survey.
1.4. Focus of the study

1.4.1. Research aims

The aim of this study is to explore how regional public hospital nurses perceive the impact of workplace violence on both themselves and their ability to interact with patients and visitors. It also investigates the nurses’ perceptions of whether hospital policies, strategies and support in a regional public hospital are successful in preventing violence against nurses and managing aggressive patients and visitors.

1.4.2. Research questions

This study explored the following research questions in order to achieve the research aims:

1) How do regional public hospital nurses perceive violence in the workplace and what is its impact on their ability to interact with patients and visitors?

2) What do regional public hospital nurses suggest to reduce or avoid the violence displayed towards them?

3) What are the regional public hospital nurses’ perceptions regarding existing strategies and support systems to address the violence displayed towards them?

4) What differences are there in a regional public hospital nurses’ perceptions of workplace violence based on their selected demographic characteristics (age, gender, ethnic background, level of education, work experience, working status and department)?

It should be noted that none of the questions were explored by setting of a hypothesis (such as validating or rejecting of hypothesis) because the research did not include preliminary assumptions regarding the results. This is in accordance with the hypothesis definition that: “a statement of what the researcher thinks is going to be the outcome of the investigation.” by Richardson Tench, Taylor, Kermode, and Roberts (2011, p. 277).
1.5. **Significance of the study**

This study is both timely and important. The most recent research in the healthcare field shows that violence towards nurses in hospitals is increasing (Itzhaki et al., 2015) and that it has individual and system effects. The serious individual effect can change a nurse from being a healthcare provider to a healthcare patient (Rosen, 2013). The system effect is significant due the impact on the nursing workforce (Henderson, 2003; Hutchinson, Jackson, Haigh, & Hayter, 2013; Pich, Hazelton, Sundin, & Kable, 2011). Violence towards nurses may have long-term consequences not only on nurses’ personal lives and their ability to care for patients (Henderson, 2003; Hutchinson et al., 2013; Pich et al., 2011), but also from the loss of experienced nurses from the health industry (Chapman & Styles, 2006; Farrell et al., 2006; Jackson et al., 2002; O’Connell et al., 2000).

The findings of this study are important because the qualitative data gathered from three focus group interviews provide accounts of the lived experience of nurses who have been subject to patient and hospital visitor violence. This data then aided interpreting the quantitative findings on the frequency and intensity of violence towards nurses in three acute departments: ICU, MHD and ED at a regional public hospital in Queensland, Australia. The findings and conclusions provide preliminary recommendations for strategies which may reduce the frequency and severity of workplace violence against female and male nurses, resulting in a safer workplace for nurses. The strategies were drawn directly from frontline nurses who were experiencing verbal and physical workplace violence on a daily basis.

Recommendations from nurses on strategies for reducing violence and implementing improved incident support services can be used to assist healthcare administrators improve or develop violence reduction policies, provide guidelines to support nurses who experience violence at their workplace and implement education programs in Australian health institutions and nursing education systems.

Reducing workplace violence has the potential to improve the quality of life for nurses in their work environment, the healthcare they provide and overall patient
wellbeing. In addition, a decreasing of violence towards nurses most likely will improve nurse retention rates in the Australian health system, and our strategies may also be applicable in overseas countries.
CHAPTER 2: LITERATURE REVIEW

Introduction

This literature review documents research findings concerning the frequency and severity of violence towards nurses on a global scale, then focuses on research findings in Australia, and finally, in Queensland. Consequences for the nurses targeted by violent patients and their visitors and the cost of this to our healthcare systems are then explored. Research and findings on management strategies and policies created to address violence are then discussed, including the need for support from co-workers and managers. A conceptual framework is lastly developed to structure the investigation of the nurses’ experiences of violence in their workplace, including suggestions for effective strategies and support.

2.1. Incidence of violence

2.1.1. Global epidemic of violence towards nurses

Violence at work has become an alarming phenomenon worldwide. The size of the problem is largely unknown and studies show that knowledge about workplace violence is limited (Di Martino, 2002; 2002; Perrone, 1999). Nurses around the world are exposed to violence in the workplace, with about a third of reported incidents involving physical violence and three-quarters of incidents involving verbal violence (Anderson & Parish, 2003; Celik et al., 2007; Chen et al., 2013; Chen, Hwu, & Wang, 2009; Chiou, Chiang, Huang, Wu, & Chien, 2013; Di Martino, 2002; Esmaeilpour, Salsali, & Ahmadi, 2011; Estryn-Behar et al., 2008; Fernandes et al., 2002; Fujita et al., 2012; Gimeno, Barrientos-Gutierrez, Burau, & Felknor, 2012; Hahn et al., 2012; Henderson, 2003; Magnavita & Heponiemi, 2011; Nolan, Soares, Dallender, Thomsen, & Arnetz, 2001; Pinar & Ucmak, 2011; Ryan & Maguire, 2006; Shoghi et al., 2008; Spector et al., 2014; Talas et al., 2011; Tang, Chen, Zhang, & Wang, 2007).

Rates of exposure to violence and the type of violence varies by region (AbuAlRub et al., 2007; Ferns, 2002; Levin et al., 1998; Spector et al., 2014). In the English speaking, Latin American and European regions, physical violence is mainly
perpetrated by patients, with relatively little perpetrated by family and friends (Gimeno et al., 2012; Hahn et al., 2012; Magnavita & Heponiemi, 2011; McKenna, Poole, Smith, & Coverdale, 2004; Ryan & Maguire, 2006; Spector et al., 2014). However, in the Middle East and Asia, the majority of violent incidents were reported to be caused by patients’ families and friends, and there were relatively high rates of physical and verbal violence; far higher than in the English speaking and European regions (AbuAlRub & Al-Asmar, 2011; Chen et al., 2013; Esmaeilpour et al., 2011; Itzhaki et al., 2015; Pinar & Ucmak, 2011; Shoghi et al., 2008; Spector et al., 2014).

The following are examples of high rates of workplace violence towards nurses in EDs perpetrated mainly by patients’ relatives and friends in different locations, such as Iran and Turkey. Esmaeilpour et al. (2011) reported a high frequency of verbal (91.6%) and physical violence (19.7%) towards Iranian nurses in the preceding 12 months. The patients’ relatives were mainly the perpetrators of both verbal (84.7%) and physical violence (84.9%). Similar high workplace violence frequency was found in Turkey by Pinar and Ucmak (2011), where nurses experienced verbal violence (91.4%) and physical violence (74.9%) mainly from patients’ relatives and friends: physical (62.3%) and verbal (31.7%) violence.

Nurses are reluctant to report violence to managers so the actual rates of violence may be underestimated (Ferns, 2002; Shoghi et al., 2008; Talas et al., 2011). Talas et al. (2011) claimed that participants exposed to physical assaults and verbal threats did not report the incidence of violence to managers (43.3% and 65.3% respectively). Only 35.9% of cases of verbal abuse and 49.9% of cases of physical violence were actually reported (Shoghi et al., 2008). However, Chen et al. (2013) found even less reported rates of workplace violence and stated that 90% of nurses who face violence at work would not report it. O’Connell et al. (2000) recommended an urgent need for the issue of violence towards nurses to be addressed, especially from an occupational health and safety perspective.
2.1.2. Violence towards nurses in Australia

The healthcare industry is the most violent industry in Australia (Chapman & Styles, 2006; Lyneham, 2000; McKinnon & Cross, 2008; Perrone, 1999; Pich et al., 2011) and there is evidence of an increase in violence incidence and severity (verbal versus physical violence) (Farrell et al., 2006; Hodge & Marshall, 2007; Wilkes et al., 2010). For example, Farrell et al. (2006) conducted a large study (N=2407) in Tasmania. They revealed that the majority of respondents (63.5%) had experienced some form of aggression (verbal or physical abuse) in the four working weeks immediately prior to the survey. In addition, nearly two-thirds (63.5%) of respondents reported that they experienced verbal and/or physical abuse during this period. About 50% of respondents reporting verbal abuse also experienced physical abuse. Similar high levels of violence were exposed by Hodge and Marshall (2007) where all emergency nurses (N = 266) who participated in the study reported experiencing some type of violence in their workplace. Verbal abuse occurred either face-to-face (58%) or over the phone (56%), physical intimidation or assault was reported by 14% and threats were received by 29% of participants. Nurses are exposed to more incidences of violence at work than police and prison officers (Anderson, 2011; Hodge & Marshall, 2007; Jones & Lyneham, 2001).

Lyneham (2000) conducted a study in New South Wales EDs and found that all nurses participating in the study experienced some type of violence from patients or their relatives on a daily to weekly basis. In a later study, Lyneham (2010) also concluded that nurses face an unacceptable level of workplace violence and no nurse is immune to violence. All levels of nurses, in all of the hospital departments, are targets of violence. However, those working in critical care areas, MHDs and EDs, are at higher risk of exposure to both verbal and physical violence (Jones & Lyneham, 2001; Lyneham, 2000; Pich et al., 2011; Wand & Coulson, 2006).

Roche, Diers, Duffield, and Catling-Paull (2010) conducted a large study (N=2,487) in two states of Australia involving 94 nursing wards in 21 hospitals. The results showed a great variation among nursing wards, with violence in some wards as
high as 65% per ward. Nurses have reported experiencing verbal abuse and physical violence in their workplace on a regular basis (Farrell et al., 2006; Hodge & Marshall, 2007; Lyneham, 2000; Pich et al., 2011).

Not surprisingly, Australian nurses report similar types of violence and exposure to violence as other English speaking countries. Even though the extent of violence and the demographics of perpetrators vary by department, Australian patients are the primary source of violence towards nurses and are more likely to be physically violent. Patients’ relatives are the next most common perpetrators and are mainly verbally violent (Farrell et al., 2006; Lyneham, 2000; O’Connell et al., 2000; Roche et al., 2010). For example, Roche et al. (2010) found that patients were the source of physical violence (88.4%) and threats of violence (77.6%) while patients’ families and visitors were less physically violent (2.5%) and relatively more threatening (8.3%). Similarly, Farrell et al. (2006) found that patients and visitors were the most likely perpetrators of workplace violence. Most patients (74.3%) and patients’ visitors (35.3%) perpetrated verbal violence (63.5%) in the last four weeks. However, mainly patients (97.2%) with fewer patients’ visitors (7.1%) perpetrated physical violence (63.5%) in the previous four weeks.

2.1.3. Violence towards nurses in Queensland

Queensland has 16 state run health service districts with a total of 281 hospitals. Of these, 178 are public hospitals and 103 are private hospitals. The public hospitals are government funded hospitals ranging from capital city hospitals with all specialties, to small rural hospitals with as few as a dozen patients. The private hospitals are located in capital cities, and regional cities and towns. There are 12 public hospitals which have all three acute departments: ED, MHD and ICU. Few studies have been conducted in these departmental sectors in Queensland. The largest study to date is Hegney’s longitudinal study that reported findings in 2001, 2004, and 2007 (Hegney et al., 2006; Hegney et al., 2003; Hegney et al., 2010). Another study conducted in Queensland by Crilly et al. (2004) was restricted in scope, dealing only with violence towards nurses in the emergency room. Hegney et al. however, studied the differences
between sectors of employment (public, private and aged-care sectors), but made no comparison between rates of violence or severity between wards within each sector.

The research aim in the Hegney et al. (2006) study was to identify the factors impacting upon nursing work. The study was conducted in conjunction with the Queensland Nurses’ Union (QNU) and gathered data from QNU members employed in the public hospital system, the private acute hospital system and aged care sectors in 2001 and 2004. One of the most significant findings of the 2004 study was the high rate of workplace violence, which increased in each of the sectors between 2001 and 2004. The rate of workplace violence differs significantly across sectors and 47% of public sector nurses experienced workplace violence (Hegney et al., 2003). Another study conducted by Hegney et al. (2010) revealed that the incidence of workplace violence was highest (53.4%) over the previous three months in the public sector in comparison with private acute (35.8%) and aged care (49.7%).

All the studies in Queensland indicate similar results with regard to perpetrators and the type of violence as the other studies conducted throughout Australia. Patients are the major source of workplace violence in all sectors, followed by visitors or relatives. Nurses are most often victims of verbal violence and to a lesser extent, physical violence (Hegney et al., 2006; Hegney et al., 2003; Hegney et al., 2010). Potential concerns, Hegney et al. (2006) found the highest increase in violence by patients was (74.8%) in public hospitals, compared with visitors or relatives (44.9%) in 2004. Both figures were substantially higher than the rates of violence in public hospitals by patients in 2001 (63%) and by visitors or relatives (33.8%). The most common form of verbal violence was being sworn at (61%) while being pushed was the most common form of physical violence (10%), followed by (3%) hit and (3%) kicked (Crilly et al., 2004).

Crilly et al. (2004) argued that social behaviours and mental illness play a role in violence. For example, the perpetrators of violence were often under the influence of alcohol (27%), drugs (25%) upon admission, or displayed behaviours associated with mental illness (38%). The time of day was also significant. The evening shift (3–11pm) was when most violence of all types was reported. During the day shift (7am–3pm), the least violence was reported (Crilly et al., 2004).
Hegney et al. also importantly found that levels of violence towards nurses did not vary according to age, gender, work experience or seniority. There were no significant differences in levels of violence towards nurses in public hospitals, differentiating between nurses’ age, gender, seniority or years of nursing experience (Hegney et al., 2003). Significantly, Hegney et al. (2006) stated that the proportion of male nurses who reported workplace violence was substantially higher than the proportion of female nurses who reported violence in the 2001 and 2004 studies. Hegney et al. also found that male nurses employed in the public sector believed they were exposed to workplace violence more often than female nurses (Hegney et al., 2003).

2.2. Consequences of workplace violence towards nurses

Workplace violence has long-term consequences not only on nurses’ personal lives, their professional work abilities, but also on their employers, witnesses to violence and nursing students. The personal impacts of workplace violence range from physical, psychosocial and behavioural to reduced emotional wellbeing (Henderson, 2003; Hutchinson et al., 2013; Pich et al., 2011). Grenyer et al. (2004) claimed that victims of violence not only face immediate trauma from physical assault, but that frequent exposure can lead to cumulative effects such as the development of post-traumatic stress disorder and substance abuse. The potential risks to nurses including psychological trauma and symptoms of post traumatic stress disorder (Jones & Lyneham, 2001). Exposure also might evoke stress and reduce the nurses’ life satisfaction (Itzhaki et al., 2015). The professional consequences of workplace violence include a decrease in nurses’ abilities to offer effective patient care, and it negatively impacts on their work motivation, work performance, work relationships and productivity—including an increased risk of making errors (Farrell et al., 2006; Gacki-Smith et al., 2009; Henderson, 2003; Hodge & Marshall, 2007; Hutchinson et al., 2013; Jackson et al., 2002; Jones & Lyneham, 2001).

Workplace violence and its consequences also have direct and indirect impacts on both employees and employers. The indirect impacts are associated with factors
that influence employees’ experience of work (Estryn-Behar et al., 2008; Gacki-Smith et al., 2009; Hutchinson et al., 2013) and include the following:

- less enjoyment in working with patients (Arnetz & Arnetz, 2001)
- perceptions of an unsafe workplace and lower morale within the workplace (Hegney et al., 2006; Hegney et al., 2010; Maslow, 1943)
- perceptions of a lack of support that can influence nurses’ feelings of resignation (Anderson, 2011; Hegney et al., 2006; Henderson, 2003; Jones & Lyneham, 2001; Lyneham, 2000)
- loss of experienced nurses from the workforce and inability to attract nurses back to the bedside (Chapman & Styles, 2006; Farrell et al., 2006; Jackson et al., 2002; O’Connell et al., 2000).

However, the direct impacts are costs due to sick leave, decreased productivity, property damage, poor nurse attendance rates and workers compensation costs (Anderson & Parish, 2003; Chapman & Styles, 2006; Dillon, 2012; Farrell et al., 2006; Fitzgerald, Dienemann, & Cadorette, 1998; Hodge & Marshall, 2007; Jackson et al., 2002; Levin et al., 1998; O’Connell et al., 2000; Speedy, 2006; Ventura-Madangeng & Wilson, 2009).

Witnesses of violence towards nurses are also negatively impacted on by the experience of being exposed to violence in the workplace. These impacts include emotional reactions (Grenyer et al., 2004), reduced number of students choosing nursing as a career (Ferns & Meerabeau, 2009) and compromised self-esteem and morale (Magnavita & Heponiemi, 2011). Given the negative consequences of workplace violence on nurses and witnesses, hospital managers have a responsibility to minimise violence towards them. Section 2.3 summaries the relevant research on how workplace violence is being addressed by hospital management.
2.3. Workplace management to address violence

Several management strategies have been used to address workplace violence towards nurses. The main interventions for managing aggressive behaviours in acute care settings include staff training programs, chemical restraints and mechanical restraints (Kynoch et al., 2011).

2.3.1. Staff training

Research into staff training programs has established that training is effective for managing aggressive patients, and has positive outcomes that improve nurses’ knowledge, confidence and skills (Arnetz & Arnetz, 2000; Deans, 2004; Grenyer et al., 2004; Kynoch et al., 2011). Participating in one to four aggression minimisation program modules, as reported by Grenyer et al. (2004), was found to improve staff knowledge, skills and confidence in dealing with aggressive patients. Kynoch et al. (2011) also investigated the use of thorough staff training programs to prevent and manage patient aggression in acute care settings, and revealed that nurses could be equipped to manage patient aggression incidents through increasing knowledge, skills, attitudes and confidence.

Another staff training program conducted by Arnetz and Arnetz (2000) assessed the effectiveness of a one-year intervention program that aimed to help staff in multiple health care settings to deal with aggressive patients. This intervention was found to be successful. Nurses who completed the intervention program were more able to cope with aggression than a control group, and the increased success was statistically significant (p < 0.05). Even though staff who participated in the intervention program in multiple healthcare settings reported 50% more violent incidents than the control group, the participants were better aware of risk situations, avoided potentially violent situations and knew how to deal with aggressive patients.

Findings from Deans (2004) confirmed the positive outcomes and effectiveness of staff training programs for nurses who participated in a one-day aggression training program in an ED in Australia. The training program resulted in a significant improve-
ment in knowledge and understanding of managing aggressive situations, and also improved staff skills and confidence in dealing with aggressive situations, while improving staff attitudes towards potentially violent patients.

Although staff training programs were found to be effective in dealing with aggressive patients and situations, often little or no training is provided by employers (Kynoch et al., 2011). Evidence suggests there is a need to educate and train nurses in how to address and manage violence (Badger & Mullan, 2004; Nachreiner et al., 2005). For instance, Badger and Mullan (2004) reported that 42% of the respondents had not received any training in the past 12 months. Furthermore, Ryan and Maguire’s (2006) study found that less than one-third of staff reported that they had had training in the management of aggression and violence. Even in acute departments, such as intensive care, Ferns (2002) reported that only 6% of nurses reported receiving training or education to deal with incidents of physical violence in the intensive care setting. Training has significant costs; nevertheless, the costs of not conducting training may be higher than conducting it.

2.3.2. Chemical restraint

Chemical restraint of patients may be required when patient self-harm or violence towards nurses, other staff or other patients is imminent (Hodge & Marshall, 2007). Chemical restraint can be implemented using a range of medications in the acute care setting. Kynoch et al. (2011) purported that Droperidol — used for managing severe agitation, aggression or hyperactivity in psychotic disorders (Tiziani, 2013)— and Midazolam, induce sedation, hypnosis, amnesia, anaesthesia and muscle relaxation (Tiziani, 2013). This combination has a more rapid and effective sedative effect than Lorazepam—used for anxiety and premedication (Tiziani, 2013), and Haloperidol—used for schizophrenia, psychoses, manic phase of bipolar disorder and during alcohol withdrawal (Tiziani, 2013) when dealing with aggressive patients. Chemical restraint may be preferred to mechanical restraint because the adverse effects are generally more accurately predictable and manageable by emergency staff than is the case with mechanical restraints (Hodge & Marshall, 2007). Chemical restraints are also less visible and may better address charters or patient rights.
2.3.3. Mechanical restraint

Mechanical restraint is another management strategy when dealing with aggressive patients who pose an unacceptable risk of violence to nursing staff. Mechanical restraint is applied to restrain a patient’s body and limbs, preventing them from injuring themselves or others. It may be necessary when de-escalation techniques such as defusing, negotiation and conflict resolution (which aims to prevent violence), are unsuccessful due to a challenging dynamic environment, or when nurse and patient protection is necessary to allow a treatment regimen to be maintained (Hodge & Marshall, 2007). According to Kynoch et al. (2011) 40.3% of patients who were physically restrained needed restraint for more than one reason, including agitation, violence, disruptive behaviour, confusion, dementia and alcohol/drug intoxication. Mechanical restraint has a low rate of minor complications, but it requires close nurse supervision and therefore is often expensive.

2.4. Workplace policies to address violence

Australian state and territory healthcare departments have adopted zero tolerance policies towards violence (Pich et al., 2011; Wand & Coulson, 2006). However, policy document are not readily available within the public domain nor it available with accreditation standards. While there are some other documents that are available only to employees. These are not for distribution and its arguable that are still lack of clarity. Therefore, there is a need for a clear policy document.

Despite these zero tolerance policies, violence towards nurses persists in healthcare settings (Wilkes et al., 2010). Two significant barriers for addressing violence are a lack of clear and consistent definition of what constitutes violence and the underreporting of incidents (McKinnon & Cross, 2008). A Hegney et al. (2006) study found that nurse awareness of the existence of violence policies had increased between 2001 to 2004 across all healthcare sectors. This may explain some of the increase in reporting of violence. However, public sector nurses believed policy inclusions for aggressive patients or visitors were inadequate. Therefore, the Hegney et al. (2006) study suggested that a “one size fits all” education program or policy would not be effective in managing workplace violence. The results in the Hegney et al. (2006)
study suggest that although there are policies in place against workplace violence, they are not as effective as they need to be, because there was no decrease in violence towards nurses between 2001 to 2004, despite increased policy development and awareness. This may be explained by nurses believing that the process of reporting is very slow and cumbersome, which will be discussed further in chapter 6.

Actual progress in reducing overall violence levels is stagnating. A later study by Hegney et al. (2010) exposed that the existence of a workplace policy did not decrease levels of workplace violence. It found that 54.3% of participants in the study stated that policy recommendations for violence perpetrated by patients or families in the public sector were inadequate.

Unfortunately, it appears that nurses believe that “nothing will be done” if a report is made (Jones & Lyneham, 2001). In some cases, a nurse victim was accused of causing the situation, and so became further victimised and traumatised. Perhaps these outcomes contribute to why there is a low level of reporting of the incidence of violence, as discovered by Lyneham (2000). Key factors in the underreporting of violent incidences include the following:

- The frequency and severity of aggressive incidents have not been well documented in the past.
- The stigma of victimisation, such as shame, isolation, fear or threat of further violence has often deterred victims from reporting violent behaviour. (Clements, DeRanieri, Clark, Manno, & Kuhn, 2005)
- Nurses have accepted violence from patients as normal in their nursing work.
- The existence of poor or unknown reporting mechanisms.
- The fear of reprisals by senior management.
- A lack of time or unwillingness to complete the necessary paperwork.
- A belief that no action will be taken (Clements et al., 2005; Hegney et al., 2010).
- A lack of support from administration and management is one of the reported reasons why nurses continue to underreport workplace violence (Clements et al., 2005).
Consequently, workplace zero tolerance policies did not decrease levels of workplace violence, and violent incidences continue to be underreported despite nurses’ increase awareness to the important in reporting violence incidences in their workplace. The following section presents the frequency of co-worker and managerial support that nurses received during and after a violent incident.

2.5. Support from co-workers and managers

If there is little support for nurses to deal with aggressive situations and violence, a crisis point is often reached because staff are not trained to deal with violent situations (Anderson, 2011). Pich et al. (2011) elucidated that nurses also experience frustration with lengthy reporting processes. Lack of support for staff who report a violent incident appears to be significant. Lyneham (2000), for example, reported that 52% of respondents did not receive any support following their most significant violent incident. In addition, O'Connell et al. (2000) found that 65% of respondents did not know what support mechanisms were available in the hospital to assist them to deal with and recover from an aggressive episode. An aggressive episode often results in physical injuries due to nurses being hit with objects, grabbed, punched, pushed, scratched and kicked. Over half of the nurses felt burnout after the aggressive incident, but they did not know they could attend support services, such as counsellors or outside counselling services for recovery (O'Connell et al., 2000).

Staff who did receive support after a violent incident most commonly received support from co-workers (49%), someone outside the workplace (18%) or from their workplace supervisor (14%) (Arnetz & Arnetz, 2001). However, hospital nurses were not as aware of available support services compared to allied health staff, even though a higher percentage of nurses to allied staff were involved in violent incidents (Badger & Mullan, 2004). Overall, the research indicates that there is a lack of support in the workplace from colleagues and team leaders. The Hegney et al. study found that 32% of nurses thought that teamwork was lacking (Hegney et al., 2010).

In summary, many nurses were not aware of support services within their organisation and some of the nurses did not receive any support. Nurses who received
support mentioned it was mainly from their colleagues and supervisors. The following section presents the conceptual frameworks that guide this study.

### 2.6. Conceptual frameworks

Three conceptual frameworks were considered for this study:

- the Haddon Matrix by Haddon (1980)
- the Three Dimensional Model of the Psychological Work Environment by Karasek and Theorell (1990)
- the Occupational Health Framework by Levin et al. (1998).

The most recent framework, the Occupational Health Framework by Levin et al. (1998) was chosen for this study. Overall, it has the ability to explore the extent of workplace violence towards nurses, and leads to better understanding of the factors that contribute to this problem, the frequency of the violence and its effects on nurses. This framework also provides a structure for analysing the solutions to the workplace violence problem, based on the nurses’ suggestions.

The two earlier frameworks were not chosen for this study as each of these frameworks explored either the factors contributing to, or the solutions for, workplace violence. However, it is superior to explore workplace violence as a whole issue from different aspects, including both factors and solutions. The Three Dimensional Model of the Psychological Work Environment by Karasek and Theorell (1990) and the Haddon Matrix by Haddon (1980) presents nurses’ suggestions for managing the prevention of violence in their workplace. The Haddon Matrix (1980) provides a framework originally designed for injury prevention and intervention analysis to identify alternative and complementary strategies for dealing with potential injury problems. The matrix identifies interventions that are applied in the three phases of a situation to identify elements that cause a risk for individual injury. The three phases (pre-assault, event and post-event) are identified during an analysis of risks with other three factors (the host—nurses; vector—offending patient or visitors; and vehicle—work environment). This was not suitable for the current study because there may be more than three factors contributing to workplace violence that need to be identified.
The Karasek and Theorell framework (1990) is a three dimensional model of the psychological work environment. The model consists of psychological demands, decision latitude and social support at work. Karasek and Theorell (1990) recommended that their model needed to be expanded, if it is to be acceptable to medical scientists, and that the physical demand domain should be used in most occupational health and safety research (p.65). This was not suitable for my current study because it required other aspects to understand the solutions and the factors that contribute to workplace violence.

In my study, The Occupational Health Framework by Levin et al. (1998) was chosen to guide and investigate the research questions, analyse the data and provide greater understanding of the factors that contribute to assault injuries. The Levin theoretical framework helps to conceptualise the complex nature of workplace violence. This theoretical framework discusses the factors that contribute to verbal and physical violence incidents and the consequences for nurses, patients, witnesses to the violence and, in the long-term, for the whole healthcare industry.

By addressing these factors, solutions for violence towards nurses are more likely to be found. The three factors of the Levin framework are: Person Factors, Workplace Factors and Environmental and Situational Factors. These three factors contribute to the assault injuries and effects of workplace violence, and also impact on the solutions to violence as shown in Figure 1 by Levin et al. (1998).

![Figure 1: Factors that contribute to workplace assault injuries](image)
Summary

Review of the literature concerning violence towards nurses shows that incidents of violence are a significant issue within the nursing profession. The rate of exposure to violence and the type of violence experienced varies by region. The incidence and severity of violence is increasing in Australia, and globally. All levels of nurses in Australia, in all areas, are targets of violence mainly from patients or visitors on a daily to weekly basis; physical violence is experienced mostly from patients and verbal violence from visitors. In Queensland, only two major studies have been conducted in this field. A longitudinal study by (Hegney et al., 2006; Hegney et al., 2003; Hegney et al., 2010) reported differences between sectors of employment (public, private and aged care), but did not report on differences in violence incidence between wards. Nurses in the public sector experience more violence from patients and visitors in comparison to the private and aged care sectors. Another study conducted by Crilly et al. (2004) focused on violence towards nurses in the ED.

Workplace violence impacts on nurses’ personal lives, professional work abilities, employers, the healthcare industry, witnesses to violence and the career decisions of students considering entering the profession. Managing violence is achieved via various strategies, including staff training programs, chemical restraints and mechanical restraints. There are also existing policies to address violence, but the existence of a workplace policy does not appear to decrease levels of violence towards nurses. Nurses report a lack of support from hospital administration and management. This may be a reason for the underreporting of workplace violence. Nurses receive support mainly from their co-workers during and after violent incidents and are less aware of support available from hospital departments following an incidence of violence.

The Occupational Health Framework by Levin et al. (1998) was chosen to guide the formulation of research questions, analyse the data and understand the factors that contribute to violence towards nurses. Chapter 3 sets out the reasons for the choice of a mixed methodology for this study, the research design and ethical approvals.
CHAPTER 3: METHODOLOGY

Introduction

This chapter justifies the qualitative and quantitative mixed methodology design for this study. The location choice for the study is explained and the ethical clearance process from both the University of Southern Queensland and Queensland Health is documented. The two phases of the study are described. For the qualitative study, these phases are the selection of participants, data collection, transcription and thematic analysis. For the quantitative study, the phases are selection of participants, design of the questionnaire, data collection, analysis and data screening.

3.1. Mixed methodology

Qualitative research is often suitable to explore peoples’ individual experiences, while quantitative research allows generalised conclusions to be formed about a population (Andrew & Halcomb, 2006). Borbasi (2012) recognised that no single method or theoretical perspective in isolation has the ability to provide a comprehensive understanding of humans and their health-related needs, and that mixed methodology research seeks to build on the strengths and reduce the weaknesses of both qualitative and quantitative approaches.

Mixed methodology designs include at least one quantitative method and one qualitative method of research, where neither type of method is naturally linked to a particular inquiry paradigm. Mixed methodology research combines elements of qualitative and quantitative research approaches for the purposes of breadth and depth of understanding and corroboration (Taylor & Francis, 2013). Andrew and Halcomb (2006) described six purposes for using a mixed methodology design. These are triangulation, complementarity, initiation, development, expansion and enhancement of significant findings. These purposes are itemised as follows:

1) Triangulation is a technique that uses multiple research approaches to answer the research questions in the same study (Streubert & Carpenter, 2011). The purpose of triangulation is to corroborate results using data collected through different methods. In this study, data were collected by using mixed methodology studies:
qualitative study of three focus groups interviews of 23 nurses and a quantitative survey of 98 nurses who work in three departments. Findings of both studies could be compared, contrasted and possibly confirmed, thus increasing validity.

2) Complementarity is a technique which seeks to elaborate, illustrate or clarify the results of one method with the data collected from the other method. In this study, the mixed methodology design uses the strengths of quantitative and qualitative data collection to complement each other and to give the study more scope.

3) Initiation increases the depth and breadth of understanding of the phenomenon by exploring it from different methodologies and paradigms. In this study, by exploring the research problem from different perspectives, the breadth and depth of the findings and interpretations are increased, and reveal a unique characteristic of the phenomenon of violence towards nurses.

4) Development is a sequential design where data from the initial collection inform the development of the subsequent method. In this study, the investigation starts with qualitative focus groups whose findings are then used for developing a quantitative research survey instrument. The newly-developed instrument is then used for a quantitative survey.

5) Expansion aims to extend the depth and scope of the inquiry by using different measures to explore different inquiry components of the research problem. In this study, different measures were used, such as interviews and survey questionnaires, to achieve an understanding of both the depth and scope of physical and verbal violence towards nurses.

6) Enhancement of significant findings is achieved by moving from one methodology of data collection that can be specifically explored by another, thereby enhancing the findings. In this study, the findings from the focus groups were used to guide and investigate the research problem in the second phase of this study, making the findings more thorough.

The topic of violence towards nurses is a complex problem that involves individual experiences. But the impact on nurses’ abilities to care for patients and interact with visitors needs to be quantified so that the problem can be adequately addressed.
For this reason, two research methodologies are necessary. Mixed methodologies incorporating qualitative and quantitative research provide a more comprehensive evaluation of the problem than either method alone. The combination of qualitative and quantitative methods of data collection in one study provides a holistic and flexible approach to address complex research problems. Understanding the phenomena of interest that can be discovered through the chosen approach is important (Luck, Jackson, & Usher, 2006a).

Mixed methodology design was the most appropriate methodological approach to answer the research questions in this study, because it has the potential to provide a richness of detail and a more complete understanding of the phenomenon of violence towards nurses. There are benefits of combining quantitative and qualitative methods, such as the richness of data available. Nevertheless, large and cumbersome amount of data is generated that could be controlled by efficient data coding and theming. An obstacle of the data-gathering method is that focus groups may have strong members who are more outspoken, and their views may influence the responses of other group members in a process known as “group-think” (MacDougall & Baum, 1997). Streubert and Carpenter (2011) described group-think as a process that occurs when stronger members of a group have the main influence over the verbalisations of other group members. This risk can be mitigated by a researcher being aware of this risk and mitigating it by paying close attention to its potential throughout the data collection process and by inviting each of the participants to contribute their perceptions in each question of the discussion. The advantages of using a focus group for data collection can then outweigh the disadvantages.
3.2. Research design

Sequential Exploratory Design was used for this research, in which the project has two phases—qualitative and quantitative—with priority given to the initial data collection (Borbasi, 2012). The first phase is exploratory, because it prioritises qualitative data collection and analyses to enable development of a generalizable of the survey. The second phase follows with quantitative data collection and analyses to test or generalise the findings from the first phase (Taylor & Francis, 2013). The qualitative methodology was given priority in this study by conducting focus groups (Phase one), while supplementing it with the quantitative methodology of survey questionnaires (Phase two) as shown in Table 1.

Table 1: The research phases, tools and participants

<table>
<thead>
<tr>
<th>Research Phase</th>
<th>Qualitative - First</th>
<th>Quantitative - Second</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tool Type</td>
<td>Focus Groups Interviews</td>
<td>Survey Questionnaires</td>
</tr>
<tr>
<td>Participants</td>
<td>Nursing Unit Managers (NUM)</td>
<td>Nursing Unit Managers (NUM)</td>
</tr>
<tr>
<td></td>
<td>Head Nurses (HN)</td>
<td>Head Nurses (HN)</td>
</tr>
<tr>
<td></td>
<td>Ward Nurses (WN)</td>
<td>Ward Nurses (WN)</td>
</tr>
</tbody>
</table>

In this design, the subsequent integration of the two data collection methodologies occurred during the interpretation phase of the study. The qualitative data explored the problem in depth and directed the study, while the second quantitative phase strengthened the findings and enabled limited generalisation of them.

The first phase examined the nurses’ perceptions regarding the possibilities of violence from patients and visitors at their workplace, taking into account the strategies, management and support they received at work. The findings of this phase, combined with the information in the literature review, were used to choose the variables for the second phase: the quantitative survey questionnaire. The key factors identified in the qualitative study used to develop the items of the survey.
3.3. Study location

The location of the study was a regional public hospital; one of 12 public hospitals with EDs, ICUs and MHDs in Queensland. The selection of this hospital location allowed me to gather data bounded in space and time, at one institution, so that the complexity of the system of human interactions at this location could be explored.

3.4. Ethical considerations

Ethics approvals were obtained prior to the commencement of this study from the Human Research Ethics Committee of the Queensland Health Department (HREC Reference Number: HREC/14/QTDD/6), see Appendix B, and from the Human Research Ethics Committee of the University of Southern Queensland (HREC Reference Number: H13REA249), see Appendix A. A letter of support to conduct the study at the site was provided by the Executive Director of the Public Regional Hospital and Health Service (Appendix D). I was aware of the important of beneficence and non-necficence as were mentioned in full details in Queensland Health full NEAF ethics application along with appropriate ways to manage distressed participants and providing options of counselling services for the focus groups participants.

After the ethics approvals were obtained, a Site Specific Assessment (SSA) was approved by the Chief Executive of the Hospital and Health Service for this study to take place at a regional public hospital in Queensland (SSA Reference Number: SSA/14/QTDD/34), see Appendix C. The SSA also included all the nurse unit managers who gave permission to conduct this study on their sites, see Appendix C. A Notification of Commencement of Research Protocol was also completed, see Appendix T. All the participants in this study volunteered and agreed to participate in the study and completed a consent form. The data was not unanimous because it was mentioned by the participants during the focus groups.
3.5. Phase one: focus group interviews

Introduction

Focus groups are group interviews where a clearly defined topic is discussed, with a focus on enabling and recording interactive discussion between participants (Burns, 2009). Focus group interviews have been found to be one of the most powerful methodologies, and the most useful, in a number of settings, but particularly, when dealing with sensitive topics. According to Streubert and Carpenter (2011) a focus group is a particular form of group interview intended to exploit the dynamics of the group best suited to the collection of qualitative data; focus groups also have the advantage of being flexible, inexpensive, stimulating, cumulative, elaborative, assistive in information recall and are capable of producing rich data based on the ability to understand the experience, feeling and perceptions of the participants. This discussion about sensitive topics can be achieved by promoting self-disclosure among participants and by explicitly capitalising on group dynamics in discussions (Streubert & Carpenter, 2011).

For these reasons, semistructured focus group interviews were chosen to gather data about the nurses’ perceptions of verbal and physical violence. The first phase of this study consisted of three focus groups held in August and September 2014.

3.5.1. Participants of the focus groups

3.5.1.1. Selection criteria

Streubert & Carpenter (2011) recommend that focus group size be between six and ten participants. Larger group size may preclude all participants from having a chance to speak, while a smaller group size may make group members feel as though they cannot speak freely or feel obliged to speak even if they have nothing to contribute.

All participants in the study were registered nurses who worked at the time in one of the three acute care departments: ED, MHD or ICU. Each focus group consisted of staff of one of the three departments being studied. A total of 23 nurses participated in the three focus groups. Of these, six nurses were from emergency, six were from intensive care and eleven were from mental health. The MHD has three units including
chapter 3: methodology

an open, closed and adolescents’ unit. Three to four nurses from each of these units formed the MHD focus group for the study.

3.5.1.2. recruitment process

Participants were recruited following a meeting in 2014 between the the nurse unit managers and me from each of the departments (see Appendix C). Information was provided about the study, and the managers were invited to ask questions. All of the managers agreed to allow me to access the nurses who work in their departments.

Contact then continued with the managers via email and phone calls to arrange dates to undertake recruitment at each workplace unit. A notice was placed by me — with permission from the hospital management and the nurse unit manager in each department — on the bulletin board of each target department to invite the nurses to participate in the study (see Appendix E). The notice explained the study and gave contact details to enable the participants to volunteer.

In addition, invitations to participate were emailed to each manager, who then informed their staff nurses about this study (see Appendix H). Both the printed and online invitations about the focus groups included information about the study, proof of ethics clearance, my contact details and contact details of the HREC Coordinator in case any participant had any ethical concerns or wished to complain about how the research was being conducted.

Documentation provided to the nurses emphasised that participation was entirely voluntary and if nurses did not wish to take part, they were not obliged to do so, and they would not be disadvantaged in any way if they chose not to participate, or if they withdrew from the study (see Appendix J).

The nurses were informed that all the information would remain confidential, and care would be taken not to identify any individual. The nurses who contacted me and wanted to participate in the focus group interviews received a written information sheet about the focus group. Prior to their participation they were asked to sign a consent form (see Appendix I).

The focus group meetings were held on the campus of the University of Southern Queensland (see Appendix F). On the day of the focus group sessions, several
notices were posted in the entrances of USQ for providing directions to the participants (see Appendix G).

### 3.5.2. Data collection

Saturation refers to a point at which sampling and data collection are stopped because the information being collected becomes repetitive (Borbasi, 2012). The collection and generation of data in this study continued until the data reached saturation, when no new themes appeared from the focus group participants and the data became repetitive and no new information emerged. A semistructured list of questions was developed based on the research questions and the literature review (see Appendix L). Two research nurses from the University of Southern Queensland reviewed the questions and provided feedback. The data was collected from the focus groups participants by informing first each group of the number of questions to be covered in the allocated 60 minute interview. Each of the groups continued longer than expected and the focus groups’ interviews were each about 90 minutes long. Once the data were obtained, each recording was transcribed. Individuals in the focus groups were given codes to ensure anonymity and maintain confidentiality.

#### 3.5.2.1. Guiding questions

Effective focus group sessions have the potential for learning about both the focus and the group. To do this, the group facilitator must have a solid understanding of group processes. Three main sections of each focus group interview are the introduction, conducting the group session and closing the group session (Streubert & Carpenter, 2011). At each of the research sessions, the topics of discussion and the purpose of the study were explained, as documented in the Participant Information Sheet (see Appendix J). All participants were informed of their ethical rights, including their right to confidentiality and their right to withdraw from the study at any time. Permission was obtained from the participants to record the focus group interviews enabling accurate transcription of the data. Participants were encouraged to ask any relevant questions and to sign the Focus Group Consent Form (see Appendix I).
Participants then answered demographic questions (see Appendix K) and the semi-structured open-ended general questions (see Appendix L). The open-ended questions encouraged narrative answers from the participants. Participants were encouraged to freely express their ideas and were assured that whatever they shared was acceptable. Follow-up questions were asked for clarification when necessary. These included questions such as: “What do you mean by…?” Probing questions were used to explore responses that were significant to the study by asking questions such as: “Please, tell me more about…” Width and depth probing questions were used to elicit data that illuminated the lived experience of nurses and thus provided evidence for answering the research questions.

At the close of each focus group session, the participants were thanked for their involvement and were asked if they had anything further they wanted to add. I offered to provide a summary of the research findings to the participants.

3.5.2.2. Confirmability of the study

Borbasi (2012) defined confirmability as the accuracy and comprehensiveness of the data collected. The term has replaced “validity” and “reliability” in qualitative research. Confirmability consists of three attributes: credibility, auditability and transferability.

1) Credibility refers to the “steps taken to make certain of accuracy, authenticity and validity of data” (Borbasi, 2012, p. 254) and examines whether or not the explanation or interpretation of data matches what has been described or recorded (Borbasi, 2012). Credibility in this study was assured by cross-checking data with the recordings and providing an audit trail (decision trails). The audit trail ensured that adequate documentation was available about the data collection and analysis process. Accurate interpretation of the data was assured by the use of direct quotations of the participants and extensive use of the quotations to validate the findings of the study.

2) Auditability refers to the ability of other researchers to repeat the research in other times, locations and contexts. In this study, enough details were provided, including the questions used to enable other researchers to repeat the study.
3) Transferability or fittingness refers to when the findings fit into contexts outside the study situation (Borbasi, 2012).

Even though Borbasi (2012) argued that confirmability has replaced the terms validity and reliability in qualitative study, other researchers such as Creswell (2013) and Streubert and Carpenter (2011) still use these terms. These terms are therefore discussed here.

### 3.5.2.3. Validity of information

Validity refers to a form of content validity. It asks whether the researcher is convinced that what the participants have shared is valid information (Streubert & Carpenter, 2011). According to Creswell (2013), qualitative validity means that the researcher checks for the accuracy of the findings by employing certain procedures. The use of mixed methodology data collection is a means for increasing the validity of research findings (Borbasi, 2012). There are two ways to ensure the validity of data when conducting focus groups, firstly by paying careful attention to the composition of the group and secondly, determining whether participants in other groups mentioned similar experiences. In this study, all three focus group interviews elicited narratives of similar experiences and similar perceptions concerning violence towards nurses.

### 3.5.2.4. Reliability of information

Qualitative reliability indicates that the researcher’s approach is consistent across different projects (Creswell, 2013). Streubert & Carpenter (2011) outline three criteria for reliability—stability, equivalence and internal consistency:

1) Stability refers to the consistency of issues over time (Streubert & Carpenter, 2011). Stability is an essential issue when data are gathered from different groups at different times on similar topics. In this study, the main issues discussed during the three focus groups were consistent. Participants from all three focus groups spoke about the same issues and discussed similar problems, similar strategies and suggested similar solutions. In addition, all three focus groups spoke about similar issues in answer to the open-ended questions and volunteered information about issues, such as a shared perception that violence towards nurses is partially gender-based. For
example, all the focus groups mentioned nurse gender and its impact on the ability of nurses to cope with violence from patients and visitors. Gender was raised in all the focus group interviews, even though it was not a direct question for discussion in the study.

2) Equivalence describes the consistency of the moderators or coders of the focus group data (Streubert & Carpenter, 2011). In order to maintain equivalence, one person, I have conducted all three focus groups and transcribed all the recordings, coded all the data and conducted the thematic analysis.

3) Internal consistency of coding refers to the importance of having one team member assume the major responsibility for coding the data, conducting the analysis, participating in as many groups and debriefings as possible (for large studies) and communicating regularly with other team members as the analysis proceeds (Streubert & Carpenter, 2011). During all the stages of this study, I have conducted the research with supervision from my principal supervisor. I have planned the focus groups, conducted the interviews, transcribed the recordings and analysed the data. Regular meetings were held with my principal supervisor to ensure accuracy and sound analysis of the data.

3.5.3. Data analysis

Data analysis is an inductive process and involves examining words, descriptions and processes that require the researcher to read and reread file notes and transcripts, to ensure familiarity with the data (Borbasi, 2012). Data analysis in qualitative research consists of preparing and organising the transcripts, then sorting the data into themes through a process of coding, and gradually condensing the codes to produce findings which can be illustrated as figures, tables or a discussion (Creswell, 2013). Creswell (2013) described the spiral data analysis of qualitative data as a process of moving in analytic circles rather than taking a linear approach. Spiral data analysis consists of six stages (Creswell, 2013):

1) Data management—in this study, the analysis process included organising the data into computer files and converting the data into appropriate text units for analysis, such as words or sentences.
2) Reading and memo making—reading the data and writing memos about the whole database was the initial step before breaking the data into smaller parts. (‘Memo’ is a tool in the NVivo program that helps to record thoughts and understanding related to the themes). The NVivo software program assisted with this task. As common words and phrases were discovered, textual analysis formed these common data items into themes and subthemes.

3) Describing, classifying and interpreting data into themes—this enabled me in this study to develop a point of view possibly supportive of findings in previous studies. The process of coding and interpreting the data involved aggregating categories of similar information and labelling them as a larger code. Several codes formed a theme which expressed an idea or thought that was common to several participants.

4) Interpreting the data—this involved abstracting concepts beyond the codes and themes to the larger meaning of the data and the context of the themes in the overall study.

5) Further interpretation of the data—included abstracting beyond the codes and themes to the larger meaning of the data in the context of other research in the field.

6) Representing and visualising the data—this was the final stage of the six-step spiral process and involved creation of diagrams, tables and figures to succinctly present the data and enhance the textual presentation of the findings.

3.5.4. Transcriptions of the data

The three focus groups were recorded by two tape recorders to ensure all participants were clearly audible. The recordings were transcribed verbatim by me and I was also the focus group facilitator. I have made sure that all the recorded data was transcribed accurately. Transcribing recorded data was time consuming and complex due to the tendency of the participants to talk at the same time. This challenge was managed by using two recorders, that allowing me to listen to the participants who were separately located closest to each microphone. By listening to both tape recordings several times, an accurate transcription was produced.
3.5.5. Thematic analysis

Following the transcribing of the focus groups interviews, the qualitative data was analysed manually and by the NVivo program to determine themes. The NVivo program provided an organised storage file system for locating data and storing it in one place. This feature assisted with managing, shaping and analysing the qualitative data. Furthermore, it provided security by storing the database and files together in a single file, as well as programs for manipulating the data, conducting searches and graphically displaying the codes and categories. The NVivo computer program simply provided a means for storing the data and easily accessing the codes that I have provided, which helped me in avoiding human error in manual thematic analysis.

The analysis process was performed manually at first, to find themes and patterns. During the analytical process, I have searched for themes and meaning in the data, and categorised this information based on the themes that had been found. Secondly, the NVivo program helped me to organise, manage and analyse the data into further categories with files, notes and themes, and also allowed me easier access to the needed data.

The NVivo program did not perform the analysis for this study, but was used as a tool to help me to organise and manage the data. In this process, I and not the NVivo computer program, assisted with the coding and categorising. The process involved identifying the text segment, allocating a code label and then searching through the NVivo database for all text segments that had the same code labels.

The process of data analysis was conducted using the inductive approach, as the identified themes were linked to the data. This meant that the process of coding took place without trying to fit the data into an existing model. The themes were developed by analysing the transcription data from the three focus groups’ responses, and then dividing this by the focus groups’ semi structured questions. Next, I have reread the data in each question from the three groups and searched for significant themes and subthemes before moving to the next question. Given that the qualitative focus group interviews were conducted for gaining an understanding of the experiences, feelings and thoughts of nurses, and to guide the structure of the survey questionnaires in phase two, the analysis was conducted by selecting broad themes. During
the thematic analysis, I have identified main themes and sub-themes. The themes were identified first and only afterwards the Occupational Health Framework was applied.

Streubert and Carpenter (2011, p. 455) defined a theme as “a structural meaning unit of data that is essential in presenting qualitative findings.” The main themes were similar to those observed in the Occupational Health Framework, see section 2.6.

In this study, there are four main themes and subthemes:

1) Assault injuries—this theme described and documented the lived experience of nurses who have experienced or witnessed verbal or physical violence in the workplace. This theme had three subthemes which categorised the violence experienced. The first subtheme described the nature of the violence, the second categorised the perpetrator of the violence and the third gathered data relating to nurses acceptance of violence being “part of the job”. The subthemes are:
   a. workplace violence
   b. perpetrator and type of violence
   c. violence is part of the job.

2) Effects of workplace violence—there were six subthemes that related to the impact of violence on the target of the violence. These subthemes were:
   a. impact on nurses
   b. impact on witnesses
   c. impact of the nurses gender
   d. impact on interaction with patients or visitors
   e. impact on the decision to stay or leave the profession of nursing
   f. impact on less-experienced nurses.

3) Factors of workplace violence—this theme consisted of four subthemes which categorised the macro and micro conditions giving rise to violence. These ranged from the macro conditions of the social acceptance of violence in society, to the specific workplace conditions of a particular hospital, and finally to the micro conditions such as the location and vulnerability of a particular person. The fourth factor related to violence perpetrated by colleagues of the same or similar power, such as others nurses and hospital staff. The four factors were:
a. social factors
b. hospital factors
c. personal factors
d. horizontal violence.

These subthemes each contained different subfactors. These subfactors referred to specific vulnerabilities in the workplace that may increase the risk of violence. A proactive, reactive or complacent hospital management may, for example, influence whether violence is reported and if steps are taken to protect nurses from future risks of violence. Elements in the environment may also influence the rate and severity of violence, and workload factors such as patient and nurse ratios were a third group of subfactors. The hospital subfactors were:

a. management factors
b. environmental factors
c. workload factors.

Personal factors had two subfactors. These subfactors referred to the variable personal conditions under which nurses work and the different personal conditions affecting patients, such as the severity of an illness, whether they were conscious or unconscious, or whether they were legally responsible for their actions or not. These subfactors were:

a. nurse factors
b. patient factors.

4) Nurse solutions to reduce or eliminate workplace violence. The solutions theme contained three subthemes:

a. management of workplace violence
b. workplace violence policy
c. workplace support.
3.6. **Phase two: survey**

Following phase one data analysis, a survey was designed to extend the findings of the first phase so that meaningful quantitative data could be gathered. The survey questions for this study were based on phase one data analysis, the qualitative study’s three focus group interviews and the relevant literature review. The survey specifically developed a new instrument for this research. Attempts to address issues of content validity associated with use of a new survey instrument are discussed below in section 3.6.2. Some of the tables associated with the survey data are colour coded to reflect the colours used within the survey, which appears in Appendix Q. For example, the colour purple reflects verbal violence and the colour blue refers to physical violence.

3.6.1. **Participants of the survey**

3.6.1.1. **Selection criteria**

The survey participants were enrolled nurses, registered nurses, clinical nurses, head nurses and nurse unit managers working in emergency, mental health or intensive care in a Queensland regional public hospital. The rationale for including clinical nurses and management such as head nurses and nurse unit managers in the target population for this survey was due to the fact that in Queensland all these nurses are involved in direct patient care. Permission was obtained from the hospital to recruit nurse participants during the Site Specific Assessment (SSA) approval (see Appendix C). Approval was also obtained from the nurse unit managers. The target population was 193 nurses, all of whom worked in these three departments.

3.6.1.2. **Recruitment process**

Following the analysis of the focus group data, the survey was written and tested and participants were then recruited for the survey. Invitations were posted to the bulletin board of each hospital department (see Appendix M). Invitations were also emailed to each nursing unit manager in the relevant departments (see Appendices N and O). The invitations included information about the study including proof of ethics
clearance, my contact details and contact details for the HREC Coordinator. Participation in the survey was voluntary, the same as in the focus group stage of the study (see Appendix P). Participants were told the survey data would remain confidential and that they would not be identifiable. Any steps were taken to recruit survey participants from three wards: emergency, mental health or intensive care unit.

The nurses who wanted to participate in the survey could gain access to the information sheet and questionnaire either in their department or online (see Appendices P and Q). After completing the survey, the questionnaires were placed in a secure box located in their department (see Appendices R and S). The participants who completed questionnaires were not required to sign a consent form because the survey was anonymous and their agreement to participate was implicit by completing the survey.

### 3.6.2. Questionnaire development

A pilot questionnaire (see Appendix V) was developed into a draft (see Appendix W) which was revised into a final survey questionnaire (see Appendix Q). The draft questionnaire was mainly derived from the research questions and the themes of the qualitative data findings. Some of the questions in the draft questionnaire were based on a combination of relevant questions adopted from two survey questionnaires by the University of Southern Queensland, Queensland Nurses Union (2010) and the International Labour Office et al. (2003).

All the survey questions were checked for face and content validity. Face validity is the extent to which a question seems to measure what it claims to measure, based on close reading and study of the question. Content validity is the extent to which a question reflects a specific domain of content, body of knowledge or specific set of tasks. This was assessed in the process of developing the questions and creating multi-item scales, by considering the concept to be measured and seeking advice from six research nurses who were knowledgeable in this topic. All the questions were checked for reliability and internal consistency, through a pilot study with a sample of 13 nurses who checked that the questions were clear. The final anonymous questionnaire was also checked for reliability and validity. The results of these checks are documented in Chapter 3 in sections 3.6.2.5 and 3.6.2.6.
3.6.2.1. **Pilot study of the questionnaires**

A pilot study is a small preliminary study that tests all the aspects of the survey prior to commencement of the full survey. The pilot study consolidates all aspects of the main study’s procedures and provides guidance for the study (Richardson Tench et al., 2011). It also allowed me to evaluate the adequacy of the study design, identify unanticipated variables and consider the impact of these on the study—while finding ways to deal with them.

The pilot questionnaire was tested by a sample of 13 nurses, the same type of participants as the nurses who would participate in the real study. This pilot study enabled me to check the clarity of questions and highlight any possibilities for confusion before distributing the final questionnaires. The pilot study assessed the feasibility of the main study and allowed me to correct some aspects in the final version, such as correcting the inadequate design of Question 11 in the pilot questionnaire before carrying out the main survey. Correcting the design of the pilot questionnaire also included adding numbers beside each question and adding the option of “sometimes” under “Is it implemented?” in Question 15. Moreover, some open-ended questions were added to the final Anonymous Survey Questionnaire such as Question 13A: “What are the reasons for workplace violence?” Furthermore, based on the advice from the participants of the pilot study, the final question in the pilot Anonymous Survey Questionnaire about “suggestion” was modified from: “What are the three most important measures that would reduce violence in your workplace?” to “What are the most important measures that would prevent and manage violence in your workplace?” In addition, the factors of reliability and validity were pilot-tested as mentioned in sections 3.6.2.5 and 3.6.2.6.
3.6.2.2. **Question types**

The final anonymous survey questionnaire (see Appendix Q) contained three sections:

Part A, which consists of demographic data including the nurses’ demographic profile (Questions 1-8) and workplace data (Questions 9-9.3);

Part B and the beginning of part C, including perceptions of nurses related to a specific violent incident: experience or witness of verbal and physical violence (Questions 10-11.8); the impact of verbal and physical violence on nurses: personally, professionally and mentally (Questions 12.1-12.9); and management possibilities of verbal and physical violence (Questions 13.1-13.12). The beginning of the last section (Part C) covers questions about support during verbal and physical violence incidences (Questions 14.1-14.4).

Part C, questions the perceptions of nurses in relation to general workplace policies and management strategies (questions 15.1-15.4); available services to nurses (questions 15.5-15.10); personal support services for nurses (questions 15.11-15.23); workload (questions 15.24-15.27) and autonomy at work (questions 15.28-15.30).

The final questionnaire consisted of both closed and open-ended questions. The closed questions sought defined responses, such as indicating their gender and whether they work full-time, part-time or casually. Open-ended questions were included in the survey to ensure participants have the opportunity to provide unanticipated information. Open-ended questions were used to seek data for which there were no defined answers, such as asking nurses what they believed caused workplace violence. Some questions were a combination of closed and open-ended questions. In these questions, the options were presented, but also allowed the respondents to add another category if necessary. (Such as Question 4: “What is your highest level of education? (Please select only one)___Nursing Diploma ___Associated Degree ___ Bachelor’s Degree ___Master’s Degree ___Doctorate Degree ___Other, please specify______)”. The last option provided the participants with the ability to write an answer that they preferred to give, as suggested by Pallant (2013).
3.6.2.3. Response scale used

The type of the response format had implications for the statistical analysis. For example, some answer options may be answered by giving a number on a continuum from low to high, or selecting a category (Pallant, 2013). Questions about age were answered by giving a number on a continuum (Question 1: “What year were you born? 19_____”) whereas other questions asked participants to answer by selecting a category.

The perceptions of the nurses were measured by using a Likert-type scale that ranged from 1 to 5 where 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree and 5 = Strongly Agree. Average participant responses for both individual and multiple items were calculated for nurse attitudes towards the impact of violence (Survey Question 12), management of violence (Survey Question 13) and support during a violent incident (Survey Question 14), see Table 2.

<table>
<thead>
<tr>
<th>Category</th>
<th>Average Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>&lt;1.50</td>
</tr>
<tr>
<td>Disagree</td>
<td>1.50-2.49</td>
</tr>
<tr>
<td>Neutral</td>
<td>2.50-3.49</td>
</tr>
<tr>
<td>Agree</td>
<td>3.50-4.49</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>&gt;4.49</td>
</tr>
</tbody>
</table>

The type of response scale above gave wider range of possible scores and increased the statistical analyses (Pallant, 2013). During the design of the questionnaires, consideration was given to how the respondent might interpret the questions and to their possible answers. In some questions, response categories such as: “Sometimes” and “Do not know” were included in Question 15. The scale of measurements for the demographic questions was coded as shown in Table 3.
Table 3: The scale of measurement and coding by variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>Scales</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Ratio or Interval</td>
<td>As stated by respondent</td>
</tr>
<tr>
<td>Gender</td>
<td>Nominal</td>
<td>Female = 1&lt;br&gt;Male = 2</td>
</tr>
<tr>
<td>Ethnic background</td>
<td>Nominal</td>
<td>Aboriginal = 1&lt;br&gt;Torres Strait Islander = 2&lt;br&gt;Australian born = 3&lt;br&gt;Other, Immigrated to Australia = 4</td>
</tr>
<tr>
<td>Education</td>
<td>Ordinal</td>
<td>Nursing Diploma = 1&lt;br&gt;Associated Degree = 2&lt;br&gt;Bachelor Degree = 3&lt;br&gt;Masters’ Degree = 4&lt;br&gt;Doctorate Degree = 5&lt;br&gt;Other = 6</td>
</tr>
<tr>
<td>Work experiences</td>
<td>Ratio or Interval</td>
<td>As stated by respondent</td>
</tr>
<tr>
<td>Work condition</td>
<td>Nominal</td>
<td>Full-time = 1&lt;br&gt;Part-time = 2&lt;br&gt;Casual = 3</td>
</tr>
<tr>
<td>Further training</td>
<td>Nominal</td>
<td>Emergency = 1&lt;br&gt;Intensive Care = 2&lt;br&gt;Mental Health = 3&lt;br&gt;Other = 4</td>
</tr>
</tbody>
</table>

3.6.2.4. Number of items analysis

The final version of the questionnaire contained a different number of items than the pilot study questionnaires. This was due to suggestions received from the nurses who participated in the pilot study, and to deleted items because of their negative or correlation coefficient less than 0.20.

Question 12 in the initial questionnaires had a total of 14 items on the verbal and physical violence impact on nurses; however, five of them were deleted due to their negative or correlation coefficient of less than 0.20. Therefore, the final version contained nine items as shown in Table 4.

Management of verbal and physical violence (Question 13) had a total of 10 items initially; however, two items were added to the final questionnaires, a total of 12 items, based on the comments provided by the 13 pilot study nurses.

Question 14 addressed support given during incidents of verbal and physical violence, and in the initial version it had five items. However, because of a negative or correlation coefficient of less than 0.20 of one item, this one item was deleted, leaving only four items in the final version.
Strategic support, workload and autonomy in the workplace (Question 15) initially had a total of 29 items; however, the final version contained 30 items due to the advice received from the pilot study nurses.

### 3.6.2.5. Reliability of the questionnaires

Pallant (2013) stated that the “reliability of a scale indicates how free it is from random error.” Reliability refers to the reproducibility of the results of a measurement technique. This means that given the same circumstances, the technique will reliably produce the same measurements (Richardson Tench et al., 2011).

Internal consistency is one aspect of reliability that assesses the degree to which items being measured are measuring the same underlying attribute (Pallant, 2013). Internal consistency can be measured by Cronbach’s coefficient alpha (α), which provides an indication of the average correlation among all the items on a given scale. Higher reliability is indicated by greater value of Cronbach’s coefficient α in a range from 0 to 1. A Cronbach α value of 0.7 is recommended and acceptable; however, values above 0.8 are preferable (Pallant, 2013). Before checking the reliability of a scale, some items that were negatively worded needed to be reversed.

The reliability of each of the subscales and the total scale were calculated as showed in Table 4. Cronbach α was calculated in the initial version with all of the items and then again for the final version, after items with negative or less than 0.20 correlation were removed. In this study, the Cronbach α values of the final pilot are high, suggesting very good internal consistency and reliability for the scale.

**Table 4: The items and Cronbach α initially and finally for each question of the questionnaire**

<table>
<thead>
<tr>
<th>Multiple Items Question Groups</th>
<th>Questionnaires Questions</th>
<th>Pilot Version</th>
<th>Final Version</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Items (N)</td>
<td>Cronbach α</td>
</tr>
<tr>
<td>12</td>
<td>Verbal violence impact on nurses</td>
<td>14</td>
<td>0.831</td>
</tr>
<tr>
<td>12</td>
<td>Physical violence impact on nurses</td>
<td>14</td>
<td>0.590</td>
</tr>
<tr>
<td>13</td>
<td>Management of verbal violence</td>
<td>10</td>
<td>0.632</td>
</tr>
<tr>
<td>13</td>
<td>Management of physical violence</td>
<td>10</td>
<td>0.729</td>
</tr>
<tr>
<td>14</td>
<td>Support during verbal violence incident</td>
<td>5</td>
<td>0.783</td>
</tr>
<tr>
<td>14</td>
<td>Support during physical violence incident</td>
<td>5</td>
<td>0.782</td>
</tr>
<tr>
<td>15</td>
<td>Strategies, support, workload and autonomy at the workplace</td>
<td>29</td>
<td>0.941</td>
</tr>
</tbody>
</table>
In Table 4, values highlighted with a * symbol indicate a Cronbach α value below 0.7, such as in Question 14 about support for nurses during incidences of verbal violence, where the Cronbach α value is 0.567. The low Cronbach α may be due to reverse scored items or true difference in responses of participants to a particular item. Cronbach α values are also quite sensitive to the number of items in the scale and with scales that contain fewer than 10 items, it is common to find quite low Cronbach α values, as Pallant (2013) observed.

In Question 14, the reason for a low Cronbach α is most likely due to using a scale with only four items, and a different pattern of response for one of these items compared with the other three. In the first statement (Question14.1), the pattern of responses indicated that nurses more frequently disagreed: more participants indicated the findings of the final version that are Strongly Disagreed (N=11) or Disagreed (N=26) that incidents of verbal violence were well managed by the hospital. For the other three items included in this scale, most nurses Agreed or Strongly Agreed with the statements related to support available from managers, colleagues and family and friends, as shown in Table 5. I am confident that the responses are not due to misinterpretation of the question, but reflect the true opinions of the nurses who participated in this study. As a result, statement 14.1 was kept in the theme of support during a specific violent incidence.

### Table 5: Support during violent incident

<table>
<thead>
<tr>
<th>Support during violent incident</th>
<th>Verbal violence (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>14.1 The incident was well managed by the hospital</td>
<td>11</td>
</tr>
<tr>
<td>14.2 My manager supported me</td>
<td>4</td>
</tr>
<tr>
<td>14.3 My colleagues supported me</td>
<td>1</td>
</tr>
<tr>
<td>14.4 My family/ friends supported me</td>
<td>0</td>
</tr>
</tbody>
</table>

Some of the questions in the questionnaires contained subscales such as Questions 12 and 15. Other questions such as Questions 13 and 14 did not have subscales, therefore only their total scale score is presented. The total scale score for all of the questions from Question 12 and Question 15 are presented in Table 4.
and 15 in the questionnaires contained a number of subscales and therefore the reliability of each of these subscales for each of these questions was calculated and are presented in Table 6.

Table 6: The Items and Cronbach α of subscale questions of the final version of the questionnaire

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Subscales questions</th>
<th>Final version</th>
<th>Items (N)</th>
<th>Cronbach α</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1 - 12.2</td>
<td>Verbal violence impact - personal</td>
<td></td>
<td>2</td>
<td>0.941</td>
</tr>
<tr>
<td>12.1 - 12.2</td>
<td>Physical violence impact - personal</td>
<td></td>
<td>2</td>
<td>0.958</td>
</tr>
<tr>
<td>12.3 - 12.6</td>
<td>Verbal violence impact - professional</td>
<td></td>
<td>4</td>
<td>0.811</td>
</tr>
<tr>
<td>12.3 - 12.6</td>
<td>Physical violence impact - professional</td>
<td></td>
<td>4</td>
<td>0.799</td>
</tr>
<tr>
<td>12.7 - 12.9</td>
<td>Verbal violence impact - mental</td>
<td></td>
<td>3</td>
<td>0.901</td>
</tr>
<tr>
<td>12.7 - 12.9</td>
<td>Physical violence impact - mental</td>
<td></td>
<td>3</td>
<td>0.920</td>
</tr>
<tr>
<td>15.1 - 15.4</td>
<td>Management strategies</td>
<td></td>
<td>4</td>
<td>*0.573</td>
</tr>
<tr>
<td>15.5 - 15.10</td>
<td>Available services to nurses</td>
<td></td>
<td>6</td>
<td>0.845</td>
</tr>
<tr>
<td>15.11 - 15.23</td>
<td>Personal support services for nurses in hospital</td>
<td></td>
<td>13</td>
<td>0.989</td>
</tr>
<tr>
<td>15.24 - 15.27</td>
<td>Workload in my department</td>
<td></td>
<td>4</td>
<td>*0.660</td>
</tr>
<tr>
<td>15.28 - 15.30</td>
<td>Autonomy at work</td>
<td></td>
<td>3</td>
<td>0.758</td>
</tr>
</tbody>
</table>

In Table 6, values highlighted with a * symbol indicate a Cronbach α value below 0.7 for subscales such as Questions 15.1-15.4 about “management strategies” and Questions 15.24-15.27 about “workload in my department” that are both considered to be low, 0.573 and 0.660 respectively. The reasons for the low Cronbach α value are as mentioned previously.

The Cronbach α of “management strategies” subscale was 0.573 due to the different perceptions of participants between the statements as shown in Table 7. The last statement, Question 15.4, “Hospital should report violence to police in each instance” had more varied responses from Disagree (N=11) to Strongly Agree (N=29) compared with the other statements. In the first three statements, most of the nurses agreed that the “Hospital has workplace violence policies,” that the “Hospital should involve nurses in developing workplace violence policies” and that “Nurses should report violence in each instance”.

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Table 7: Level of agreement of management strategies

<table>
<thead>
<tr>
<th>Management strategies</th>
<th>Level of agreement (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>15.1 Hospital has workplace violence policies</td>
<td>2</td>
</tr>
<tr>
<td>15.2 Hospital should involve nurses in developing workplace violence policies</td>
<td>1</td>
</tr>
<tr>
<td>15.3 Nurses should report violence in each instance</td>
<td>1</td>
</tr>
<tr>
<td>15.4 Hospital should report violence to police in each instance</td>
<td>0</td>
</tr>
</tbody>
</table>

The Cronbach α of “workload in my department” was 0.660 as a result of different perceptions between the statements. The first three statements show nurses have similar perceptions regarding “workload in their departments negatively affects their ability to manage patient care;” “[workload] contributes to violence towards nurses” and that “nurses do not have sufficient time to complete their work”. However, in comparison with the first three statements, the last statement has relatively more disagreement and neutral perceptions and fewer Strongly Agree responses that “there is a process in place that deals with workload issues,” as presented in Table 8.

Table 8: Level of agreement of workload in my department

<table>
<thead>
<tr>
<th>Workload in my department</th>
<th>Level of agreement (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>15.24 Negatively affects my ability to manage patient care</td>
<td>4</td>
</tr>
<tr>
<td>15.25 Contributes to violence towards nurses</td>
<td>5</td>
</tr>
<tr>
<td>15.26 Nurses do not have sufficient time to complete their work</td>
<td>2</td>
</tr>
<tr>
<td>15.27 There is a process in place that deals with workload issues</td>
<td>4</td>
</tr>
</tbody>
</table>
3.6.2.6. Validity of questionnaire

A study is valid only if it measures what it claims to measure (Richardson Tench et al., 2011). According to Pallant (2013, p. 7), “Content validity refers to the adequacy with which a measure or scale has sampled from the intended universe or domain of content.” Therefore, in the design procedure of this survey, all the aspects of the questions were checked for content validity. The multi-item scales were designed carefully to ensure content validity and were reviewed by six researcher nurses knowledgeable about this topic. Overall, six research nurses reviewed the draft questionnaire; five research nurses and the principal supervisor, who was also a research nurse. Following this review, a pilot study of the questionnaires was tested with a sample of 13 nurses to check the clarity of questions and to identify any possible confusion before distributing the final questionnaires. Based on the review of the six research nurses, the questionnaire was revised before the pilot study, see section 3.6.2.1.

3.6.2.7. Final version of the questionnaire:

Based on the pilot test of the questionnaires, the response scale used a number of items for analysis, reliability and validity of the questionnaire, and the final version of the questionnaire was formulated. The final Anonymous Survey Questionnaire (see Appendix Q) was used to collect the data from participating nurses. The items included 9 questions regarding the impact of verbal and physical violence on nurses, 12 about management of verbal and physical violence, four concerning sources of support during verbal and physical violence incidents, and 30 items regarding strategies, support, workload and autonomy in the workplace—a total of 55 items, see Table 4. The printed survey questionnaires (see Appendix Q) were printed on different coloured paper to distinguish the different sections of the questionnaire.
3.6.3. Data collection

After the development and pilot testing of the questionnaire, the final version was distributed within four weeks between 28 October 2014 and 28 November 2014. The target population of nurses in the three departments totalled 193 nurses, who participated in the survey by answering either an online survey or a printed survey.

The printed surveys were returned to a secure box in each department (see Appendix R). Invitations (see Appendix M) were posted in each department and under each there was a box with the Anonymous Survey Participant Information Sheet (see Appendix P) that was attached to the Printed Anonymous Survey Questionnaire (see Appendix Q).

The online survey was by distributed by sending a package to the nurse unit managers, with a request to distribute the package to all 193 nurses through internal email. The package contained an online invitation to participate in the survey (see Appendix N), a cover letter (see Appendix O) and an Anonymous Survey Participant Information Sheet (see Appendix P) explaining the purpose of the study and a link to the survey questionnaire. In the cover page, participant nurses were assured that their participation was entirely voluntary and that their replies would be kept anonymous.

The data collection procedure occurred during the previously mentioned four weeks, and each week I have picked up the surveys from the secure boxes in each department and counted the number of responses. As it could have been be difficult to collect responses from all the target nurses, the respondents were divided into those who responded early and those who responded later, to minimise the non-respondent errors. There was no significant difference between the early and late respondents. Therefore, it was assumed that the responses were representative of the target population. Participants were asked to complete either the printed or online survey, but not both, to ensure that each participant only completed the survey once.

Early responses were categorised as those received from 28 October 2014 to 5 November 2014. During this period 50 surveys were completed, representing 51% of the total. The late responses were received from 6 November 2014 until 28 November 2014. During this period, 48 nurses (49%) completed the survey, see Table 9: The time
of the respond rate, frequency and per cent of nurses by department. The response rate of the nurses who worked in the MHD (68%) was the highest, followed by the ED (39%) and the ICU (36%).

Table 9: The time of the respond rate, frequency and per cent of nurses by department

<table>
<thead>
<tr>
<th>Period of time</th>
<th>Form</th>
<th>MHD</th>
<th>ED</th>
<th>ICU</th>
<th>Total number</th>
<th>Percentage of survey participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Respondents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 October – 5 November, 2014</td>
<td>Printed</td>
<td>21</td>
<td>13</td>
<td>7</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Online</td>
<td>6</td>
<td>3</td>
<td></td>
<td>9</td>
<td>51%</td>
</tr>
<tr>
<td>Late Respondents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 – 11 November, 2014</td>
<td>Printed</td>
<td>15</td>
<td>4</td>
<td>3</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>12 – 19 November, 2014</td>
<td>Printed</td>
<td>13</td>
<td>6</td>
<td>5</td>
<td>24</td>
<td>49%</td>
</tr>
<tr>
<td>20 – 28 November 2014</td>
<td>Online</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Printed</td>
<td>13</td>
<td>6</td>
<td>5</td>
<td>24</td>
<td>49%</td>
</tr>
<tr>
<td>Total number</td>
<td>Printed and Online</td>
<td>56</td>
<td>26</td>
<td>16</td>
<td>98</td>
<td>100%</td>
</tr>
</tbody>
</table>

The total number of respondents was 98 nurses (100%) and the total response rate was 50.78%, see Table 10. The 98 respondents consisted of 56 nurses from the MHD, 26 nurses from the ED and 16 nurses from the ICU.

Table 10: Response rates for each department

<table>
<thead>
<tr>
<th>Department</th>
<th>Respondents</th>
<th>Target population</th>
<th>Response rate (rr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Department</td>
<td>56</td>
<td>82</td>
<td>68%</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>26</td>
<td>67</td>
<td>39%</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>16</td>
<td>44</td>
<td>36%</td>
</tr>
<tr>
<td>Total number</td>
<td>98</td>
<td>193</td>
<td>50.78%</td>
</tr>
</tbody>
</table>

3.6.4. Data analysis of the survey

The quantitative data were analysed using the IBM SPSS Statistics version 21 software. Descriptive statistics, such as frequency counts and percentages, as well as means and standard deviations were calculated. ANOVAs and t-tests were used to explore whether any significant differences existed in the responses of the nurses based on their demographic profiles, see section 5.7.
3.6.5. Data screening

The dataset was checked for errors prior to analysis. Checking for errors in data entry involved checking each variable for scores that were out of range of the possible scores, and by running the frequency analysis of all the variables. Any errors found were corrected in the data file. After correcting the errors, the dataset was double-checked to make sure the analysis began with a clean and error-free dataset.

Summary

Sequential exploratory mixed methodology design combines two methods, qualitative and quantitative, to create a rich dataset and enable better understanding of the problems addressed in this study. This chapter detailed the research design, study location and ethical considerations that were required prior to data collection. Phase one of the study was then introduced, including selecting participants for the focus groups, collecting, analysing and transcribing data and finally, conducting the thematic analysis.

Phase two of the study was then introduced, including selecting the survey participants, developing the original draft questionnaire, testing the pilot questionnaire and modifying and revising the pilot to produce the final survey questionnaire. Through the process of developing of the questionnaire, all the survey questions were checked for content validity and for reliability (internal consistency) via a pilot study. Data were then collected, analysed and screened.

Chapter 4 presents the findings of the qualitative study and Chapter 5 presents the findings of the quantitative study. Findings of both phases of the study are then discussed in Chapter 6 and conclusions are drawn in Chapter 7.
CHAPTER 4: FOCUS GROUP FINDINGS

Introduction

This chapter sets out the three qualitative focus group interview findings in phase one of the study, and assembles the evidence as it relates to the four research questions, see section 1.3.2. The evidence was gathered during three focus group interviews with 23 nurses currently working in a Queensland regional public hospital during August and September 2014. The results reported here represent the first gathering of focus group data on violence towards nurses in a Queensland regional public hospital. The focus group findings provided broad-ranging data that were used to prepare questionnaires for the subsequent nurse surveys.

This chapter first presents the demographic profile of the participant nurses, followed by the four main themes that were deduced from the transcriptions. The codes were developed independently first and the themes were identified and only afterwards the Occupational Health Framework by Levin et al. (1998) was used to present the data gathered in this study within a theoretically framework. The Occupational Health Framework presents the four aspects and main themes of this study: “Assault injuries,” “Effects of workplace violence,” “Factors” and “Potential solutions”. The theoretical framework enabled clear categorisation of the data provided by the participants about their experiences, feelings and thoughts on the four main themes identified that contribute to violence towards nurses. These four main themes were:

1) Assault injuries from patients and visitors experienced by nurses in acute wards of a regional public hospital, including what is happening currently and why.
2) Factors which contribute to violence towards nurses in their workplace, including social, hospital and personal factors.
3) Effects of workplace violence on nurses, witnesses to the assaults and the effects on patients.
4) Potential solutions based on the participating nurses’ suggestions for management strategies, including general management of violent incidents, management strategies during and after violent incidents, implementation of workplace policy and increased support for nurses who have experienced violence.

4.1. **Demographic profile of participants**

The nurses who participated in the three focus group sessions consisted of 6 nurses from the ED, 6 nurses from the ICU and 11 nurses from the MHD, see Table 11. The nurses ranged in age from 25 to 69 years old. Of the 23 nurses, 17 were female and 6 were male. The predominant ethnic background of the nurses was European Australian. Participants held a range of educational qualifications: 3 held Registered Nurse certificates; 14 held Bachelor of Nursing degrees and 6 held Masters Degrees. Staff in the acute care sections each hold specialist qualifications for the acute department in which they work, and some hold additional specialties. The nursing experience of the participants ranged from 2 years to 37 years. 16 of the nurses worked full-time, with the remaining 7 working part-time.

<table>
<thead>
<tr>
<th>Demographic profile</th>
<th>Ward participants</th>
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<tbody>
<tr>
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<td>3 Bachelor 3 Master</td>
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<td>5 Emergency 3 Midwifery 1 Intensive Care 1 Mental Health</td>
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<td>Experiences (Years)</td>
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<td>2-32</td>
<td>4-37</td>
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<tr>
<td>Work</td>
<td>5 Full-time 1 Part-time</td>
<td>2 Full-time 4 Part-time</td>
<td>9 Full-time 2 Part-time</td>
</tr>
</tbody>
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Table 11: The demographic profile of nurses in three departments: ICU, ED and MHD
4.2. Themes

During the thematic analysis, main themes and sub-themes were identified first and derived from the focus group data and afterwards the Occupational Health Framework by Levin et al. (1998) was used to present the data gathered in this study within a theoretically framework, and addresses the four themes: “Assault injuries,” “Effects of workplace violence,” “Factors” and “Potential solutions”. The headings and subheadings of the themes are summarised and presented in Figure 2.

Figure 2: Headings and subheading of the four themes explored in the focus groups
1) The first theme documents the assault injuries, describing the nurses’ experience of violence from both patients and visitors. Workplace violence is categorised according to the source of the violence: a) the perpetrator b) the type of violence and c) the level of acceptance by nurses that violence is part of the job.

2) The second theme describes the effects of workplace violence. The effects are categorised into: a) impacts of workplace violence on nurses b) impacts on witnesses c) impact on nurses’ interactions with patients and visitors d) the impact on nurses’ decisions to stay in nursing (or to leave the profession) and e) impact on less-experienced nurses.

3) The third theme describes the factors that contribute to violence in the workplace. These factors are categorised into: a) social factors b) hospital factors and c) personal factors. In addition, factors of horizontal violence are also presented.

4) The fourth theme sets out possible solutions based on the nurses’ suggestions for managing violence in their workplace to reduce or to avoid violence. Solutions are also categorised by the source of the solution: a) management of workplace violence b) workplace policy and c) workplace support.

The following is an analysis of the themes and subthemes that were prompted from this specific sample of nurses who work at a regional public hospital. The themes that emerged from this sample confirmed that they might also be experienced by other nurses in similar departments at other hospitals. There were connections between all of the themes. Sometimes it was necessary to include data in more than one theme. The reason for this appears from the context of the interviews, and that occasionally some participants included data about several themes in one conversation.

The focus group results of the data analysis are presented as a list of themes that are illustrated with direct quotations from participants. The quotations are indicated by the use of italics. The themes may also be displayed and depicted in such a manner that portrays the cyclical impact of workplace violence.
4.3. **Assault injuries**

The assault injuries experienced by nurses in their workplace included verbal and physical violence (encompassing potentially life-threatening situations, such as being threatened with a knife or with being stabbed with a pair of scissors). Physical violence was varied and included being pushed, punched and having a shoe tossed at their head. Data gathered in the focus groups were analysed and categorised according to the following categories: workplace violence; perpetrator and type of violence and the opinion that violence is part of the job, see Figure 3.

![Assault Injuries Themes and Subthemes](image)

**Figure 3:** Assault injuries themes and subthemes

### 4.3.1. Workplace violence

All nurses from the three departments who participated in the focus group interviews experienced workplace violence on a daily basis. Participants experienced violence themselves and also witnessed violence towards other nurses, as described:

*ED4:* It is almost like you can go to work and expect to come across some kind of violence in the workplace. That is the standard expectation.

*ICU2:* It comes from patients all the time. In fact, we get to the stage where we are quite complacent about it because I think it has happened so regularly it is a day-to-day thing and I am a bit worried about it. We have patients who are quite violent towards us and aggressive.

*MHD2:* Yes, it happens frequently. Lots of verbal.
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MHD5: It happens daily, often more than once a day. It seems to have increased.

ICU1: You do not want to go to work expecting to be hit all the time.

The verbal and physical violence experienced and witnessed by nurses was investigated further in this study by asking questions in the second phase survey, to gather data that would quantify and qualify the findings of the focus groups.

4.3.1.1. Verbal and physical violence

Nurses experienced verbal and physical violence from patients and visitors. The violence affected them in a range of ways, including causing difficulties coping with their work, as well as feeling guilty, ashamed, unsafe, worried and scared:

ED6: We cop verbal abuse. We cop physical abuse. All day people are rude to us, nasty to us. But then we have to […] all the things that we deal with from other people: spewing on us, pooping on us, vomiting on us, bleeding on us…

ED1: I have lost track of the amount of times that I have been physically threatened, intimidated and [had] my family threatened. I remember a few years ago a colleague and I – when a patient tried to stab us with a pair of scissors and we had the police there, with capsicum spray, with a Taser.

MHD5: … the nurses are punched, the nurses are sworn at, the nurses are called f***s, all the things that you can imagine.

MHD7: I had a patient come in today and she was quite irritable and aggressive and I explained to her we do not tolerate aggression and I had a shoe tossed at my head.

MHD10: I will never forget one day in [department Y], 10 years ago, there was an Indigenous young lady. She was five foot nothing and I was trying to give her medications and I worked for hours trying to give her medications and then she pulled a knife on me. She came to the High Dependency Unit (HD). She had a pocket-knife in her belongings. I will never forget [person x], 6 foot 5 [inches] – he just came around to me. I just yelled out, “Knife!” and he just came around and picked her up and just put her in her room. And that was the end of the episode. And I am then thinking, Oh my God, I have just had a knife pulled on me and we are not going to do anything. I felt guilty, I felt ashamed, because she was four foot nothing and
here she is with a pocket knife.

ICU2: Last year was my most frightening moment and I have been in nursing all this time, I have been smacked by everybody including geriatric [patients] and I have been verbally abused, but I had a drug addicted patient last year with terminal respiratory failure. The whole family were drug addicts. We had nothing more to offer to this patient, so the doctors made it very clear that they were going to withdraw treatment and let her wake and see what the consequences were. At the time she woke up, she was in the most dire way. She was moaning, yelling and making noises. We had become aware that her level of drug use was very high - up to 400mg/day of morphine. So it was unlikely we were going to be able to match that. The son said to me, “You give her something and you fix her,” and I said, “I have already given her some morphine that is prescribed for her and I have given her as much as I am allowed.” He said, “you get her something now.” And I said to him, “I am not here for you, I am here for her. And if you cannot control yourself please step outside.” So he said to me (luckily, I had witnesses) but he said to me, “I will be waiting for you in the car park.” I have never felt safe after that. That was really, really scary.

The data indicate verbal violence occurs as frequently as daily, and ranges from swearing to threats to the safety of the person. Physical violence may be frequent or infrequent and with a wide range of severity, from pushing or hitting to assaults with fists, thrown objects or weapons. The assaults can be as severe as life-threatening assaults with weapons, such as scissors held by patients under the influence of legal or illegal drugs. Verbal and physical violence experienced by nurses was from patients and visitors but also from colleagues, as described in the following section.

4.3.2. Perpetrator and type of violence

Nurses from the three departments experienced verbal and physical violence mainly from patients and their visitors (vertical violence). In addition, some of the nurses had also experienced violence from colleagues (horizontal violence).

4.3.2.1. Vertical violence

All the nurses working in the three departments indicated that vertical violence occurs mainly from patients and visitors:

MHD6: Mainly patients
MHD7: And visitors.
ED5: Patients mainly.
ED3: Or, visitors too, yes.
ED6: Yes, definitely both.

However, patients were mainly physically violent while relatives and visitors were more verbally violent:

ED3: It’s physical aggression that is usually the patient, I would say.

ED4: Relatives can get – if someone is very unwell – under extreme pressure and they can get very more verbally [aggressive] rather than physically aggressive.

ICU2: It comes from patients all the time . . . verbal violence from visitors is very common, yes.

Nurses experienced predominantly vertical violence from patients and visitors with patients being more physically violent and visitors and relatives more verbally violent.

Nurses have also experienced horizontal violence from their colleagues.

4.3.2.2. Horizontal violence

Some of the nurses experienced horizontal violence from doctors, nurses and other staff:

ED3: But even from the doctors and sometimes the staff around you. It is very hard not to pick negatives up from all around.

ICU1: I mean most of it [is] patient violence but you can get verbal violence from doctors all the time.

ICU3: Other nurses too.

Nurses experienced verbal abuse from doctors and other nurses. Both vertical and horizontal violence occurred in their wards as well as in other locations within the hospital.

4.3.2.3. Location of workplace violence

The nurses stated that the location of workplace violence was not restricted to their department was but occurred in other departments of the hospital:
MHD3: I think, that is Queensland Health, you see it up in orthopaedic wards, you see it up in medical ward you see it everywhere. So it’s not a mental health specific problem.

MHD11: I have been in ABM (Aggressive Behaviour Management) a few years ago with nurses from medical wards, and they had worse stories than what everyone at this table [had]… what they were exposed to, it’s everywhere, in every specialty.

Nurses believed that workplace violence is everywhere within their organisation. This means that targets for violence are not just nurses who work in the ‘high risk’ units, but also all nurses from other wards. The high frequency of violence everywhere within the organisation may be a reason why nurses accept violence as part of their job.

4.3.3. Acceptance of violence as part of the job

The high frequency of violence against nurses in the workplace has resulted in some nurses perceiving violence as part of their job:

ICU4: I think it is part of our job.

ICU5: It is part of day-to-day work…. They [the patients] do not have any right to treat us that way, but we accept it.

While nurses believe they should not tolerate violence, they feel powerless to prevent it. This attitude of tolerance is now being challenged by the perception of nurses that violence is becoming both more severe and more frequent.

4.3.3.1. Increase in frequency and severity of violence

Nurses from all the departments say that violence from patients and visitors has been escalating over time:

ED4: Violence is escalating.

MHD2: Yes, for sure [workplace violence] is increasing, especially with our adolescent population. It’s getting worse.

ICU2: I think it [is] accelerating… it is accelerating more often.
There is a general escalation in violence. One MHD nurse noted increased violence from teenage patients.

Even though nurses believe that violence has increased, they believe that there is a lack of awareness in the community of the frequency and severity of violence directed towards them.

4.3.3.2. Lack of community awareness of violence towards nurses

Most of the nurses from the three focus groups said that the public and the families and friends of nurses were not aware of the level of violence that they experienced. This lack of awareness has partially occurred because nurses do not think their family would believe them if they reported the violence; that they would remain working in a situation where they were routinely subjected to verbal and physical abuse; that community members would not believe patients would physically strike nurses, or that the community would not believe that middle-class people would perpetrate violence on nurses:

ED1: They would think that we are making it up. They wouldn’t believe that it surely [happens]. How could you cop violence and abuse every single shift, every single day of [your] life? People wouldn’t behave like that, would they?

ICU1: The community just doesn’t understand. When you say that the patients kick and punch you all the time, they say, “Oh.” They do not really think about the fact that a complete stranger punched you.

MHD5: To think that there is violence towards nurses. I think that is still ‘all out there’. In the normal community, the middle-class or whatever, the nurses are punched, the nurses are sworn at, the nurses are called F@#$s, all the things that you can imagine. And I think there is this thing out there that people would be shocked.

Only one participant said that the community is aware of violence towards nurses:

ICU4: I think it is an increasing problem but the majority of people are reasonable. I think there is a greater recognition within the community that we are dealing with violence more and more. I do not think that people accept it. I do not think the community at large accepts that violence should be pointed in our direction.
Family and friends are not generally aware of the violence towards nurses or the severity of it:

\textit{ED1}: ... there was a show on, I think, ABC or SBS and that was called 24 hours in the emergency department and was a ‘no-bars’ filming of various emergency departments around the world. My wife wanted to watch it and I thought why would you want to? And basically after half an hour she said, “Oh this has to be a dramatisation.” I said, “That is pretty well spot on, that is real, that is my normal working day.” And she was gobsmacked. Yes, she was horrified.

\textit{ED4}: . . . and that is the response that I got from people after that. Friends will watch it and go, “Is that what you do every day?” It is like, “Yeah, that is my job, every single day.” They are horrified and [ask], “Are you serious?”

4.3.3.3. Possible reasons for the lack of awareness of violence towards nurses

Nurses suggested three reasons for the lack of community awareness of violence towards them. Firstly, violence is seen as being antithetical to the caring role that nurses perform, secondly, nurses do not disclose the epidemic nature of violence out of concern for their family and friends who might be overly concerned for them and thirdly, violence has become more socially acceptable.

1) The nurses’ jobs are to care for people, and community members believe it is impossible that nurses who are caring for others could be subjected to abuse while providing care:

\textit{ED3}: Possibly because it is not [publicised] and perhaps they do see the police—because that is their job—to control disorderly behaviour, I suppose, but our job is to care for people.

2) Nurses do not speak about their experiences of violence with their family or friends because they do not want their families to be worried:

\textit{MHD10}: I never told my parents. I have never [told them] in 20 years that I have been nursing, [about the violence]. They would be horrified. That is my way of protecting them. I have never told them anything.
3) Society today is exposed to, and accepts, more violence than it used to in the past:

*ICU3:* I think generally in society today, we accept a lot more violence. There are violent movies, there are violent games, there is violence on the TV, there is domestic violence. It is a growing problem and I think it is more frequent. You do not turn the TV on and there is no violence on it. And more and more of us are more subject to violence on a daily basis. And 20, 30 years ago, you did not see violence everywhere. We are a lot more exposed to it because of the multimedia and you can pick it up and see it anywhere. So, we accept that society today is a more violent place than it was 30 years ago.

*MHD10:* [Participant 2] and I have worked together for many, many years and I think she would agree, people 20 years ago, they were very different. It was a very different type of violence.

Nurses believe that community awareness of violence is limited because nurses are reluctant to tell their families and friends for fear of being disbelieved, for fear of worrying them or because violence is so prevalent in society. Reasons for workplace violence are explored in the following section.

### 4.4. Factors contributing to workplace violence

The nurses from the three departments said there were many reasons for experiencing an increase in workplace vertical violence. Vertical violence was the main focus of this study and is defined as violence between healthcare professionals and the care recipients. However, nurses also said horizontal violence, which occurs among healthcare professionals or among care recipients, happens as well. Factors that contribute to horizontal violence were therefore added to the list of factors contributing to workplace violence.

The factors contributing to vertical violence, as perceived by nurses, were analysed and categorised into four main sets of factors: Social factors, hospital factors and personal factors. Personal factors include nurses’ factors and patients’ factors, see Figure 4.
### 4.4.1. Social factors

Social factors are the factors that contribute to vertical violence within the hospital, but are not within the hospital’s control; therefore, they cannot manage these factors. The nurses said several social factors that contribute to violence in their workplace include changes within the community today and public disappointment with the Mental Health System in Australia.

All of the research participants said social change has contributed to violence in their workplace. The aspects of social change which have impacted on violence in hospitals towards nurses include the following:

1) The public are more demanding.

2) A lack of personal boundaries and patient feelings of entitlement.

3) People are now questioning authorities.

4) People are unaware of the consequences of their behaviour.

5) Community members have become angrier and more stressed, which they express through violent behaviour.

6) Community members accept bad behaviours such as violence and alcohol abuse.

Each of these aspects was supported by data obtained from the focus group interviews.
1) The public are more demanding and think that they have the right to receive everything that they want:

*MHD3:* We are dealing with different sorts of people and other sorts of people [are] making it into patient units.

*ICU1:* But, I think, years ago, when I first started nursing, relatives and patients would not dream of offering any sort of aggression. That was measured more often in care and they were appreciative. These days they just think that they have a right to everything. I think it is just the community attitudes these days. Years ago, if the kid misbehaved the police slapped him around the head and took him home, the parents carried out the discipline. These days, you cannot touch him. And it is just ongoing attitudes; they get away with it when they are young and it gets worst when they get older.

*ICU3:* People...demand stuff. It’s not, “Oh thank you for helping me,” it is just, “You should be,” “It is up to you,” “You should be saving my life,” “You should be doing this,” “You should be doing that.”

Attitudes to nurses have changed over time, from patients being thankful for the care they received to being demanding of nurses.

2) Lack of personal boundaries and feelings of entitlement:

The public has the attitude that they can do whatever they want without responsibility for their bad behaviour:

*ICU2:* They think that they are entitled to that in the community. There are no personal boundaries. I think that the first thing that was lost was there are no personal boundaries. They used to do [violence] behind closed doors. But the thing is now everybody’s going overt about it because they think they are entitled [to be violent]. They are entitled to be angry. Their responsibility for personal control has just gone out the door.

*ED6:* I think it is more [about] being entitled and—particularly my generation and younger—is a very entitled generation. We are entitled to a job, we are entitled to sick leave and a degree and we are entitled to a high-paying job. There is so much entitlement going around that we are entitled to be treated exactly right. We are allowed to act poorly, because nobody is going to pull us up on it.

*ED4:* I think people have the attitude that they can do with us what
they want. They are entitled. Yes, they own our nursing skills—“I pay my taxes and I pay my Medicare. I am entitled to be here and you’re going to see me and you’re going to treat me, no matter how badly I behave.”

3) People are questioning authorities. In the past the public respected and accepted the doctor’s assessment. Today the public question authorities:

   MHD7: Once upon a time it was accepted, what the doctors said. It was accepted and not questioned.

   Unquestioning attitudes towards doctors in the past have given way to a situation in which patients doubt or question doctors.

4) People are unaware of the consequences of their behaviour:

   MHD5: I do not think people know consequences and perhaps they have no idea. I think it is a general social change.

5) Community members have become angrier and more stressed, which they express through violent behaviour:

   ICU2: I think it is a present-day problem... a society that has become so angry.  
   MHD11: I also think there is a lot more stress within the community as well. There is more financial strain within families, a lot more pressure on kids to be performing at certain levels at school. So I think, generally speaking, pushing it all back to them and us. It is also a lot of stress for the community as well, and it is how people express their stresses—just being angry, kicking the cat.

   Nurses believe that some reasons for stress are due to family financial problems and the pressure for children to perform well at school.

6) The community accepts bad behaviour, such as violence and alcohol abuse:

   ED2: I think as a society we have become so much more accepting of bad behaviour and poor behaviour that it becomes normal and that is what has changed.

   ICU5: The community push it. It has been more about the community again, if it is alcohol-fuelled violence.
Disappointment with the Mental Health System in Australia was mentioned as an additional social factor that contributes to workplace violence. Some nurses believe that mental health patients are not supported by the Australian mental health system:

*ICU2: We are not psych trained. The thing is that mental health issues have become more and more apparent because there is much more emphasis put on taking care of mental health issues and there is a huge percentage of our patients who are mental health patients. That is why there are so many overdoses. I just think, quite frankly, that the system does not support them.*

*I think it is a very weak system. The Mental Health System in Australia is quite disappointing. It is overwhelmed. It is because we have now come to recognise really, in the last 10 years, how important mental health issues are. But there simply is not the infrastructure to take care of it. A Mental Health Act, building new buildings, is not the answer to the problem. It is actually getting the right people to do the job and that is where our mental health patients get let down.*

The nurses described a variety of social factors that contribute to workplace violence—the public are more demanding, the lack of personal boundaries and feelings of entitlement, questioning of authorities, the lack of awareness of the consequences of their behaviour, increased anger and stress which is expressed via violent behaviour and increased community acceptance of bad behaviours due to drugs and alcohol. Nurses believe that there are conditions within their hospital that lead to vertical violence, as discussed in the following section.

### 4.4.2. Hospital factors

Hospital factors are the conditions that contribute to vertical violence within the hospital that the hospital has the responsibility, to manage. There are two types of hospital factors: a) hospital management factors and b) hospital environment factors.

#### 4.4.2.1. Management factors

Nurses believe hospital management contributes to violence in the workplace by setting heavy workloads that leave nurses with less time for patient care, reducing the number of experienced staff, creating long waiting lists and adverse publicity in the media about hospitals, delaying treatment, enabling medical errors, increasing overall frustration and giving conflicting information to staff.
Each of these management factors was supported by data obtained from the focus group interviews.

1) Workload increases causes staff busyness and less time to spend with patients, which may cause patients to become agitated and aggressive. Nurses who have worked at Queensland Health for several years describe the deterioration in working conditions whereby nurses are getting busier; the proportion of mental health patients has increased and the numbers of alcohol and drug-affected patients has increased:

   ED4: I think things were very different 10 years ago. I think the changes are getting busier and [violence] is getting worse. Violence is escalating. We are getting more mental health patients. We are getting more drug and alcohol problems coming through. The population is growing. It has not exponentially increased but [violence] has exponentially increased [indicating a steeper increase].

   ICU1: Years ago, if you had a dying patient, the [hospital] would allocate a nurse to sit with that person when they died. These days, people die by themselves. If they do not have a family, they die on the bed and no one is with them. There is just not the amount of staff around as there used to be, or the amount of important placed on being with [dying] people. It is all about getting them their medications and their treatment and getting them out the door. We want them out of bed so we can put somebody else in it.

   ICU3: I think we do not have the time, when we are busy. I think if you say to a family, “I am really busy; I have a few things to do, I’ll get back to you,” and you have to be honest and upfront with the family. Because it make them more agitated if you do not [tell them].

2) Reduction in the number of experienced staff contributes to increased workloads:

   AMH1: I think the reduction in the experienced staff is adding a lot of pressure on the more senior staff.

3) Long waiting lists and media coverage contributes to anger towards Queensland Health. Patients are waiting for years to receive treatment in the public system which increases their frustration. By waiting in the waiting room sometimes for hours, violence may escalate:

   ICU3: But usually they have been on a waiting list for three or four
years and they have been through dozens of doctors and they have been trying to get something done for so long. That by the time they get to us they are so frustrated, that we are the end point where they just let fly [with violence].

ED4: Waiting, in general, is a big cause of aggression. The longer it takes the people to come through the waiting room, escalates all the violence and the aggressive behaviour. People are waiting and we are getting more frustrated and then, it escalates.

ICU5: I think there has been a lot of anger towards Queensland Health in general because certainly the media has a lot of that [coverage]. People expect to come to hospital and for bad things to happen because they are always being exposed to that. So they come to hospital already with their defences up and they are angry that their relatives are unwell. They have heard stories and they come to hospital with preconceived ideas. And often you are trying to de-escalate something before it happens because people come to hospital expecting something bad to happen. The majority of patients, not in ICU, but generally, get well and go home again.

4) Delay in treatments, medical errors and receiving conflicting information from different staff causes patient frustration with the healthcare system:

ED2: [Patients] will get frustrated with the system, I find. But when things are delayed and we cannot get them a very definitive time frame for when things are going to happen, they can get frustrated. They get upset and it is an interesting process to see the escalation out of proportion.

ICU5: Sometimes it is due to the problems that have happened surgically or medically and we are the end of the line. So by the time the relative gets to us there may have been errors made, they are frustrated and want an answer – and we are the person sitting at the end of the bed. So we are the person who they are going to direct a lot of the anger towards. We are representing the hospital. So yes, it may have been the fault of the patient though, his mismanagement, but ultimately they want answers from the person who is looking after the patient.

ICU4: Mental health [nurses] quite often are not willing to come forward [to ICU] until they are totally satisfied that the person can communicate with you. They will say, “Are they awake? Are they awake? Are they doing this? Are they doing that? Oh no, they are too sleepy. I am not going to bother showing up for an interview.” So, it might stretch it out for another half a day, but in that half a day, that person is up, eating, moving around and doing whatever,
and as far as psych is concerned, until they can sit down and converse easily, they are not really willing to show up. So we’ve got a frustrated psych patient who is not going anywhere, and is basically, physically acting up, and also verbally. So, we are twiddling our thumbs, waiting for psych to come and do their review and we have got a frustrated psych patient who you cannot predict. They can be verbal and we hope they stay verbal and that is it.

5) Conflicting information from staff and the inconsistency of ward rules leads to frustrated and aggressive patients. Conflicting information could be from doctors regarding the treatments plans or receiving conflicting information from different doctors:

ICU1: Particularly if you have doctors conflicted about what type [of medication], what treatment plans are happening, they are getting conflicting information from everybody and no one is agreed on a treatment plan.

ICU5: Or typically, the surgeons are overly optimistic and the intensivists are unduly or can be unduly pessimistic and so from the family point of view they are getting two conflicting sets of info from the doctors. We had a patient the other night. The surgical people came along and said he can have free fluids. The ICU guy said, “No. He is ‘nil by mouth’.” And the catering staff brought him corned beef. So the family are sitting and wondering what is going on and who was right. And yes, they were getting a bit frustrated because they also brought him in food as well. I know it was only something really very simple but they started wondering if everyone knew what was going on.

MHD5: I also think the different streams of clinicians have different ideas. So the nurses might say one thing. The psychologists say [say] another thing. The doctors will promise them this thing and then come and tell you afterwards. And it does cause a lot of splitting; it always does. It is not a very good experience.

Hospital management factors are varied and can contribute to violence in the workplace due to heavy workloads, reductions in experienced staff, long waiting lists, delayed treatment, medical errors and receiving conflicting information from staff.

Environmental factors within the hospital also have a perceived impact on violence.
4.4.2.2. Environment factors

Participants detailed several aspects of the hospital environment that impact on workplace violence. These aspects are the stressful environment, lack of space, constant change, frustration, negative environment and the perception that the hospital is not a safe environment.

Each of the environmental factors is illustrated by evidence obtained from the focus group interviews.

1) Stressful environment:

   *MHD7: A lot of the environments we are working in are stressful.*

   *AMH 3: There is a decrease in work and job satisfaction: the [lack of] collaborative problem-solving. It is just that dilemma I suppose, and trying to find a happy medium. In an environment like the High Dependency Unit (HDU), when there are so many restrictions, it is difficult to do sometimes.*

2) Confined environment:

   *AMH11: I have always thought that our department is not big enough because to me it is a dinner party. You have eight people around for a dinner party and these eight people intensively live with each other 24/7 in such a confined space [there is] no breathing room at all. So environmentally, we have not got [enough] space.*

   *AMH7: So yes, violence can be from the environment—you can try to manage eight people in a confined space, sitting around two little round tables—and they are bumping each other.*

   *AMH4: In department [X], patients have not got their space to go away and get away from each other and from staff as well.*

3) Constant change—a dynamic environment:

   *AMH2: No two shifts are the same. It is such a variable and changeable environment.*

4) Frustration:

   *ED4: We want to be there to care for people and to look after them to the best of our ability and we cannot. So we sense their frustration but there is nothing, nothing that we can do about it, because you
have got not just one person frustrated, you have got the whole area frustrated, trying to spread yourself [thinly] like vegemite.

5) Negative environment:

   ED6: I think it affects everybody differently but for me personally, I think it is hard in this environment where we are always coping negativity. We are always getting put down and that is why we are a very good team and always have to support each other because that is that is all we have, [each other].

6) Not a safe environment:

   ED2: I prepare myself mentally, knowing that I am going to be abused at some point during this shift. You should not have to do that. You should be able to go to work and say, “Fantastic, I am going to work, I am in a safe environment.”

Six causes of workplace violence were identified that relate to hospital management creating a stressful environment for staff, with lack of space, constant change, frustrations, a negative environment and the perception that the hospital is not a safe place for staff.

The third group of hospital factors is workload factors.

4.4.2.3. Workload factors

All the nurses agree that workload impacts on violence levels because heavy workloads result in patients becoming more aggressive and frustrated, due to receiving less attention and care from staff:

   AMH8: If we are busy trying to deal with everything else, especially when you have certain diagnosis types that tend to take up a huge amount of time, yes it is difficult to attend to all the other ones to keep everybody settled and calm. Busy wards promote more agitation.

   ED4: We do have a lot of sick patients and thus we cannot give the care that we want to give to them in the timeframe that we are allocated a lot of the time and that does impact on the frustration which can make people who would not normally probably be testy, say something [abusive].

   ED2: It is also workload because if there are more staff we can give [patients] what they want.
ICU1: If you are busy you do not have time to talk to a patient or the relatives and you have to brush them off because there is so much to do. Whereas if you have that hour to sit down and to talk to them, they usually calm down. But if you walked past them 10 times they get to the point when they are not going to let you walk past again. They want attention now.

ICU3: The workload is huge in both the private and public sector. I think it is probably increasingly difficult for the private sector because they are more under-staffed. But certainly it does affect violence.

Workload does not just impact on patients’ aggression and frustration levels, but also impacts on nurses in several ways by increasing exhaustion and impatience, decreasing their time to care for patients, increasing stress on senior nurses and leaving insufficient time to complete work.

The impact of heavy workloads on nurses is supported by evidence obtained from the focus group interviews.

1) Nurses become exhausted, burn out quickly and have less patience:
   
   ED4: The higher your workload, the quicker you burn out, even during your shift. Yes, the busier it is, the quicker the turnover [of patients] and the shorter your patience.

2) Less time to care for patients due to a heavy workload:
   
   ED2: I had a patient the other day who I looked after—I barely got to see him. I wanted to be able to give him more [time] because I could see that he needed it and I wanted to be there but you cannot because the workload is so big and there is not anyone who can help you because they are busy somewhere else, or there is a trauma or there is something else [happening], and there is just never enough staff to be able to cope with the workload.

3) More stress on senior nurses from the reduction in the number of experienced nurses:
   
   AMHI: I think the reduction in experienced staff has [placed] a lot of pressure on the more senior staff.

4) Insufficient time to complete work and discharge patients:
   
   ICU5: We probably are more affected by the heavy workloads in the wards because that makes it harder for us to get patients out [of...
Workload impacts on both patients and nurses. Patients become more aggressive and frustrated while nurses become exhausted, impatient, more stressed, less caring of patients and struggle to complete their tasks.

There are also personal factors that contribute to violence in the workplace—these relate to nurses and patients.

### 4.4.3. Personal factors

Personal factors relate to the personality attributes and attitudes of nurses and patients that may potentially contribute to workplace violence.

#### 4.4.3.1. Nurses' factors

Nurses’ factors refer to two main aspects: firstly, the nurses’ attitudes towards patients and secondly, factors related to the nurses’ abilities to manage their workloads.

The nurses’ attitudes towards patients that potentially lead to violence are poor communication and customer service, and secondly, being defensive due to expectations of violence.

1) Bad communication and customer service of nurses:

_EDI_: But it is a two-way street. There are staff who just through how they talk to people, how they interact with people, certainly promote an aggressive response. The way that some of the nurses talk to the public, I would want to punch them in their face. If somebody spoke to me like that, that would be the first thing I would be doing. But the whole of the staff are quite good in their customer service. We need to be uniform in our response if we expect the public to respond likewise—to have that demand or expectation.

2) Nurses who expect violence and are defensive contribute to workplace violence:

_ICU5_: I think there is work [being done] in that area. I think you can put up that guard that you expect violence and you also could be contributing to that too because you are in the defensive straight away and you have to be very careful of that.

There are two main factors which are related to the nurses’ complications in managing their workload—firstly, difficulties in finding a balance between caring for

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*ICU*.
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patients and getting their work done, and secondly, the lack of time for communicating with patients.

1) Difficulties for nurses managing their workload and providing the required care for patients:

   AMH2: *It is hard to find a balance sometimes.*

   ED4: *From a patient point of view, the [family member] is usually worried or they are worried about their relative because the relative is sick. A lot of sick people in our department are not just stubbed toes—we do have a lot of sick patients and thus we cannot give the care that we wanted to give to them in the timeframe that we are allocated—I think a lot of time—and that does impact on the frustration, which can make people who wouldn’t normally probably be testy, say something.*

2) Nurses do not have time to communicate with patients, causing frustrated patients:

   AMH3: *Most people in department [X] are in the same position. It is so busy sometimes that you do not have time to talk to patients or anything.*

   AMH2: *I just think, when you are really stretched as far as time [is concerned], that you tend to dismiss a patient much quicker than if you actually sit there and explore things, concerns and that ups the ante—and causes more frustrations.*

A lack of time for caring for patients and lack of time for communicating with patients both contribute to violence against nurses.

Personal factors also includes the nurses’ attitudes towards patients, such as poor communication and being defensive, as well as factors that compromise nurses’ abilities to manage their workload; they then experience difficulty balancing patient care with other nursing tasks. There are also patient factors which influence the frequency and severity of violence towards nurses. These include patients’ personalities and attitudes, patients’ lack of understanding of the healthcare system, patients with addictions, patients with mental health conditions and involuntary patients.
4.4.3.2. Patients’ factors

Patients’ factors refer to attributes of particular patients which impact on the level of workplace violence directed towards nurses. Five patient factors were identified by the focus group participants: patient personality and attitude issues, lack of understanding of the healthcare system, addict patients, mental health and confused patients and patients who are hospitalised against their will.

Each of the patient factors is supported by evidence obtained from the focus group interviews.

1) Personality issues and patient attitudes that affect violence towards nurses include six characteristics: lack of respect, aggressiveness, anxiety, unrealistic expectations of patients.

a. Patient aggression and lack of respect when aiming to secure their needs:

    ICU5: Patients have no sense of respect that you are doing as much as you can. When somebody becomes louder and does threaten, they get attention and often they get what they want. They are reinforcing that bad behaviour.

b. Patients are aggressive to attract nurses’ attention to their needs:

    ICU1: So I think they feel neglected and they feel they have to be aggressive to get the attention.

c. Patients who seek attention at the busiest time:

    AMH1: Well, you get certain individuals who have a tendency to be attention-seeking. They will wait until the staff is really stretched and they’ll act out—cut, scratch things or complain of chest pain.

d. Aggressive and violent patients:

    ICU1: I think it is a personality thing. A lot of patients who are usually violent—that is just their personality—everything they do is about aggression and violence.
e. Patients’ attitudes towards nurses versus doctors—patients treat doctors with respect, but subject nurses to violence:

ED3: They are sometimes different to the doctors than they are to the nurses. We are treated a lot more poorly and then the doctor will arrive.

f. Anxious and unrealistic families may express these feelings as violence:

ICU2: When we start to play into family dynamics, you play into an awful lot of guilt—and maybe they haven’t seen that person for months—and all of a sudden they are at death’s door and somebody is responsible. So it is a verbal thing, family members who are ill-informed and are not aware, are anxious. Maybe they feel guilty because they have not seen the patient for a while. The family dynamics are quite poor. So they have to find somewhere to ventilate and it is usually at us or over the top of the bed.

2) Lack of understanding of the healthcare system and high expectations are the second patient factor that contributes to workplace violence.

  g. Focus group participants described situations where high expectations of patients and lack of understanding of the health system can lead to violence:

  ED2: I think from a patient perspective, they are coming in and they often do not understand the triage system. And they say, “Well, I was here first, I should been seen first.” They do not understand that in an emergency department you are seen based on your immediate need. And I think that contributes a lot to the violence. I think there is a lack of understanding there. But if you have come in because you have run out of your tablets and it is a public holiday and the shops are all closed and you want your script filled, you are going to be waiting six, seven, eight hours.

  ICU2: I think it is a lack of understanding first of all. The worst thing about working in intensive care that stands out for me is that I think there is a huge expectation in the community in general that once you come to the intensive care I am going to fix you. And we are the least likely people to fix anybody because they come to us so broken. So I think they expect if they are ventilated and if they are treated, then all of a sudden they are going to be well. [It is] not likely. And when you start having those conversations, it can go a bit pear-shaped.
h. Patients do not understand the healthcare system and workload in the wards:

*ED2: Having an understanding of a nurse’s workload. A lot of patients they think they have one nurse and that the nurse has one patient. Patients do not realise or recognise that you have four, five, six patients to look after and they just do not comprehend beyond themselves. And that, I think, contributes a lot too because they are getting frustrated thinking, What are you doing? You are just sitting at the desk, doing nothing. Where in fact, I could be sitting at the desk writing out notes for another patient, or organising. A level of understanding is just not there.*

3) Addictive patients who use more drug and alcohol.

i. Patients use more drugs and alcohol that contributes to increasing of violence:

*ICU1: Most of our worst patients are ones who are actually intubated and sedated simply because they are so violent in the emergency department that there is no other way of controlling them and then of course you have got to try and wake them up without getting punched out.*

*MHD2: I think that the drugs and alcohol is a contributing factor.*

*ED1: I have also noticed an increase in the amount of alcohol and drugs and also mental health-related violence as well, has definitely escalated in the last decade, has skyrocketed a thousandfold. Once the police would just get a drunk person and put them in the watchhouse and now they come through the emergency department so, no, we are not in the environment where we can contain these people or have the appropriate security.*

4) Mental health patients and confused patients due to delirium or dementia.

j. More mental health patients and increasing high-risk behaviours:

*ICU5: In recent times [there has been] an increase in the number of mental health patients too and overdoses with antidepressants and things like that. And they have been placed on involuntary treatment orders. I think they are not well enough to go to a psychiatric unit but they are well enough to lash out and walk around the unit.*

*MHD1: We are seeing more high-risk adolescents, more high-risk adults, who engage in more high-risk behaviours in the community.*
ED3: The mental health patients cause the real threat because they either do not have control or they choose not to have control of their actions. I think a lot of it is choosing. You get the odd really psychotic person who genuinely cannot control themselves but a lot of it is choice and that is the really scary situation.

k. Confused patients due to delirium or dementia who are aggressive. However, nurses do not see them as a threat:

   ICU2: There is dementia as well. We are a lot more tolerant towards an old man [who has dementia].
   ICU1: That is more delirium. We do not see them as such a threat.

5) Patients who are hospitalised against their will do not cooperate and are more aggressive.

l. Patients who are hospitalised against their will are not co-operative:

   MHD3: Most of our aggression comes from Involuntary Treatment Order patients who do not want to be there.

   ICU3: You walk a really fine line between treating someone, but not overstepping the mark where we are forcing them to have treatment. At what point do you decide that they are not mentally competent to say that, “I do not want treatment, I do not want this done.”

   ICU1: It is the assumption that we know better, that we will treat you whether you want us to treat you or not. You came to the hospital so we are going to give you treatment. Whereas, some people do not want it.

Five patient factors were identified as patient factors that contributed to workplace violence. The next section presents the factors for horizontal violence.
4.4.4. Causes of Horizontal violence

Horizontal violence, also described as lateral violence, occurs among healthcare professionals or among care recipients. Even though horizontal violence was not the focus of this research, nurses spoke about horizontal violence during the focus group interviews. Therefore questions were added to the survey to ask about horizontal violence.

Nurses described two contributing causes of horizontal violence within their work departments, or between departments. Firstly, a lack of team interaction and reciprocal help, and secondly, staff stress caused by heavy workloads.

1) Teams are not interactive or don’t help each other:

   ED1: Typically, in your team leader role, you are doing a co-management position with the boss, the medical consultant. It depends on that consultant and how interactive they are. That can make or break the shift. And that is management partly working as a team. And then we get horizontal violence—would be a good way to describe it—from the wards upstairs where we get, say, a look—we need to get this patient out so we can provide these spaces—and they will stall.

2) Staff members who are very busy or stressed can contribute to horizontal violence:

   ICU2: The interesting thing is that occasionally, when we are really stressed and busy, we do it to each other. We do not realise until later that something we have said got misinterpreted or got, not only misinterpreted, but it was just a response to a stressful situation and I think we have to actually be kinder to each other, or as kind as we can possibly be to each other, because once that level of interaction or communication breaks down, I think it is really, really hard. And that has definitely happened to me. I have had a colleague wear me down constantly [and] constantly let me down.

   ICU6: At the moment with the ward restructuring, sometimes it is actually the patients and the nurses whose stress levels are already up because you have been working for [the patients] for two hours. So it is not just the patients, it is also the nurses. So yes, there is a lot [of horizontal violence], for sure.

Social, hospital and personal factors all contribute to vertical workplace violence. In addition, when nurses are busy and stressed they sometimes say things to
each other that they only later understand might have hurt someone’s feelings—contributing to horizontal violence in the workplace.

The next section addresses the effects of workplace violence on nurses.

4.5. **Effect of workplace violence**

The consequences of workplace violence on both nurses and witnesses to violence can be far-reaching. This section examines the impact of workplace violence on nurses, the impact on witnesses to violent incidents, the impact of violence on the different genders of nurses and their perceptions about their professions (Figure 5).

Focus group participants revealed that male nurses are impacted on in different ways by workplace violence compared with female nurses. Participants also perceived that less-experienced nurses found it more difficult to cope with violence in the workplace. The seriousness of the impact on nurses is underlined by reports from participants. These reports establish that workplace violence impacts on nurses’ abilities to interact with patients, and influences their decision whether to remain in the nursing profession.

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![Table: Effects of workplace violence](image)

**Figure 5: Effects of workplace violence**

### 4.5.1. **Impact on nurses**

All the nurses from the three focus groups agreed that verbal and physical violence at their workplace impacts on those who experience it. The impacts range from individual emotional and physical effects to personal and professional life dissatisfaction, lower productivity at work and even career abandonment. Emotional impacts include feeling stressed, unsafe, fearful, intolerant, desensitised, cynical and hypervigilant. A wide variety of effects of workplace violence were raised by the participants.
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1) Nurses are hurt by patients and visitors:

   ED2: I do not think people realise the implications that their words or their actions have on others. The burnout rate in nursing is already so high, we do not need to cop any more violence, whether it is verbal, physical or even emotional. I do not think people realise the extent of damage they do with the things that they say or do. And I do not know about anyone else here, but I’ll openly admit that there have been a number of times when I have gone home and cried my eyes out because of things that patients have said to me, families have said to me [when I am] going out of my way to try and help, and do everything I can for them.

2) Nurses feel helplessness because of workplace violence:

   ED1: Yes, that definitely impacts because you have the feeling of helplessness. You are just battered.

   ED4: There is nothing that you can do.

   ED6: [You feel] crushed.

3) Nurses feel threatened and have frightening moments:

   MHD5: Everything is fear. It is what people do, especially younger people, elderly people. I do not think anyone signed up to get hurt or bashed. And children, I think [over] the years I have been here, I think it is very lucky somebody has not been more seriously injured with some of things that happened. [They] could have led to a head injury or even death. And I think the knee-jerk reaction will happen and it does happen and it will be too late for whoever it is.

   ICU2: Last year was my most frightening moment and I have been in nursing all this time. The son [of a patient] said to me, “I will be waiting for you in the car park.” Luckily I had witnesses. I have never felt safe after that. That was really, really scary.

   ICU1: It is the threat to get us afterwards [that is frightening].

   ICU4: I am actually more worried about the underlying subtle stuff which the visitors hit back at you. Now I am thinking, Oh, I have got to walk out here at the end of the shift. If I am going to see him in the car park, if I am going to see him in the cafe, I am uncomfortable with that. That to me is a threat. The patient in the bed lashing out is not a threat for me. We can escalate very fast ourselves and we can control that.
4) Nurses’ stress levels impact on their personal lives:

*MHD8*: Stress can then pour over into home life as well—my family and myself. That is why I asked to change wards at one point because I was getting snappier with my wife and my fuse had become shorter. We can trace it all back to the increased violence [at work] that has been occurring.

*ED6*: There is a build-up and you absorb all of this negative energy from around—from all the people around you—and then you go home and you have got to bottle it up. I know that I have come home sometimes and I am telling my hubby about my day and I am upset, I am miserable and I am half-baked, yelling and I am not meaning to be upset with him. He has not done anything wrong—it is just the day has just been so busy, so stressful.

*ED3*: The stress does impact on you. I find it occurs in triage that [you are] anticipating it, you are waiting for it, you are always on guard, you are always waiting and you become very cynical.

*ICU5*: It is one of those kinds of things that build up over time. If you have conflict with people, it may not affect you initially but after it happens a few times, it starts to worry me. I start to stress up.

Nurses describe moving to different wards to escape violence, feeling hypervigilant about the possibility of violence occurring and having their home life affected by being short-tempered with family members and feeling stressed even after they have left work. They also note the cumulative effect of repeated exposure to violence, which is worrying and stressful.

5) Workplace violence affects nurses’ personalities. They become exhausted and hypervigilant, and feel unsafe, cynical, intolerant, de-sensitised and tough-skinned:

*ED1*: It has made me a lot more hypervigilant, not only at work but I am always coming into the workplace expecting it, looking for it. [I] constantly scan, waiting for it. Also in my everyday life at home, if we go out somewhere that I am not familiar with or even to the shopping centre, I am constantly scanning [for threats]. There is no real relaxation point outside of the home. A good way to put it [is that] my wife sees the good in everyone first. My immediate reaction is, “What is your game?”
ED2: The staff might go home and have nightmares with post-traumatic stress. You do not feel safe.

ICU1: You become much more careful about how much information you give out to people. I cover up my surname and they only have my Christian name showing on the [staff] badge because that at least gives me some protection when someone wants to find you.

ICU2: I agree, I have mine in the pocket, it stays there.

ED3: You are constantly alert. People become very cynical.

MHD2: I think we become more intolerant, rather than actually trying to recognise the trigger factors and dealing with those. I think we need to use more medications instead of trying to [self-medicate]. I think there is a tendency to have a glass of wine at the end of the day.

ED6: For me personally, when I first started working in emergency, I was very sensitive and naïve and compassionate and believed everybody’s sob story and got sucked into everything. Now I feel that I am more desensitised and tough-skinned and more cynical, definitely.

Nurses describe feeling unsafe at work or in public, being unwilling to identify themselves for fear of patients tracking them down, using alcohol to medicate their stress, losing their feeling of care and compassion for patients and feeling cynical towards them.

6) Nurses feel vulnerable or are criticised for defending themselves:

ED6: We have got nurses who are currently being [accused of assaulting patients], even if the patients come in intoxicated or psychotic and assaulted the nurses. A couple of nurses have made statements and have to go to court because they have been [accused of] using aggressive behaviour management to manage the patient. Now the patient is trying to say that the nurse has hit the patient. So instead of us being protected, we are being attacked for defending ourselves.

ED1: [I feel] extremely vulnerable that if we defend ourselves, then we are the ones going to end up being the perpetrator of the aggression, or the perceived perpetrators.
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Nurses describe the sense of unfairness when a violent patient brings allegations against a nurse, whereby the nurse has to defend him/herself in court. Nurses then experience a sense of helplessness in the face of aggression, for fear of being blamed for being violent towards a patient.

7) Nurses facing a dilemma of hurting the patient in order to save themselves:

*MHD5: Many years ago, at [X] hospital, I was actually attacked by a man who was chasing me from behind and I remember thinking, Let it all finish, but I was more worried about what would happen if I hurt him to save myself than actually [thinking about] my own safety. I always hoped that it definitely would never happen again and I do not have to deal with it, because I think that is dangerous. The inference is that you had to hurt someone to try to save yourself. The thing would be that you hurt this [patient] and that is very dangerous and very sad.*

Mental health nurses can be more worried about hurting the aggressor than being harmed themselves.

8) Nurses face the dilemma of being professional although they do not feel safe, as their basic needs are not provided:

*ED6: In nursing we are always looking after everybody else. But where are the boundaries for us? Where is me? Do I even matter? Where is the boundary? You feel like there is nothing of you left anymore. You do not get your meal breaks. You are out on your feet, starving.*

*ED2: Who is looking after us? You do not feel safe. You cannot have a drink of water or go to the toilet. [Nursing] is the most trusted profession in that big list that comes out every year. We are on the top of the list nearly every year, aren’t we? How could someone treat us like that?*

*ED4: You do not have to be happy all the time but you do have to present a professional front. Say, “Hello” [with a] smile on your face. Even if someone is throwing a chair at you, you have got to be professional.*

Nurses describe the dilemma of maintaining their professional caring role when they feel unsafe, miss meal breaks or even if they are directly under physical attack.
9) Some nurses believe they have mental health issues due to violence at their workplace:

*ED5: But in reality, all of us with these [violence] issues we are going through it every day. We get some mental health issues too.*

An emergency room nurse describes the effect of being subjected to ongoing violence and the possibility that nurses may suffer mental illness themselves as a result.

10) Sick leave, job dissatisfaction and reduced productivity at work has consequences on the general healthcare system:

*MHD3: The decrease in work and job satisfaction, probably the workplace culture as well and the impact on the system.*

*MHD5: [Nurses] take sick leave [to escape the violence].*

The experience of violence in the workplace reduces job satisfaction for nurses, harms workplace morale and can lead to individual nurses taking sick leave.

Violence in the workplace has severe and lasting personal and professional effects on nurses who experience it. Violence affects their personal lives because they feel hurt, unsafe, vulnerable and helpless to defend themselves from violent patients and visitors. Nurses are threatened, have frightening moments and react in a variety of ways, such as feeling stressed and exhausted, and becoming hypervigilant, cynical, intolerant, desensitised and tough-skinned. Some of the nurses may suffer mental illness as a result of workplace violence. The violence that nurses experience also impacts on the profession as a whole through absenteeism, job dissatisfaction and reduced productivity. Nurses also face the dilemma of risking harming a patient in self-defence while maintaining their professional care role towards patients even when they do not feel safe.

Workplace violence also impacts on witnesses of violence, such as other patients.
4.5.2. Impacts on witnesses

Violence in the workplace affects both staff and the other patients who witness it. Witnesses to violence may feel unsafe, frightened, distressed, intimidated or have an extreme reaction. Nurses feel they are under extra pressure and are embarrassed during a violent incident because they feel they will be judged by witnesses of the workplace violence.

Some witnesses to workplace violence acknowledge the hard work that nurses do.

1) Violence affects other patients and staff who witness it:

*MHD5: But in HDU [High Dependency Unit] you can get violence, and it affects some other patients and staff as well. So you could start in the morning—it is an easy day and things are not too bad—and then because of a particular incident, it can change.*

2) The witnesses to violence react in a variety of ways such as being frightened, distressed, intimidated, feeling unsafe or having an extreme reaction:

*MHD1: I believe it impacts on the whole ward. If you have a violent patient in the ward it does impact on the other patients because instead of going into a lock-down and [the patients] get all the attention, they have to witness you secluding a patient or something. That is distressing for people who are really unwell, especially in the HDU.*

*ED4: I think it is very frightening to patients and for family [members] to witness other patients because if they are yelling—but particularly if they are becoming physically violent and when security had to take them down, you can guarantee that they might not remember the positive things that you did to them while they were there. But if they see a violent incident or they have a very scary experience while they have waited five hours, they will remember it and they will remember it for years. They will never forget, “The day I went to emergency and we saw that patient get taken down and those nurses. We had to wait.”*

*ICU2: If people witness it, it becomes quite intimidating.*

*ICU3: We had to bring a family group into the unit because the other relatives in the waiting room were so aggressive and loud and intimidating that they felt unsafe here, so we brought them in to sit with the relative because they just did not feel safe in the waiting room.*
MHD11: We have just recently had a patient who was very dysregulated and that impacts on another patient. [Because of] her particular diagnosis, she reacts—her triggers would be loud noises. So she ends up in a fetal position and ends up potentially unable to respond, as a reaction to witnessing a patient who has been very verbally abusive towards nursing staff. That is how it affects another patient.

Nurses describe patient distress in wards where a violent incident occurs and patient trauma is triggered, where conflicting family members need to be separated and where there are possible long-term impacts on witnesses who remember an incident for several years.

3) Nurses feel extra pressure and embarrassment when they are being judged by witnesses to workplace violence:

ED6: The waiting room was all full and I felt like it is an extra pressure on all of the staff because not only are you having to deal with a violent patient but you have got a whole audience watching every little move that you do. I feel like that is a big part of it too, because they have not seen [anything like] it before. They do not understand and they are sitting there watching a patient attack someone. I feel very judged. Sometimes I feel they can understand but then other times I feel very judged—that they are so embarrassed. I am embarrassed because I feel like it reflects on us; that we are not providing a proper service and our resources are not good enough. It is never an ideal situation. We are always under-staffed and if we do not handle these situations absolutely perfectly I feel embarrassed that they think that we are not good enough or they are not going to want to come to us if they have health problems or you are not professional. I do not think they would be scarred for life—I just think they will probably look at this situation and think, Oh this is not a place where I want to go to get health care.

An emergency nurse described the discomfort she and other staff felt dealing with a violent patient where the incident is visible and audible to other patients in the ward. The discomfort is distressing, leaving the nurse not only being the target of violence but also feeling unfairly judged by witnesses. Nurses also feel embarrassed, not good enough (to prevent violence) and that the experience will lead to the witnesses avoiding using the hospital in future.
4) Some nurses believe that witnesses of workplace violence do acknowledge the hard work of nurses:

ICU1: [Witnesses] acknowledge you are doing a tough job, saying, “I do not know how you do what you do.”

MHD7: I think [witnesses] often feel that we are like a prison system institution and you are trying to contain the situation, and trying to defuse everything before it happens, always.

Some nurses believe witnesses of violence against nurses admire their stoicism in the face of violence from patients. Nurses give themselves some credit for containing and defusing difficult and dangerous situations despite being under threat themselves.

Violence affects other patients and staff who witness it. Witnesses of violence react in a variety of ways such as feeling frightened, distressed, intimidated, unsafe or even triggered, resulting in an extreme reaction. Nurses feel extra pressure and embarrassment during the violent incident because they feel that they are being judged by witnesses. However, some nurses believe that witnesses of workplace violence do acknowledge the hard work that they do.

Participants of the focus group interviews think that nurse gender can also contribute to violent incidents. For example, female nurses believe that patients verbally abuse more female staff and that male patients intimidate female staff.

**4.5.3. Gender and violence against nurses**

Participants in the focus groups identified the gendered nature of the type of violence towards nurses, and differences in its frequency and severity. Female nurses who participated in the focus group interviews said that patients verbally abuse more female staff, whether they are nurses or doctors, and that male patients intimidate female staff, whether they are nurses or doctors, more so than male staff.
Female nurses said that the presence of male nurses in their department could prevent violence. However, allocating male nurses to care for violent patients raises concerns that the male nurses may be seen by their patients as bodyguards for the female nurses. Both female and male nurses think that male patients are more aggressive and physically violent towards male nurses in comparison to female nurses.

1) Female nurses believe that patients are more frequently verbally abusive towards female staff (nurses or doctors) than male staff:

   ED5 (Female): I think sometimes it is a male/female [dynamic]. Female doctors get verbally abused more than male doctors do; and often patients think male nurses are doctors and that female doctors are nurses, just because they are female or male.

   Gender stereotyping in which patients perceive men as doctors and women as nurses affects the health care dynamic and the occurrence of violence.

2) Female nurses believe that male patients intimidate female staff (nurses or doctors) and that the presence of male nurses in their department can prevent the intimidation:

   ED4 (Female): If someone is becoming physically or verbally aggressive, if you have a male nurse in the department, and you swap staff around, it can settle things down a lot quicker than if there is just the [female nurses] on [the ward]. A lot of the male patients, particularly, feel that they can intimidate female staff, I think they realise fairly quickly that we have a good proportion of male nurses in our department. If one of the males comes out, even to show he is present, things can settle down very quickly.

   An ED nurse described the entitlement that male patients exhibit to be verbally or physically aggressive towards female nurses if the patient believes no males are around. The behaviour of male patients changes in the presence of male nurses, to being less intimidating of female nurses.

3) Male nurses are concerned that patients consider male nurses as a bodyguard rather than professional nurses:

   MHD8 (Male): Male nurses are seen by a lot of people I spoke to as not being a nursing sister. “You’re there as a bodyguard for other people.” There have been a few nurses, who rightly or wrongly as males, have been picked out as the strongest—not as an antisocial
thing—to be dominant. The [male nurses] often do get it. Once they feel that, they realise that often happens.

A male MHD nurse described being seen as a bodyguard for the female nurses rather than as a nurse in his own right. However, he said male nurses are perceived as dominant by male patients and male nurses accept their role on the ward to be dominant, when necessary, to protect their colleagues.

4) Some male and female nurses believe that male patients are more aggressive and physically violent towards male nurses compared with female nurses:

   ED1 (Male): We still have more violence, particularly [patients who] will try to challenge us. They want to provoke us into a response, so they will become quite intimidating and aggressive. [There is] the perception that if a male [patient] attacks a female [nurse] then there is a social taboo about it. But male [patient] versus male [nurse]—they are considered fair game.

   ED5 (Female): Male nurses probably get punched more often than the female nurses.

   The social respect men are expected to give to women moderates the violence by some male patients towards female nurses. However, male patients may be less restrained with male nurses and feel more entitled to physically attack male nurses.

5) A team leader takes into consideration a nurse’s gender and personality for allocating nurses to patients during the handover:

   ICU3 (Female): Your handover is very important and lets me allocate the next shift coming on. If you get someone who is particularly violent, I am not going to put [a female nurse] there. I am going to put one of the [male nurses] with him because [a male nurse] will be able to manage [the patient] better or [the nurse’s] character or personality will be able to deal with him better. Or, the patient might respond better to a male nurse. But saying that, sometimes that backfires. And you do not want the patients to see [a small female nurse] and think, She is a pushover, and that he has free rein with his aggression. So it is very difficult when you are allocating [staff] as the team leader of the next shift. I am a team leader. I spend hours on allocation thinking, He is getting worse, I need somebody more assertive, somebody a bit bigger, someone with a bit more aggressive personality to match that, and you are probably meeting aggression with aggression.
A nurse unit leader describes the complex task of assigning nurses to patients to protect them from aggressive patients; assigning males to manage aggressive patients, even though they realise the risk of aggression could escalate.

Both nurse genders believe that male patients are more aggressive and physically violent towards male nurses. Female nurses believe patients verbally abuse more female staff than male staff and that the presence of male nurses in their department can reduce violence against female nurses. However, the use of male nurses as de facto body guards for their female colleagues raises concerns among male nurses that patients could consider them as unprofessional, which might interfere with the therapeutic relationship of carer and patient. But, even though male nurses prefer not to be seen as bodyguards, their team leaders take into consideration nurse gender and personality when they allocate nurses to patients.

Workplace violence has consequences not just on the nurses, but also on the interactions of the nurses with their patients and visitors.

4.5.4. **Impact of violence on interactions with patients or visitors**

Workplace violence negatively affects patients because nurses get burned out, withdraw from interacting with patients, may become less caring and compassionate and may avoid patients. Nurses may become overly cautious and more restricted when they interact with patients and visitors. However, some nurses said regional nurses were kinder to patients and visitors because they might see them again. In a big city there is a less chance of seeing them again.

1) Violence towards nurses negatively impacts on patients because nurses become burned out:

*MHD3: [Violence] probably does have a negative impact on patients who aren’t necessarily aggressive. As nurses, we have a bad day and tend to take it out on other people and sometimes they are patients and probably looking back on it, is not the best thing to do. We are only human. It is probably what does happen. But if we are getting burned out, we should ask to be moved to another area, if we*
have too much pressure.

A mental health nurse admits the consequences of workplace violence may affect patients who are not aggressive because of the effect of violence on staff being transferred to patients.

2) Nurses may avoid patients and be less caring of patients who are verbally and physically violent:

**ICU1:** You tend to avoid the patients who are a pain in the butt. Then you go and do your [observations] and you walk away and think, I am not going to talk to them. Why should I? I mean they are likely to punch me, so I think that they do probably receive less care because you just stay away from them.

**ED4:** You cannot become very caring and compassionate, which is a big part of the culture of nursing. We are there to care for people and show compassion and look after sick people. If you cop physical or verbal abuse, the last thing you feel like doing is more than what is absolutely, one hundred per cent necessary for that patient. You keep to your basics, and that is all that you give. So it definitely impacts on what we can provide for that particular patient, I think. And it is also if you cop a lot of flak over a shift, by the end of the shift, your compassion has nearly dried up, has it not? You are at the point when it is basics only, because you just have nothing left in the tank. If you have copped a lot of flak from a patient at triage, your compassion pretty much goes down.

**ED1:** [In that situation] it is really difficult to care, become very caring.

**ED 6:** If I have an aggressive patient, I might not nurse-initiate those treatments. If that patient is being aggressive to me verbally, or if it was a patient who was being compliant, we could nurse-initiate and start treatment before the doctor has seen them. I can walk away. I am a nurse and if my patient is not dying this instant, I do not have to deal with them, I do not have to. I have three other patients who have needs.

Intensive care and emergency nurses said they avoid patients who are verbally or physically abusive, providing them with only the required care, unless they are dying. An emergency nurse said she would not initiate treatment with an abusive patient, preferring to provide treatment to other patients in her care instead.
3) Nurses are becoming overcautious, hypervigilant and more restricted in their interactions with patients or visitors:

MHD7: Yes, you become over-cautious around certain people, and fragile.

MHD4: I think you become more restricted as a clinician, as in problem-solving skills because you think, Well, last time, I had that patient I tried this way of problem-solving. It did not work. It blew up in my face, so I am not going to try that again. So I think with a different individual from a different background with different stressors, you think, I am not going try that with him because it just didn’t work. So you become more restrictive in your problem-solving with new patients.

ICU4: I am probably a little bit more hypervigilant with relatives [of patients]. But I try in my interaction with the patient to get off to a professional start. It doesn’t always work, but you try. I think you still have to be a little bit careful that you are not just judging the patients just that little bit too fast. It is hard to [suspend judgement], especially if they have been particularly aggressive. You do not want to be a sucker, you do not want to get caught out. But I think all of those sorts of things must colour how you deal with the patients. If people aren’t careful with the words they use, you can be a little bit too hypervigilant and it can make it obvious that you are not comfortable with that patient, although you have only met them for two minutes.

Mental health and intensive care nurses described how they felt themselves becoming cautious towards patients, more restrictive in their practice, quick to judge aggressive patients and hypervigilant.

4) The ICU nurses said that regional nurses are friendlier to patients and visitors because they might see them again. However, in a big city there was less chance of seeing them again:

ICU1: And the other time I recognised you, I was thinking, Well, yesterday you really punched me out. There is no anonymity like there is in a like in big city.

ICU5: So I think that makes it harder in a regional hospital. I was talking about knowing your patients and knowing your patients’ family. I think it keeps you honest because you have to be really nice to people because you do not want to run into them in [a shop].
Workplace violence negatively impacts on patients because nurses get burned out, become over-cautious, hypervigilant and more restricted in their practice while interacting with patients or visitors. In addition, nurses who experienced verbal or physical violence from a patient may avoid or be less caring for the aggressive patient. However, nurses from the ICU believe that regional nurses are friendlier to patients and visitors despite their aggressiveness, because regional nurses might meet the patients again. In a big city there is less chance of meeting former patients. Workplace violence affects the interaction with patients and visitors. The consequences of workplace violence may be so serious that nurses may decide to leave nursing rather than remain in the profession.

4.5.5. Impact on the decision to stay in, or leave, nursing

Violence towards nurses is such a serious issue to them that it affects their decisions to remain in, or leave, the nursing profession. Nurses may decide to resign from the profession due to workplace violence:

*ED3: I am really depressed now. I do not think I want to be a nurse any more.*

*ED5: Is there any one of us who has not been down in the dumps about working and coming back the next day. That is a form of depression really. You have a choice, do you go back, and go on or do you need help? Do I get help? Am I at that stage?*

*ICU2: It is often not a major incident that is the breaking point. You might have a major incident and you get past it. But it is something little that actually triggers you to the point where you say, “I just cannot come to work.”*

Two ED and one ICU nurse spoke about the long-term impact of violence and the difficulty in coping with repeated threats and experiences of workplace violence. All three described reaching breaking points, stopping work due to depression and realising a small trigger will eventually be enough to force them to resign.
Even though violence at work can affect the nurses’ decisions to resign from their profession, many nurses choose to stay in their job despite workplace violence for various reasons, including the fact that they love their jobs.

4.5.5.1. **Nurses love their jobs**

Even though nurses experience violence in their wards on a daily basis, nurses love their jobs and choose to stay in their profession despite workplace violence. The reasons they give for staying are that:

1) they love their jobs
2) they like interaction with patients and relatives
3) they have a relationship with staff and feel like part of a team
4) they like the variety of each shift being different.

Each of these reasons was supported by evidence obtained from the focus group interviews.

1) Nurses love their jobs:

   **ED5:** You like what you are doing; you love what you are doing.

   **ICU2:** How fortunate are we to be in this position in nursing? I am thinking about the wards—they are so task oriented. How fortunate are we to be that person who has the capacity to be the frontline person.

   An emergency nurse and an ICU nurse spoke about their love of the job in caring for patients. The intensive care nurse spoke about feeling fortunate to be on the frontline, providing medical care to patients.

2) Interaction with the patients and their relatives:

   **ICU1:** I think you need to want to do nursing. It is so much more interactive with the patients and their relatives. We have more contact with them. We are more involved with what is happening with them. Whereas on the wards, they do their tasks, they do not have the time to interact with the family and patients as much as we do. It is more intense because you are actually more involved.
Despite experiencing violence from some patients and relatives, contact with patients and relatives was described as a primary reason for being a nurse.

3) Relationship with staff and feeling part of a team:

ICU2: Our relationship with our doctors is unique. They are our team. They are not our superiors. They are just our team.

An intensive care nurse described the satisfaction of belonging to a team, including doctors and nurses caring for patients.

4) The variable and changeable environment in every shift:

MHD2: No two shifts are the same. It is such a variable and changeable environment.

MHD10: That is what I love about mental health nursing. No two shifts are the same.

ED6: That is why I like working in emergency—because of the autonomy.

Variety in the working shift was described as another benefit of the job. Nurses love their jobs due to the privilege they feel of being on the frontline of healthcare, interacting with patients and relatives, feeling like they are part of a team and because of the variety of work they do each shift.

The effect of violence on less-experienced nurses compared with more experienced nurses.

4.5.6. Impact on less-experienced nurses

The ICU nurses discussed the difficulties of the younger and less-experienced nurses in dealing with violence at their workplace, compared with the way more experienced nurses dealt with it. Several reasons for these difficulties were suggested, such as inexperienced nurses having fewer strategies and less resilience, feeling like a failure and taking the violent event personally:

ICU1: I think it is harder for the younger ones who feel like they have failed if something happens. Trying to convince them that it is...
not something they have done wrong, it is something out of their control. Young [nurse X], I think she felt she had done something wrong and because she reacted badly, because she cried, I think she thought she had failed in some way. She found it harder to cope with the blue and we just said, “It just happened, let’s get past it.” I think she found it hard to cope with. I think she took it more personally rather than realising that people are like that.

ICU4: The older you get the more resilient you become.

ICU2: ... and the more laterally you think. You have many more strategies.

Experienced nurses displayed concern for young nurses who had not yet learned to accept violence as being impersonal and beyond their control. They also acknowledged becoming more resilient with experience and developing better skills when they thought laterally about effective strategies for coping.

Experienced nurses are aware of the effect of workplace violence, particularly on the inexperienced nurses, and therefore they support, compensate for and protect them:

ICU3: If someone is aggressive in the ward, you do not put your inexperienced staff with them. I think because of the support in the environment that we are working and the colleagues that we work with, [an inexperienced nurse] has the best support. And even apart from violence, we have a few really sad cases of a few deaths or something like that. As a group we all pull together and you put your arms around somebody younger and experienced registered nurses will say, “How are you going today? You had a really rough day yesterday.” And that is just so important. As well as the violence, as well as the other things that happen in the unit.

ICU2: I think there is an old cliché about when nurses get together they all talk shop. It is absolutely true—and everybody is nodding because it is the most valuable tool they do: talk shop. They do de-brief with each other. They do buddy up with the young ones. Once they have made close friends among themselves, they get together a lot and they have little [talking] sessions and drinking sessions. And yes, they do talk shop, because that is our way of de-briefing. So yes, I do think, regardless of whether you are a newbie, like [person x] or whether you have been around the traps for a while, I think your colleagues are your most likely [support].

ICU1: I think a good unit over time builds a closeness. People come
Nurses describe the need for them to work as an emotionally supportive team, for example, when they experience patient deaths or violence. Nurses support each other by “talking shop” to debrief from their work and support younger colleagues.

This chapter has established the types of violence to which nurses are exposed, the factors that contribute to it and the effects of the violence they experience. Workplace violence also impacts upon other staff or witnesses. Violence is partially gender-based. Violence impacts on interactions with patients and visitors. Workplace violence is such a serious issue for them that it can influence their decision to remain in nursing or leave the profession. Yet, most nurses love the job so much that they remain in the profession. Violence has a disproportionately negative effect on less-experienced nurses who have not yet developed coping strategies or realised violence is not directed personally towards them, but rather at the role they are fulfilling. The following section canvasses potential solutions to workplace violence, as suggested by nurses working on the front line of high-care nursing in the ED, ICU and MHD.

4.6. Potential solutions to workplace violence

During the focus group interviews, the nurses proposed many suggestions for managing violence in their workplace. These included suggestions to be implemented by management during and after an incident, implementing a workplace violence policy and increasing support during and after a violent incident, see Figure 6. Top-down strategies suggested by nurses included three types of strategy: general management strategies, management during violent incidents and management after violent incidents. These three management strategies were divided into four types of solutions: social, hospital, nurses and patients, see Table 12. These potential solutions have the ability to manage workplace violence. In addition, managing violence includes implementing management strategies and reporting violent incidents.

The second potential solution suggested was implementing a workplace violence policy that includes making staff aware of the policy, creating an effective policy
and actually implementing the policy. The third nurses’ suggestions concerned support during and after violent incidents. These suggestions ranged from colleague, managerial, family and friend to hospital support. Nurses also made suggestions about who should provide support for nurses in the workplace.

Figure 6: Suggested solutions for workplace violence

4.6.1. Management of workplace violence

Nurses said that was difficult to predict when aggressive behaviour would occur:

*ICU4:* That is normally after the first punch has already been thrown. So I suppose, the only problem is how you recognise it before it actually happens?

*ICU5:* I do not know whether we initially recognise it quickly enough because we get caught out often. I think once it is recognised that yes, we can deal with it, we can protect ourselves fairly fast. But recognising it initially—that is more of a problem.

*ICU2:* I do not think there is any way to either manage or predict how a person will behave. I think it becomes like an instant thing that you have to solve at the moment. I do not think you could define that or say, if this is happening, we will do this, if this is happening, we will do that. We are already addressing that every year in our
behaviour management programs. I do think that the crux of all the problems with the patients is related to de-escalation. I believe that. I think that is the first thing we need to know, is how can we defuse this?

Even though the nurses find it difficult to predict aggressive behaviour, they have suggested various management strategies. They have also suggested improvements to managing violence, such as implementing effective strategies and solving the problems of current strategies.

Managing violence has three levels and four types of proposed solutions, based on the nurses’ suggestions, see Table 12. The three levels of management interventions are: (A) general management strategies, (B) management interventions during violent incidents and (C) management interventions after violent incidents. The four proposed solution types are: social solutions, hospital solutions, nurse solutions and patient solutions. Each of the levels of management interventions and proposed solution types are presented and supported by evidence from the focus group participants.
Table 12: Workplace violence management: timing of management interventions and proposed solutions:

<table>
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<th>General management strategies</th>
<th>During-incident management</th>
<th>Post-incident management</th>
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<td>(2) Supporting mental health patients</td>
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<td><strong>Hospital</strong></td>
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<td>(1) Secluding patients</td>
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<td>(2) Better communication between departments and staff</td>
<td>(2) Using medication</td>
<td>(2) Providing counselling services for staff</td>
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<td>(6) Excluding aggressive families and visitors</td>
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<td>(7) Shortening waiting times and updating relatives</td>
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<td>(5) Explaining the situation to patients</td>
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<td>(6) Following through promises</td>
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<td>(7) Being consistent according to the ward rules</td>
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4.6.1.1. General management strategies

Proposed social solutions

Proposed social solutions are the first aspect of the proposed general management strategy. There are two aspects: firstly, educating the community and secondly, better support for mental health patients.

1) Educating the community:

*MHD8: I think a lot of this needs to start outside of hospitals, in the community and try to re-educate people to be civilised, so people are not growing up with this entitlement. People [should] look at what is happening. It is my hope that we learn from what has happened, bringing the next generation up a bit better. But you cannot expect someone who has felt entitled to be aggressive their whole life to not react with violence. We cannot expect someone who is violent, and place him in a hospital, in a stressful situation, and then expect the [violence] policy to magically fix them, or make them calm. This is not going to work.*

*ED6: I think patients need to be educated on what’s expected of them. They need to understand that it is illegal for them to assault us, in any way, verbally, physically or emotionally. Society needs to know that.*

Community awareness and education are seen as important beginning steps because policies alone cannot be expected to prevent violence in hospitals. Greater community understanding of the illegality of verbal and physical assault is also needed.

2) Better support to mental health patients:

*ICU2: We are not psych[ology] trained. I do not think that the system supports them. I think it is a very weak system. The Mental Health System in Australia is quite disappointing. Building new buildings is not the answer to the problem. It is actually getting the right people to do the job and that is where our mental health patients get let down.*

Educating the community that it is illegal to be aggressive towards nurses and providing better support to the mental health patients has the potential to minimise violence towards nurses. Hospitals and hospital management are also responsible for addressing the issue.
Proposed hospital solutions

Hospital solutions are the second general management strategy and consist of 10 management strategies:

1) implementing policy and laying charging against offenders
2) communicating better between departments and staff
3) educating and training nurses
4) increasing security, especially at night
5) moving nurses to other departments when necessary
6) excluding aggressive families and visitors
7) shortening waiting times for treatment and updating relatives
8) informing patients about the National Code of Conduct for Health Care Workers
9) flagging patients with aggressive behaviour
10) providing a screen in waiting rooms listing the order for patients to be treated.

Each of these strategies is supported by evidence obtained from the focus group interviews.

1) Implementing a policy of laying charges against perpetrators of violence against hospital staff:

ED1: The hospital needs to start having people charged [for violent assaults]. We need to have people dragged out of the waiting room by the police and the public needs to see that we are serious about it—not just a poster going up [on the wall] but actual action.

ED2: I know I am not going to cop any abuse or flak and if I do, it is going to be dealt with appropriately. I think the ideas for how to deal with it are there, they are just not implemented. They need to be implemented.

Police investigation of perpetrators is suggested in order to show the public that hospital management is serious about protecting their staff. Implementing existing policies is also needed.
2) Better communication between departments and staff:

*ICU1: The [other department] missed one once—they forgot to tell us—and this patient got out of the bed, walked across and punched another lady in the face. She did have an alert in place but they forgot to tell us.*

*AMH6: [A patient] is irritable because some of the other team mates should be brought up to have a look at the ward were she will stay. She was not given a proper explanation down in emergency by the doctor who admitted her and so she was quite irritable. The nurse said, “Sorry, you are under the Mental Health Act, you are staying in department [Y]”. So she wasn’t happy with that. [Better] communication is needed; nurses need to know the policy on the ward.*

*AMH3: That is a communication thing. I think that is where a large percentage of the aggression violence comes from: poor communication.*

Breakdowns in communication were blamed for nurses failing to receive warnings about a violent patient. Improved communication is necessary to allow nurses to have sufficient warning that a patient has been abusive or violent.

3) Educating and training nurses in de-escalating violence techniques and risk assessment:

*ED6: Education for these nurses who are rude and who escalate violence need to accommodate [patients] but, at the same time, we need to have some sort of improvement for the nurses who are inciting violence because that does happen a lot. I do sometimes think our de-escalation skills are a bit lacking.*

*ED1: I think the [hospital] can do it—not that they provide it—[they can provide] training on emotional intelligence, know that a lot of people are under duress, maybe just to know what their normal behaviour is, quite acceptable and quite socially appropriate but when they are under duress they become [violent]. We need to have the ability to be able to disassociate [from the aggressor]. They are calling me everything under the sun but it is not directed at me, it is directed at the situation that they are in. And this is their coping mechanism. And for me, that has been an invaluable tool to use. [I have] had the opportunity to go and do that training and that was quite vital for me having those skills.*
Chapter 4: Focus Groups Interview Findings

ED4: It is not just doing [an] Aggressive Behaviour Management [course]. For us, perhaps understanding some of the emotional reasoning behind why people get so frustrated, that could be something that could be very beneficial.

ED1: Instead of this aggressive behaviour management and taking people down, there is another course, a private one, where they train you to premeditate the aggression and then to be able to de-escalate. It is like a risk assessment technique to be able to de-escalate the situation before it even becomes a problem.

ICU1: We do workplace training every year on workplace violence and how to de-escalate situations and we are taught how to do that. And then we talk about different things that happened when we are at the workshop and it is a good refresher every year.

Courses and workshops are provided to help nurses manage aggressive patients. De-escalation techniques are vital to calming patients before they become aggressive or violent.

4) Increasing security, especially at night:

   ED1: I think security is very minimal, particularly with night duties, extremely minimal. The police are generally pretty good in their response time, if we call them or need to.

   ICU4: Maybe a greater presence of security within the hospital. Although they are pretty good, aren’t they? They get to us pretty quickly.

Night security for nurses entering or leaving the hospital is inadequate, although police responded to calls promptly. Nurses suggested a greater presence of security staff to improve the safety of nurses at night.

5) Moving nurses to another department:

   MHD10: I think it is very important, you have to move every 18 months to two years. I have always done that. It is also an opportunity when you can step back and reflect on what you have actually been through for 18 months. And you go back into it again differently, with a different view.

   A mental health nurse suggested that nurses move around wards, enabling them to reflect on their work.
6) Excluding aggressive families and visitors:

   ICU2: With the families and visitors we do exclude them. We are able to exclude them from the unit, so that is another strategy. It may not be a very good strategy but it has the pros and cons.

   ICU4: Because we are a locked unit, so we can control who comes and goes.

Exclusion of aggressive patients and/or families is a strategy that is employed. In secure units, such as the ICU, staff members are able to control who enters or who is excluded.

7) Shortening the waiting time for treatment and updating the relatives in waiting rooms:

   ICU3: If you have got a critically ill family member, and you have got a family outside who have been there for three hours, and they are desperate to come in and they have not have been told any information, they are pretty agitated. The longer it goes on, the longer it takes to get them in and get them updated. Often you get a lot of aggression there. So, having a locked unit does have advantages because you are locked in and you are safe. But it often creates a lot more anger outside in the waiting room, because families are not being updated. Often when you are stabilising patients it can take a couple of hours and they are waiting outside and sometimes you have got a chance to go out and just allay their fears and keep them updated. As more family members arrive they often get more agitated sitting out there waiting and [don’t know] why are they kept waiting.

Locked wards enable nurses to exclude aggressive family members, but may increase the agitation of family members in the waiting room. Nurses can help to reduce the agitation of family members by updating them as soon as a patient has been stabilised.

8) Informing patients about the National Code of Conduct:

   ED6: I think patients need to be educated on what is expected of them. They need to understand that it is illegal for them to assault us, in any way verbally, physically or emotionally. Management should at least inform the patients that there is the Code of Conduct that you have to abide by, but we also have a Code of Conduct which we all have to do training on. But, I am not even sure if we have posters up in the waiting room to say the patients have to abide by a code of conduct and that nurses so as well. They all expect us to, but
I do not know if we have got something in place.

Community awareness about codes of conduct for staff and patients is low. Nurses suggested that management should make patients and staff aware of the applicable codes of conduct.

9) Flagging patients with aggressive behaviour:

ICU4: On the HBISCUS system (the computerised admission system) there is actually a way for a unit to identify aggressive patients and flag them. And very occasionally, we do get a patient who has been flagged, who is known to be violent. By the time they get to us through emergency, we actually already know about them. The flagging probably helps emergency and the triage nurse. That does come through because that is just reminding them that this person does have a history [of aggression]. So by the time they get to intensive care we have already had all the feedback, so the flagging is probably not as important. But the hospital does have the flagging system in the HBISCUS system. I think the ward can actually produce this information for allergies or for MRSA infections but it can also [flag] for aggression and behavioural matters.

Hospital computer systems, such as the admission system, can flag patients for medical warnings such as allergies, MRSA infections and risk of aggression.

10) Providing a waiting-time screen:

ED6: We were talking about a strategy to reduce this frustration, [we were] talking about having a screen, like they have in a pizza shop that says the names and waiting times and where you are on the list.

ED1: A triage number and say, Medicare.

Informing patients of approximate waiting times helps to reduce frustration because patients can see their appointment advancing in the queue.

The ten suggested proposals, in combination, have the potential to reduce violence towards nurses. Implementing policies, having offenders charged and increasing security, especially at night, might reduce workplace violence. Nurses also suggested that improving communication between departments and staff, educating and training
nurses in violence de-escalation techniques and moving nurses regularly between departments may contribute to reducing violence. In addition, shortening the waiting times for treatment, updating relatives regarding the patient’s condition and providing a waiting-room screen in the ED are additional strategies to minimise violence towards nurses. Furthermore, informing patients about relevant codes of conduct, flagging patients with aggressive behaviour and excluding aggressive families and visitors are all hospital solutions that have the potential to prevent or reduce workplace violence.

There are also nurse solutions that might assist in reducing violence towards nurses.

**Proposed nurse solutions**

Nurses believe they have the ability to directly reduce or prevent workplace violence. This can occur through patient allocation on each shift, and through nurse attitudes and behaviours which minimise the risk of violence. Thirteen strategies were proposed by nurses:

1) allocating staff
2) calming patients by contacting their family
3) taking responsibility for the care of patients
4) communicating better with patients and being professional
5) explaining treatments to patients
6) following through on promises
7) being consistent with ward rules
8) being assertive
9) putting barriers
10) making deliberate choices to minimise the risk of violence during handover
11) being aware of risks to de-escalate violence
12) recognising patient reactions and stepping back
13) improving communication among staff and their knowledge of ward policy.

Each of these strategies is supported by evidence from the focus group interviews.
Chapter 4: Focus Groups Interview Findings

1) Allocation of staff:

Nurses in charge of each ward allocate staff based on their knowledge of patient needs and the ability of each nurse. In addition, the nurse in charge can contact the family and invite family members to support any agitated patients, which can help calm these patients:

*AMH 2:* (A nurse leader) "I can minimise the risk of violence because I know which staff handle certain situations the best. [I ask staff,] ‘If you cannot cope with this, you need to withdraw because somebody else is better equipped.’"

A nurse leader can match the abilities of their staff to the medical and nursing needs of patients. Staff should have the freedom to withdraw from a patient if they feel unable to cope with a particular patient, or unable to provide a required treatment.

2) Calming patients by contacting their family:

*ICU 3:* Most of the time it is more family [than nurses] who calm [patients] down. It is easier to ring a family member to come and visit them.

Each nurse should take responsibility to try and meet the patients’ needs, as well as communicate better with the patients. Additionally, explaining treatments and medical procedures to patients can reduce their anxiety and consequently reduce the risk of violence.

3) Taking responsibility and caring for patients:

*ICU 4:* Sometimes you think you sideline issues by giving responsibilities to someone else. You can say, “Oh well, let the social worker deal with pastoral care,” but at the end of the day a lot of the concerns can only be dealt with at the bed side. And [nursing] is about meeting peoples’ needs.

*AMH 11:* If visitors come near, you should always offer them a cup of tea [if] it is a long waiting period. [Visitors] seem to calm people down a little bit. [Offer them] some water and some food— maybe they have been waiting for a long time.
Patient distress can be mitigated by providing timely interventions rather than waiting for a particular allied health provider to be available. Visitors should be recognised and welcomed as part of the therapeutic team, and offered food and drinks during long hospital visits.

4) Communicating better with patients while being professional:

ED6: We need to work as a team on communication and presenting a professional demeanour.

ICU1: I think at every step, in every contact a person has with the system, people need to be more willing to talk to people and try to solve problems before they become overwhelming because people just feel like they are ignored. Sometimes something simple, like saying to someone that you understand what they are going through and [asking] “What can I do to help?” is just the beginning. Instead of somebody brushing them off a dozen times and all of a sudden you have to cope with an angry person.

AMH5: Treating people with respect as individuals. It is also knowing your patients: What are the triggers? The history of people. What caused those in the past? You’ve got to try to work with them.

AMH10: [What is needed is] good communication; collaborative problem-solving. [And to remember that] there is a human at the other end.

Open, clear and respectful communication is necessary to reduce the risk of patients becoming anxious and distressed, and thus reduce the risk of violence. This can be achieved by keeping patients informed, and by explaining that if the nurse is currently busy, they will return and speak to the patient.

5) Explaining the situation to patients:

ICU2: If you are in that situation that you cannot get back [to a patient] for a little while, say to somebody, “I know you want to talk to me and I am busy for a little while but I will come back at so and so time and I will spend some time with you and I’ll tell you everything.” [It] doesn’t take very long but it certainly works.
When a nurse knows a patient requires attention and they cannot give it immediately, the nurse can let the patient know they recognise their need and that they will come back and talk to them.

Explaining the situation to patients and following through on promises are important strategies to keep a good therapeutic relationship and reduce patient frustration.

6) Following through on promises:

ICU1: [Following through on promises] is more an organisational thing [that needs to be prioritised better]. You [might] have a patient who is told at 8 o’clock in the morning that they can go home but it is not until that night that they get out of hospital because they haven’t had a sleep, the doctor has got to do this and that. And they are just not organised enough to get that person discharged. I think the patients get frustrated. If you tell a person they can go home then that person expects to be able to go home in a couple of hours—not 10 hours later.

ICU4: Always follow through; do not off-load onto someone else.

Intensive care nurses described patients’ frustrations after being told something will happen (like they will be discharged), only to experience long delays (like waiting for 10 hours for that discharge to be finalised).

Nurses believe that they need to act assertively with patients. Consistently applying ward rules also assists in reducing violence towards nurses.

7) Being consistent according to the ward rules:

MHD 2: That causes all of the violence, the inconsistency between generic rules that are in place, or safety systems. Keep everyone on the same page, so one person doesn’t feel like they are favoured over another. Those inconsistencies can cause a lot of aggression.

One mental health nurses believes unfair treatment or favouring one patient over another leads to a substantial amount of aggression. This can be avoided by nurses being careful to apply ward rules fairly.

8) Acting assertively:

ED2: I think a level of assertiveness is good. A lot of people would benefit from doing a course in learning how to be assertive without
coming across as grumpy and cranky or aggressive, because I myself am not assertive. I, at the first sign of any confrontation or verbal abuse, or physical abuse, I am like a bullet out of a gun, I am out of there. I am totally not a confrontation type.

**ED4:** You cannot be meek and mild to work there. You have to be tough-skinned and be pretty assertive to make things happen.

**ED 5:** It is your background, your experience of life that makes you like that. If you have not learned to be assertive or aggressive, and even sometimes you can be too assertive or too aggressive as well. But you do not run to the head of the department screaming, “I am going home.”

Three emergency nurses highlighted their lack of assertiveness and their lack of confidence in dealing with confrontation.

9) **Placing barriers:**

**ED4:** Sometimes you have to put barriers.

Nurses can prepare themselves at the beginning of a shift by being aware of handover comments, while being careful not to pre-judge patients who might have been aggressive to nurses on previous shifts. Learning to de-escalate violent situations or to step back from them are additional management strategies that may mitigate violence.

10) **Taking care not to pre-judge patient behaviour based on handover discussions:**

**ICU4:** It depends whether you have prepared yourself at the beginning or outside of the ward and also too, it is not without getting decked here by my colleagues but it does actually start on the handover. The language that people use on the handover will, whether you like it or not, colour your interactions for the first little while with that patient. And I know people like to give colour to what happened in the last few shifts about what happened with the patients. And so you need to make deliberate choices at the beginning to try to ignore what you have just been told. And I’ll just see how they are and just try to see whether I can start off on a new footing but that does not always work. So, I suppose, the history of what happened in the past 24 hours will always colour what a nurse is presented with. But I think you still have to be a little bit careful that you are not just judging the patients just that little bit too soon.
ICU3: At handover you do form a picture of what the patient is about and you probably do need to step back [from premature judgement].

ICU6: Before and during the handover, if the patient [has been aggressive] before I am ready, my stress level is already up and then I notice that the next eight hours are really, really stressful. But now, during the handover, for example, [I see] that the family is like this and the patients are like this… I am aware but I will not put my stress level up. I can relate the patient to the family better because I am just aware but I do not put my guard up, so that is how I cope...

11) Awareness and de-escalating violence:

ICU4: Learning how to de-escalate it is probably a good way to go and maybe keeping an open mind.

Techniques for de-escalating patient distress and aggression are necessary to reduce the risk of escalating violence.

12) Recognising reactions and stepping back:

ICU1: I think a lot of it is previous experience—recognising that you are reacting to something that has happened before. It is not that patient that you are reacting to—you are recognising something that you have seen before and you do not step back and say, “It is not them; it is what happened to me before and I am over reacting to what happened.”

ED5: You’ve got to recognise when you get too far down that [road to reacting].

ED1: Your whole attitude, your interaction with everybody—not just one person—but everybody. At that point we are thinking, I cannot deal with this anymore; I have been through something, because I have had points where I have recognised it in myself and said, “Right, time to step out because otherwise I am going to say something that I cannot retract.”

ED4: Particularly people who have been there for a longer time, they do not step away; they do not realise that they have to [step away].
Memories of previous violence can influence how nurses react, possibly making them more reactive than is helpful. Nurses need to be aware when they are reacting to past incidents rather than current ones in order to moderate their reactions.

13) Improve communication among staff and know the ward policy:

* MHD3: *That is a communication thing. I think that is where a large percentage of the aggression and violence comes from: poor communication [among staff].*

* MHD4: *[Violence has been affected by] misleading information [about patients] who unfortunately ended up in seclusion, which was not good at all.*

* MHD5: *The other thing is, how many times has everybody around this table been told by doctors to tell other patients bad news and “Hey, you’re not having leave; no, you’re not going home today?” Very often.*

* MHD6: *Communication—[staff] need to know the policy on the ward.*

* MHD8: *[Doctors] do not tell you, but they take off and then you have to try to pick up the pieces.*

* ICU2: We do not realise until later that something we have said was misinterpreted or was not only misinterpreted but it was just a response to a stressful situation. I think we have to actually be kinder to each other, or as kind as we can possibly be to each other, because once that level of interaction or communication breaks down, I think it is really, really hard.*

Communication breakdowns precipitate a significant amount of violence. These breakdowns may constitute failures in communication between nurses, between doctors and nurses and between staff and patients. One intensive care nurse suggested that nurses should aim to be kinder to each other to avoid communication breakdowns.

Thirteen suggestions were made by focus group participants to reduce the risk of violence towards nurses. These include knowing the ward policy and improving the communication among staff, as well as communicating better with the patients and explaining treatments to them. Nurses should also consider following through on promises, acting assertively and placing barriers on patients. These strategies will all
assist in reducing violence on their wards. However, there are also patient and visitor responsibilities to behave appropriately and be accountable for their acts.

**Proposed patient solutions**

1) Responsible behaviour of patients and visitors:

   *ED5:* [Patients should be] made accountable to a person or somebody as well as we are. And, at the end of the day, once they have informed [the hospital] and they know they have done something wrong, it should be their responsibility to come back and apologise. Say, “I’ll try not to repeat that.”

   Nurses believe patients should take responsibility for their behaviour and apologise if they behave aggressively towards nurses.

   The nurses suggested particular management strategies that could be implemented during a violent incident.

4.6.1.2. **During-incident management**

   In addition to the general management strategies that nurses provided, they also suggested management strategies that could be used during and after a violent incident. The proposed management strategies during incidents are hospital-based strategies and nurse-based strategies.

**Proposed hospital solutions**

   Participant nurses believe that their hospital has the ability to seclude aggressive patients and use medication during violent incidents, for both patient and staff benefit.

1) Secluding violent patients:

   *MHD9:* Perceptions of us doing seclusions [are that] we are just doing it for fun, when really it is for everyone’s safety. It is for the patient’s safety. It is for our safety.

   Secluding violent patients is a last resort for nurses, but it is implemented for the safety of patients and staff.
2) Using medication:

*ICU1*: I think doctors are getting better at recognising that patients need chemical assistance, because you get patients in who are on medications or drugs at home and all of a sudden they come in and all that is stopped. And then you are trying to wean them off antibiotics and get them mobilising and ready to be discharged. But they are coping with withdrawal. So they are more likely to put them on medications to help them cope with that [withdrawal] process. Most of our worst patients are ones who are actually intubated and sedated, simply because they are so violent in the emergency department that there is no other way to control them.

Medication can be used to subdue patients who are withdrawing from medications and have withdrawal symptoms. Severely violent patients may need to be sedated and intubated to control their behaviour.

**Proposed nurse solutions**

The nurses believe that during violent incidents the nurse in charge can reallocate staff during the shift, while during the incident, nurses might use the following strategies:

1) reallocating the staff during the shift
2) protect yourself first
3) premeditate, de-escalate, restrain and find a safe place
4) using medication
5) ask for a break or stop working on the shift.

Each of these strategies was supported by evidence from the focus group interviews.

1) Reallocating the staff during the shift:

*ICU1*: *I have changed staff half way through a shift and you can see they were not coping, so you move staff around.*

*ED4*: *If someone is becoming physically or verbally aggressive, if you have a male nurse in the department, and you can swap over,*
move them around. It can settle things down a lot quicker than if there are just [female nurses] on. [The ward] can settle down very quickly.

If aggression emerges during a shift, staff can be moved to ensure that the most suitable staff members are assigned to difficult patients.

2) Protect yourself first:

ICU6: It is really hard—like in infection control. We have to protect ourselves first, before we can help others. So I think that is what we should do.

ED5: Everybody gets security on board early. You call out for help first and then start resuscitation. It is better to be safe than sorry.

Nurses should protect themselves first and then call for backup, rather than risk being attacked.

3) Premeditate, de-escalate and find a safe place:

ED5: You have to try to think what they think. If you react to what is happening, it is different than if you stop and think because you have actually premeditated what you are going to do. You can de-escalate it. And get out of there and, take other patients or other staff with you. Get yourself to a safe place. Give everybody space to get out of the way.

ICU2: I still think that pre-support [of] de-escalating the situation is step one, I think you can get a lot out of that. And I think that is where we need to start. Instead of being reactionary, we need to be more proactive and try to reduce the level of violence. I think this is definitely the number one strategy.

AMH 3: At the end of the day I think everyone, every nurse, turns up to do a good job, and no one turns up to provoke any patients. Some of them [the patients] are aggressive and you try to talk them down, try to de-escalate. If that doesn’t work, you offer medication. If that doesn’t work and it is escalating, obviously they need medication. If you are under the Mental Health Act then this leads to restraining somebody with medication and you use another policy, and you use aggressive behaviour management techniques.
Being in control of a violent incident by using de-escalating techniques and getting to a safe place is the main strategy. If de-escalation fails, medication is used. If that fails, aggressive behaviour management techniques are used.

4) Using medication:

\textit{AMH 9: I think another nurse can help the patient to get more access to more medication if they are very under-medicated. When we have those issues, it does get to that point where we haven’t got the medication to sedate them.}

\textit{ICU1: Doctors are getting better at recognising that patients need chemical assistance. You get patients in [the ward] who are on medications or drugs at home and all of a sudden they come in and all that is stopped. And then you are trying to wean them off antibiotics and get them mobile and ready to be discharged. But they are coping with withdrawal, so, they are more likely to put them on medications, to help them cope with that process.}

Sedation is not a first resort, but sometimes it is necessary to use sedating medications.

5) Ask for a break or stop working on a shift:

\textit{ICU2: Sometimes you cannot endure for a shift. You have to ask if you can stop half way because we do 12 hours. I cannot do this. I need to stop.}

\textit{ICU4: She has to come back and say, “I cannot do this for 12 hours.”}

\textit{ED1: A lot of us get to saturation point, where we have to step out[side]. A few times I have had to leave the department and go and do other things because I just needed to get out of that space.}

Nurses who feel unable to cope during a shift need to let their manager know, and take a break from the ward.

During violent incidents nurses recommended four strategies, including protecting themselves as a first priority, de-escalating violence and getting to a safe place, using medication when necessary and taking a break when needed during a shift.

After violent incidents, different management strategies are needed.
4.6.1.3. **Post-incident management**

After a violent incident there are several management strategies that the hospital can implement, including:

1) pressing charges by contacting the police  
2) providing counselling services for staff  
3) enabling debriefing after the incident  
4) calling police  
5) enabling nurses to report the violent incident  
6) supporting and caring for assaulted staff members  
7) utilising social workers.

Each of these strategies was supported by evidence obtained from the focus group interviews.

**Proposed hospital solutions**

1) Press charges:

*MHD3:* Getting the police involved. [The] staff member should press charges. People need to be careful. [Patients] might think about it the next time, before they are violent.

*ICU3:* You have the option of making a personal complaint against them. Assault with any intent, any threat to hurt someone—if you have the capability of doing it, then it is an assault whether or not they touch you. And I think the penalty for injuring or doing verbal assault to government employees is lots higher than other people, so you have the option of making a personal complaint if you feel threatened.

*ED1:* The hospital needs to start charging people and we need to have people dragged out of the waiting room by the police and the public needs to see that we are serious about it—not just a poster going up [on the wall, but actual action].

Taking legal action against violent offenders was suggested by staff in all three departments. Nurses believe police action would be seen by other patients as a sign that violence against hospital staff is unacceptable.
2) Providing counselling services for staff:

   ED1: I think encouraging an awareness of counselling services for staff is not particularly well promoted at all, or the defence of staff from a legal point of view. There was a campaign a couple of years ago that we would have zero tolerance for violence and they put the posters up and that was about as far as they got.

   ED4: I do not think that counselling is promoted. The times that I have been in big resusc[itation] traumas and paed[iatric] re-susc[itations] particularly, I do not think I have ever been offered any chance to debrief or have counselling when we have needed it.

   Counselling is not well promoted in hospitals for assisting staff following violent incidents, even after serious incidents such as resuscitation of children.

3) Enabling debriefing after the incident:

   MHD8: That is why I think it is important with an aggressive incident that nurses will do a debrief and speak to other patients. That is something that we do with any seclusion. The person in charge should counsel the other patients and the other staff involved and make sure everything is okay.

   ED6: Sometimes it would be better to have more opportunities to debrief about things. There is a build-up and you sort of absorb all of this negative energy from all the people around you. And then you go home and you have got to bottle it up. And I know that I have come home sometimes and I am telling my husband about my day and I am upset, I am miserable and I am yelling and I am not meaning to be upset with him—he has not done anything wrong. It is just that the day has been so busy, so stressful.

   ED5: Probably we should have a day where you can just all go down to the pub and not necessarily drink alcohol but you just go somewhere that is off-campus and in a non-confrontational sort of area, where you can debrief. Just say, “Oh my God I did this the other day and somebody hit me here.”

   Debriefing with colleagues was recommended as a necessary step after aggressive incidents so that nurses do not carry stress home from their day at work.
4) Calling the police:

   ED3: I think the public needs to know that [violence] is [unacceptable]. And I think follow through with some information that, “If you behave badly to us, we will call the police and you will be taken away.”

   ICU4: I think with offenders, there probably needs to be a harder approach taken, such as contacting police.

Police should be called to violent incidents and patients removed from the hospital.

5) Enabling nurses to report on the violent incident:

   ED4: The [hospital] needs to give us the ability to report. Once we start doing that, then it is going to create a culture within the workforce that we are valued; that we are going to be protected; and if anyone plays up they are going to be dealt with. And then that is going to eventually transfer to the community, that when you come here, this is the expectation. And that expectation will be enforced and these are the consequences.

   ED6: Perhaps someone could ring [police]. You put in a name and a date and an incident and then someone could ring me back so that they can type it in for you.

Nurses suggested violent incidents should be reported to police to create a culture in which hospital staff are valued more highly by the community.

6) Supporting and caring for assaulted staff:

   AMH3: The other day when a male nurse was assaulted, a nurse manager of the ward rang him up at home to see if he was okay. So I think staff get fairly good support when it comes to violence, if they know. Sometimes it does not get in the notes, as well. But if you do not make a concerted effort to let people know how you are going, go to a counselling service.

Nurse managers can show care and support for staff who have been attacked, by phoning them to check how they are after a violent incident.

7) Utilising social workers:

   ED5: I do not think we use, or know, the resources that are available to us. I have been at the hospital here for 30 years and I only found
out in the last two years that there is a social worker counsellor person. You just have to make one phone call. You can make an appointment and go and talk to him. You can have several visits with him. But that is not really readily available. It took our social worker to tell me that that was available, that is okay, that wouldn’t be a bad idea. And you do not need somebody that has no idea what you have been through. You need someone who understands.

ICU6: There is a social worker. Sometimes just talking to someone could relieve your anxiety. But of course the patients want to talk directly to the doctor or the nurses. Sometimes we do not have the time because you are focused on the patient. So before they go to you, they are already feeling stress and probably, a social worker would help. But I am also thinking that probably not, because they are really wanted with the person who is looking after the family. So I do not know.

The availability of a social worker is not widely known; however, a social worker is available although they may also be caring for the family of the patient who was violent to the nurse.

Several post-incident strategies were found useful by nurses, for example, pressing charges in serious cases of violence, giving nurses enough time to report violent incidents, enabling staff to debrief, providing counselling services and supporting and caring for nurses so they feel reassured that violence is well-managed by their hospital.

Proposed nurse solutions

Nurses may make a personal complaint about the offender and they should report the incident to their hospital.

1) Personal complaints about offenders:

ICU3: You have the option of making a personal complaint against the [offender]. Assault with intent and threatening to hurt someone, if you have the capability of doing it, then it is an assault whether or not they touch you.
2) Report the violent event:

   ED 6: Documenting an incident is important. If it is not on paper, it didn’t happen. I wish we had time to do the paperwork. But it is too hard to do, we are not educated on how to do it and nobody bothers to do it because if you do it once, it is not going to make a difference. Everybody has to do it. Everybody has to do it all the time.

   Consistent reporting of assaults by all nurses is necessary to quantify the violence being experienced in hospitals. Hospital and nurse management strategies post-violent incidents could involve reporting offenders to police or the hospital. Existing management strategies were assessed by the nurses who commented on their effectiveness and implementation.

4.6.1.4. Effectiveness of management strategies

The nurses believe that the most effective violence management strategies are communicating with patients, explaining the situation to patients and allocating or re-allocating of staff by the nurse in charge.

1) Communicating with and respecting patients:

   AMH5: Treating people with a respect as individuals...and also knowing your patients: what are the triggers, history of people, what caused those [outbursts] in the past, you know, as long as you don’t go outside too much, you’ve got to try to work with them.

   AMH10: Yes, good communication collaborative problem-solving...there is a human at the other end.

2) Explaining the situation to patients:

   ICU2: I think, what I think I have learned since I have been out there, if you are in that situation that you cannot get back for a little while is to say to somebody, look, I know you want to talk to me, and I am busy for a little while but I will come back and so and so time and I’ll spend some time with you and I’ll tell you everything ... doesn’t take very long but it certainly works.

3) Allocating of staff:

   AMH2: And I think knowing which staff handle certain situations the best, you know, so you know, if you can’t cope with this, you need to withdraw because somebody else, you know, is better equipped.
4.6.1.5. Implementation of management strategies

Nurses do not think that the hospital management strategies are fully implemented, or effective. They identified several problems related to the implementation of management strategies:

1) staff are not trained properly
2) nurses do not have time to take a break or leave the department following an incident
3) nurses do not have access to the medication strategy
4) nurses are not encouraged to debrief following an incident
5) nurses are not aware of counselling services and find it hard to access them
6) nurses do not believe that reporting violence will fix the problem.

Each of these problems is supported by evidence from the focus group interviews.

1) Acting professionally and proper training:

ED6: We have staff members who are not trained properly. We do not have procedures in place for lots of different situations.

2) Taking a break or leaving the department following an incident:

Nurses can rarely take a break or leave their department following a violent incident:

ED4: If I really need a break from emergency, I think that unfortunately, at the moment, for the majority, it is not allowed. So there is not enough staff on the floor who have enough experience that any of us is allowed to go anywhere at the moment.

ED3: Most nurses do not just pick up and get back to work.

3) Medication strategy:

Nurses claim that medication plans depend on the team leader’s decision or that they do not have access to it:

AMH2: We do not have access to [medication plans] most of the time.

AMH5: In some places the team leader only [has access to medication plans].
4) Debriefing following an incident:

Consultations and debriefing do not occur soon after the violent incident and therefore are not effective; nurses find it difficult to have a debriefing as a team, due to their heavy workload:

*ICU5:* I sometimes wonder whether the consultation or the debrief is so far removed from the incident in time. You get something in a month's time. By then it has lost the point.

*ICU1:* But it is often very hard to get everybody together. There might be a couple of times set-up but to get people there at the same time when we are not busy and there is time to sit down and talk about things, it is really difficult.

5) Counselling service:

Some nurses are not aware of the counselling service. Others find it hard to access because it is outside of the hospital and some nurses who use the service claim that the debriefing is not good:

*ICU4:* If the employee was entitled to four to six counselling sessions but then the actual service has actually been outsourced outside the hospital, my feeling is it is irresponsible to take that service outside of the hospital. So basically, we have a service but it is not here. And you can access this service from Monday to Friday 8am–4pm. I feel that the debriefing is not very good.

*AMH 5:* People need to know it is available again.

*AMH 2:* Sometimes when you need it you have to be on your own.

6) Reporting of violent incidents:

Nurses generally want to report violent incidents but they do not believe it will fix the problem nor do they have the ability to report on an incident. These reasons can be due to lack of time and resources, heavy workloads or lack of knowledge about how to compile the incident report, see section 4.6.1.6.
4.6.1.6. **Underreporting of violent incidents**

Nurses understand the necessity for reporting a violent incident:

*ICU5:* It is probably worth [reporting] it because if you were to have an altercation down the street later on, then we have evidence that something happened before.

*ICU3:* Probably document it in the patient’s notes.

*ED1:* I think the nurses need to take responsibility for reporting. The organisations have to support the nurses and actually carry through and charge individuals and carry it to its full extent.

However, nurses are not reporting violence in their workplace:

*ED 2:* I have been an emergency nurse for four years now and I am sure if I was to look back, there would be incidents that I should have reported of violence, whether it be verbal or physical, against me. I have never once put in a report for violence.

*ED 6:* I had physical harm and I haven’t reported it. I am blaming myself when I say, nobody cares. But I haven’t reported it.

*ICU3:* We are meant to report all instances of violence. However, we do not. I do not. They want us to report violence. And they say that all the time. And yet, we do not. So it is certainly underreported, absolutely.

*ICU1:* I think the only time you really report it, if it gets to the physical violence stage and more because of an incident report where somebody punched you and you have an injury. You will do it more from the Work Cover requirements rather than the fact it has just happened. So you are covering yourself in case you have got a cracked bone or something.

Only the serious violent incidents get reported:

*ED1:* I would say less than 5% [of violence] is reported.

*ED4:* I would say few are reported, apart from the very serious [incidents].

*ED5:* Unless there is physical harm, it is seen as, unnecessary to report.

There is great reluctance on the part of nurses to report assaults. Three ED nurses ventured possible reasons for this, such as reporting only occurs if the incident
involves serious physical harm. One nurse estimated that only about five per cent of verbal and physical assaults are reported.

Reasons for underreporting were explored to determine why nurses do not report that they have been verbally or physically attacked in their workplace.

**Reasons for underreporting**

Nurses gave several reasons for not reporting violent incidents, such as:

1) reporting will not prevent violence  
2) lacking the time to report  
3) reporting forms are not easy to use and are too long  
4) reporting is a long process, requiring justification and not the worth procedure  
5) reporting carries a risk of being blamed by hospital managers  
6) receiving a lack of feedback about a report  
7) reporting requires time and is not time-friendly  
8) receiving insufficient training to fill in the form  
9) believing violence is part of the job.

Each of these reasons was supported by evidence obtained from the focus group interviews.

1) Reporting will not prevent violence:

   *ICU1: It is not fixing the problem just documenting that you’ve got a problem.*

   One nurse said reporting violence did not fix the problem so she saw no point in reporting.

2) Not enough time to report:

   *ED 6: I do not know how often recording happens, but I know that there have been incidents that I haven’t [reported] that I should have reported, of patient violence. I haven’t [reported] because I have not got around it and have forgotten about it. You remember when you are going home and I am not going to come in to work [to report]. And you forget about it when you come back [to work] because you are so busy.*
ED 5: Even the management [staff] do not have time to process all of the reports so there needs to be a whole system [for reporting], doesn’t there?

Very busy workloads mean nurses are too busy to stop work to report, may remember after leaving work, but do not return to work to report. And the next day, they forget to report because they are busy again.

3) Not easy to use and too long:

   ED 1: The tool they give you to do the reporting on is so user-unfriendly.

   ED 5: Not everyone will be able to finish the reporting form report and we will never be able to get to the end of it.

Existing reporting forms are long and complicated which dissuades nurses from reporting violent incidents.

4) It is a long process, requires justification and is not a worthwhile procedure:

   ED 1: When a staff member makes a complaint or charge, they have to go externally to get support. The amount of paper work that is involved, the amount of cross examination—you have to justify yourself. And then a lot of the nurses just think it is a worthless exercise. They just do not do it because they know they will not be supported in the endeavour.

The amount of paperwork involved in making a report and the challenging of facts presented by nurses creates feelings of managerial unsupportiveness, and results in nurses deciding not to report.

5) Having the risk of being abused by hospital managers:

   ED 5: But it is obviously another part of this, that you might have been abused [in the ward] and you report it, but then you can be also abused from the [management] for not doing something right. Or, for example, you can be blamed by the hierarchy. What are the consequences of reporting back to them?
An emergency nurse describes the fear nurses experience after having been attacked verbally or physically in a ward—that they will be blamed by management for putting themselves in a situation which resulted in violence.

6) Lack of feedback about a report:

   *ED4*: We want a feedback absolutely.

   *ED 6*: [You want] somebody to call and tell you that someone is dealing with it now.

Lack of feedback to nurses who do lodge reports is a disincentive for them to report. Nurses who report need feedback from management that someone is attending to the problem.

7) Reporting requires time and is not user-friendly:

   *ICU1*: There is just not time to think about reporting everything.

   *ED 4*: They need to give us the ability to report because if we have to sit—and we do not get time to scratch ourselves—we do not get time to go to the toilet. We do not get meal breaks. We do not get anything. The last thing we have time to do is sit at a computer and fill in a very user-unfriendly form to try to report an incident.

The busyness of shifts combined with the complexity of reporting forms means incidents are not reported.

8) Not trained to fill in the form:

   *ED 6*: I wish we had the time to do the paperwork but it is too hard to do. We are not trained in how to do it. And nobody bothers to do it because if you do it once, it is not going to make a difference. Everyone has to do it all the time.

One ED nurse said nurses did not receive training to complete report forms. They are also ambivalent about reporting because unless everybody reported every incident, nothing would change.

9) Violence is considered as part of their job:

   *ICU2*: Maybe we just take it as everyday stuff. I think it is part of our job. It is part of day-to-day. He was septic, he was confused, so we
let him pass.

An intensive care nurse said reports are not made because nurses excuse patient behaviour due to their medical conditions, and do not hold them responsible for their actions.

Despite the large number of reasons for not reporting violent incidents, nurses also provided suggestions for potential solutions if incidents were reported.

**Solutions for encouraging the reporting of violent incidents**

Participating nurses offered several solution suggestions that could encourage nurses overall to report incidents of violence. The solutions included a having a user-friendly reporting system that could be completed by a complaints officer, who also provides feedback to each nurse:

**ED 6**: Perhaps someone could ring. You could put in a name and a date and an incident and then someone would ring me back so that they can type it in for you. Somebody calls and tells you that someone is dealing with it now.

**ED 4**: We have a complaints officer for patients. Do we have a staff complaints officer? A staff complaints officer where you could put a name and a date and an incident in a computer—a two second job—and they can ring you on a phone and say, “What actually happened?” If they, if we, if everyone reported every incident that happened in emergency, our funding would be huge.

**ED 1**: I suppose the emergency responses within the hospital could give a colour code, and the threat of physical violence or actual physical violence is a Code Black. And the amount of times that actually gets reported is quite minimal. I suppose it is our own fault as well. If we carried that through and actually rang up and stated “Code Black,” which [activates] the police to come, the whole lot would come. We would do that a minimum of half-a-dozen times a day. And really that is something that we are falling down on, something easy that we can do is pick up the phone and say “Code Black Emergency” and then that does get recorded.

Ideas which may increase reporting include having a telephone reporting system whereby a nurse phones a contact complaints person, who then asks for infor-
information and completes a report form. A second suggestion was a “Code Black” reporting system whereby police were called if there was a threat of physical violence or actual physical violence.

Nurses in this study suggested general management strategies and incident management strategies, including interventions during and post incidents. Workplace violence policies should also be implemented.

4.6.2. Workplace violence policy

Workplace violence policies are ineffective if staff are not aware of the policy and if the policies are not effective.

4.6.2.1. Knowledge about the policy

Knowledge about workplace policies is a controversial issue because many nurses are not even aware that these exist:

ED2: Until you brought up the question, as far as I was aware, there was no policy. That is how much I know about it.

AMH3: I have never seen the policy. I do not think there is a policy. I think it is just a poster that says zero aggression. There is a procedure for managing aggressive patients but again I think it just results in someone going back to seclusion and de-escalation, and refers to other policies. I am not one hundred per cent sure but I do not think I have ever seen a policy that says zero aggression. I do not think there is a policy.

AMH10: We have procedures for [isolation of a patient] and that deals with aggression. That is it.

AMH8: I think there is one. I think I have seen something saying “management of aggression patients”. I think there is a policy to be honest.

ICU2: It is a zero tolerance policy. We do know that—that this is right across the board—I think there is a great big sign in [the ward] that says pretty much that and there are signs throughout the hospital so people are aware.
Knowledge about the existence of workplace violence policies is poor. Some of those who know there is a policy have not seen it. Staff who believe there is a policy are not aware of the contents of the policy.

However, the nurses who know about the workplace violence policy also know how to access the policy:

ICU3: Yes, [the policy] is there on the internet. They are easy enough to find.

ICU1: I think it is on the Queensland Government website.

Two intensive care nurses know about the policy and where to find it online.

4.6.2.2. **Effectiveness and implementation of policy**

Given the lack of awareness of a workplace violence policy, it is not surprising that nurses believe the policy is ineffective:

AMH5: I do not think there is a policy that can be effective. But policies can sink you as well as save you because something can happen and if you haven’t followed the policy, then all of a sudden that could give you legal issues or deny you compensation.

ED1: I think that what the organisation has done has ticked all the boxes to protect themselves, without actually happening to carry it through. What they are providing us with is the aggressive behaviour management training. They have the policy. They have the counsellors. They have security. But at the same time they do not carry any of them through. The organisations have to support the nurses and actually carry through and charge individuals to the full extent.

A mental health nurse and an emergency nurse are not confident that the hospital has the best interests of the nurses at heart. They suggest the hospital has instruments such as a policy, counsellors and security which they use to protect the hospital, but management do not follow through with implementing the policy and making the support services readily available to staff.
Reasons for the lack of an effective policy

Nurses gave several reasons for the ineffectiveness of workplace violence policies and their lack of implementation. These include:

1) difficulties in writing a policy to cover a wide variety of situations
2) people who write the policy are not working on the ward
3) policy is not acted upon or implemented
4) support needs to be added to the policy.

Each of these reasons was supported by evidence obtained from the focus group interviews.

1) Difficulty in writing a policy to cover a wide variety of situations:

*MHD 3: Looked on case-by-case and without more information, blanket rules like that do not work, there is nothing worse than it.*

*ED5: There is no one approach that is standardised and it needs to be [standardised].*

*AMH 4: There is not a blanket policy. There are a lot of situations with different rules. All patients are different.*

The construction of a policy to cover every different scenario is unworkable. Flexible blanket rules are needed to cater for different patients and situations.

2) People who write policy are not working on the ward:

*MHD 5: Unfortunately the people who make the policy are not the people on the floor. And even if they were, it would be very difficult to write a policy that would cover all the situations. You cannot, as we were saying before. Blanket policies are no good. And a lot of us here who have a lot of experience have seen hundreds of different things happen. So one policy is not going to cover [them all]. [The policy] has to be a pattern—very vague—things that say well, this is what we would like not to happen, but if it does happen, this is what we will try to do because it is complex and it is legal. It is a minefield.*
The lack of experience in working on an acute hospital ward, such as emergency or intensive care or mental health, means policy writers do not have the experience to be able to construct a policy that will suit every situation. Therefore, the policy needs to be general because of the legalities and complexity of the field.

3) Policy is not acted upon or implemented:

   ED5: [The issue] is when [the violence] happens. It is not the policy that handles [the violence].

   ED1: There is a policy and it is very clear, but it is never acted on. I thought the policy, the way it is worded is fine, they just need to act according to the policy. What they say in the policy, they need to do. They need to carry it through. They need to action it. The hospital needs to start charging [offenders]. We need to have people dragged out of the waiting room by the police and the public needs to see that we are serious about [stopping violence]—not just a [zero violence tolerance] poster going up—but actual action.

   AMH 1: There is supposed to be a zero tolerance policy. It never happens.

   AMH5: It is very unrealistic. That would be like saying police are not to arrest people or there will be no violence against a policeman or an ambulance driver or in emergency or there will be no blood in theatre.

   AMH9: There are a lot of signs saying aggression will not be tolerated. That has been ignored.

   ICU4: The signs actually point to people who are reasonable. Management policy should reflect this. The idea of putting signs up is just crap.

   There is anger among the staff that the policies in place are not acted upon by management. Posting zero tolerance signs does not stop violence when the policy is not enforced.

4) Required to add support to the policy:

   ED3: The [hospital] needs to add a lot of support.
Nurses suggested that they should be familiar with the policy regarding workplace violence and that the policy should be supported with action. Nurses believe that greater support is required from the hospital following a violent incident.

### 4.6.3. Workplace Support

Nurses highly value the support of colleagues, managers, family and friends during and after incidents of workplace violence. Nurses from the three focus group interviews described their experiences of both needing and offering support.

#### 4.6.3.1. Support from colleagues

All of the nurses agreed that they supported each other during their work and after a violent incident:

*ED 6:* *We are a very good team and always have to support each other because that is all we have, especially senior staff members. I found that a senior staff member supported me hugely. If something happened they always came to me and said, “Are you okay? Do you need to talk about it? Do you need to debrief?” And that is not a formal thing. That is just the team—that we can care about each other—and know your colleagues are going to listen to you.*

*ED5:* *I get a lot of encouragement from the team work and from my co-workers who support each other and afterwards, discuss anxiety and we all have been there. The respect from our colleagues is both from nursing and medical.*

*ED4:* *The team support each other and say, “You did a good job. Do not worry about it.” I think colleagues are number one. You get support from your colleagues. You have got the chance to debrief. You get support and you support others.*

*AMH 5:* *[Support comes from] each other.*

*ICU3:* *We know each other reasonably well and we can sit down and honestly talk about most things together. And we are all going through the same sort of emotions about what happened at work. It may not be that particular incident but everyone has similar incidents that occur. So we are a unit where we have worked together for a long time and we know each other’s strengths and weaknesses and we do support each other in the workplace.*
Team support is highly valued by the nurses. They debrief informally, complement each other on their work, empathise with the emotions of other nurses and accept each other’s strengths and weaknesses.

On the other hand, some nurses felt unsupported by other colleagues, such as doctors:

AMH 11: The doctor who was on in Outpatients, who referred the child, was actually very rude to me. It made me feel quite degraded. I actually was following procedures. You can have people charged [over abuse] at the workplace or on the street. Abuse like that was really horrible. And you do go home and reflect, “What did I do wrong?” That particular staff member I was speaking about was being unprofessional towards nurses.

A mental health nurse described feeling degraded by a doctor who spoke rudely to her, and spoke of the impact of the interaction which distressed her after she left work.

4.6.3.2. Strong support from managers

Nurses felt supported by their managers and nurse unit managers.

AMH 6: We have had major events on our level. We actually had the managers come in with a debriefing session, a more formal debriefing session. We have had two separate [debriefing sessions] on whether nurses were showing signs of being traumatised.

AMH 3: The other day, when a male nurse was assaulted, a nurse manager of the ward rang him up at home to see if he was okay. So I think staff get fairly good support when it comes to that sort of thing.

ED 4: I think we have a very good manager at the moment. They probably will be very supportive of us having time off.

ICU2: Yes, [we have the] support from the nurse unit manager. Absolutely. We have an excellent nurse unit manager.

Support from nurse unit managers is perceived to be caring and proactive. However, some nurses experienced a lack of support from managers:
ED3: I think the closer your managers are to being in the front line, the closer they are. They will give you more support. The further they are away, by time and up the line, they get removed from what reality is. And reality now is not the same as reality was five years ago.

ED 1: [Support from unit managers] is fair enough. Management sit up here, clinical staff are over here and very rarely do they intermingle but they treat themselves as separate entities.

Managers who were closer to their staff were better able to provide support and understanding, whereas managers who were uninvolved in time and space from the nurses were perceived as removed from the reality of front line nursing.

4.6.3.3. Variable support from family or friends

Family and friends are not fully aware of the violence at the workplace and therefore cannot be sufficiently supportive:

AMH 10: I never told my parents. I never have in 20 years that I have been nursing. What I do they would be horrified. [I don’t tell them] because that is my way of protecting them. I have never told them anything.

ED 1: There was a show on ABC or SBS that was called 24 hours in the emergency department. It was a no-bars filming of various emergency departments around the world and my wife wanted to watch it. And I thought, Why would you want to? After half an hour she said, “Oh this has to be a dramatisation.” I said, “That is pretty well spot on. That is real. That is my normal working day.” And she was gobsmacked.

ED 4: That is the response that I get from people. Friends will watch it and say, “Is what you do every day?” I say, “Yeah, that is my job, every single day.” They are horrified and ask, “Are you serious?”

ICU1: When you go home to your partner, and they say, “Yes Dear, yes Dear” as they are going to sleep. They have never had a bedside table thrown at them.

ICU3: Your partner does not understand.

Nurses feel they cannot tell their family about the amount or severity of the violence they experience at work. Family members who see footage of EDs are shocked at the level of violence nurses encounter during their routine working day.
4.6.3.4. Lack of support from the hospital

Nurses feel that they are not generally supported by their organisation:

ED1: I had an incident where I was injured from an altercation and there was a police officer involved as well in the same incident. The charge for assaulting the police officer was serious assault. I was hurt just as much as the police officer but the charge for hurting me was a lesser offence. That made me feel not particularly valued and also I had very little representation from the hospital itself. I had to get the union for legal representation. They were very good but the hospital as my employer did pretty well nothing. They are pretty much protecting themselves. We are very legally vulnerable and professionally, extremely vulnerable. If we defend ourselves then we are the ones going to end up being the perpetrator of the aggression, or the perceived perpetrators. We are certainly not. We are certainly not valued as a person. We are a number. There are some protections for the organisation but not for the staff member.

ED5: If you help make someone leave the department because they have been aggressive towards you then you get charged with assault because you dragged him out of the department. It is our duty; the hospital does not do anything about [violence against nursing staff].

However, one nurse described being supported by hospital management:

ED 4: If the nurses want to press charges then they support them.

The difference between the charges laid on behalf of an injured police officer compared with an injured nurse who was hurt just as badly in the same altercation is perceived as unfair. It also leaves nurses feeling exposed to litigation by violent patients who may press charges against nurses for [nurses] defending themselves. One nurse described being supported by hospital management to press charges.
4.6.3.5. **Primary support given by colleagues**

Two intensive care nurses said support from their colleagues was the first and most important avenue of support:

\[ \text{ICU3: [Colleagues are] often the first place that we go. [You go] to your colleagues before you go down other avenues.} \]

However, the ED nurses thought that during a violent incident the team leader should be the first person to provide support:

\[ \text{ED 2: In our department, in terms of support after a violent incident, I think our first point of call should be our manager, [who is] on shift at the time, the team leader, and say, “I have just experienced this and this.” In some cases you will be able to turn around and go back and continue dealing with that patient. In other scenarios, you just have to leave. Again, it depends on the severity of the sort of trauma that you as a nurse have experienced. Just being aware that you are allowed to say, “Hey, I was treated poorly. I suffered abuse during this shift,” whether it be from patients, their families or other staff members, and being able to feel safe enough. You can say, “I was treated really poorly. And I am probably going to go home and bawl my eyes out.” And that is what happened about a month ago.} \]

\[ \text{ED6: In terms of support that you should be, like [participant 2] said, you should be able to go to your team leader and say, “This just happened. I am really upset. I need just 10 minutes to go sit in the tea room and collect myself.”} \]

A nurse’s ability to immediately report an incident to a team leader is most effective in supporting that nurse to speak about what has happened, and receive care and understanding from the team leader. When reporting happens immediately, the nurse is most empowered to return to duties, depending on the severity of the incident.
Summary

Participant nurses in the emergency, mental health and intensive care wards of a regional public hospital report that they experience verbal and physical violence daily in the workplace. The severity of the violence varies and includes punching, kicking, biting and scratching, as well as threats of using weapons, such as knives.

In focus groups with nurses from each of the three departments, patients were reported more likely to exhibit verbal and physical violence towards nurses. Hospital visitors, however, were more likely to exhibit verbal violence towards nurses, especially when they were worried about their ill family member, if they were not informed about their family member’s condition or if their family member was kept waiting for a long time before being given treatment. Questions about the frequency of violence and the severity of violence were added to the survey to extend the findings of the focus groups, to determine if the frequency and severity of violence remained at such high levels across a larger sample of participants.

Violence towards nurses has become so prevalent that nurses appear to accept violence as part of the job, and therefore, they are not likely to report it to management because they do not expect management to do anything about it.

Workplace violence affects nurses personally and professionally. Violence impacts on their personal lives and on the interactions with their partners. Violence impacts on nurses professionally, by affecting their interactions with patients, increasing medication errors, reducing job satisfaction and causing some nurses to leave the profession altogether. It was a perception of the nurses that some nurses may have left the profession due to violence and no evidence is provided to support that nurses who have been most affected by severe workplace violence are no longer nursing. This study, therefore, does not capture the most serious effects of workplace violence towards nurses, or the cost of lost nurses to the healthcare sector.

Nurses made suggestions for reducing violence that could be implemented, and provided potential solutions. They suggested a combination of general management
strategies, improvements to existing management strategies during and after an incident of violence and implementation of existing workplace policies, together with increasing emotional and practical support for nurses affected by workplace violence.

Nurses are supported after incidents of violence primarily by their nursing colleagues and managers. However, there was a lack of awareness of workplace violence towards nurses in society. Nurses believed their family and friends were not aware of the frequency or severity of the violence they encountered at work. Nurses were reluctant to tell their family and friends about the workplace violence they experienced because they wanted to protect them, and preferred their family not to be worried about them.

Evidence gathered from the focus groups was used to inform the questions asked in the survey to extend the data to a sample of 98 nurses. The results of the second phase of the study are reported in Chapter 5. The findings reported in Chapter 4 and Chapter 5 are discussed in Chapter 6. Conclusions are drawn in Chapter 7 and recommendations for future research are suggested.
CHAPTER 5: SURVEY FINDINGS

Introduction

This chapter presents the quantitative survey findings of the second phase of this study. The aim of this chapter was to analyse the collected data from the questionnaire both numerical quantitative data and qualitative data derive from the open ended questions. The aim of the survey is to quantify the data found in the focus groups to a larger cohort. The results of the survey are presented in the same order as in Chapter 4: the demographic profile of the participants, nurses’ experience of assault injuries, the effects of workplace violence, management strategies, support during and after violent incidents and results of the statistical tests. Finally, the qualitative data is described, including the factors and the proposed solutions to workplace violence.

The survey findings included quantitative and qualitative data. The quantitative data are presented first in each section of the findings, followed by the qualitative data. Sample sizes varied in the following descriptive demographic profile results, as some respondents did not answer all of the demographic questions.

The respondents’ mean scores for the impact, management, strategies and support-related statements were calculated by using IBM SPSS Statistics 22. Some of the tables associated with this data are coloured as these coloured tables reflect the colours used within the survey (Appendix Q).

5.1. Demographic profiles of nurse participants

The nurses ranged in age from 22 to 68 years, with an average age of 40 years. For analysis purposes, 3 age groupings were formed based on the nurses’ ages (Table 13). The highest proportion (42.7%) of nurses was in the 36 to 50 years age group. Nearly two-thirds of the nurses were female and one-third of them were male. Almost four-fifths (79.5%) of participating nurses were born and raised in Australia, 19.4% of them immigrated to Australia and only one (1.1%) nurse was Aboriginal. The majority of nurses (60.2%) had a bachelor’s degree and 26.5% had a master’s degree. Some of the nurses had lesser qualifications than a bachelor’s degree—8.2% had a diploma in nursing and 5.1% had an associate degree or a certificate of nursing.
Table 13: Demographic profile of the nurses

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<tr>
<th>Demographic Profile</th>
<th>Number (N=98)</th>
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<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22-35 years</td>
<td>32</td>
<td>33.3</td>
</tr>
<tr>
<td>36-50 years</td>
<td>41</td>
<td>42.7</td>
</tr>
<tr>
<td>51-68 years</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>37</td>
<td>37.8</td>
</tr>
<tr>
<td>Female</td>
<td>61</td>
<td>62.2</td>
</tr>
<tr>
<td><strong>Ethnic background</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immigrated to Australia</td>
<td>18</td>
<td>19.4</td>
</tr>
<tr>
<td>Australian born</td>
<td>74</td>
<td>79.5</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Level of education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma in nursing</td>
<td>8</td>
<td>8.2</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>59</td>
<td>60.2</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>26</td>
<td>26.5</td>
</tr>
<tr>
<td>Other: associate degree, certificate of nursing</td>
<td>5</td>
<td>5.1</td>
</tr>
</tbody>
</table>

**Working parameters**

Table 14 summarises the working parameters of the participating nurses, including their department, work status, years of work experience and special training. The majority of the nurses worked in MHD (57.1%), followed by ED (26.5%) and ICU (16.3%). Most of the nurses worked full-time (75.3%) compared with part-time (22.7%) and casual (2.1%). Nurses participating in this study had a large range of years of work experience, with a minimum of one year and a maximum of 43 years, (N=96, Mean =14.15 years and Std. Deviation= 10.69). Specialised postgraduate formal training of nurses was taken up by those who worked in MHD (60.4%), followed by ED (30.8%) and ICU (23.1%) as shown in Table 15.

All of the ED nurses had training in emergency, most of the nurses (98.1%) from MHD had training in mental health and the majority of nurses from ICU (93.8%) had specialised training in intensive care. The number mentioned in Table 15 would
Chapter 5: Survey Findings

exceed the number of participants because the participants could take more than one further training.

Table 14: Distribution of nurses according to their working parameters

<table>
<thead>
<tr>
<th>Working Parameters</th>
<th>Number</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>16</td>
<td>16.3</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>26</td>
<td>26.5</td>
</tr>
<tr>
<td>Mental Health Department</td>
<td>56</td>
<td>57.1</td>
</tr>
<tr>
<td>Working status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>73</td>
<td>75.3</td>
</tr>
<tr>
<td>Part-time</td>
<td>22</td>
<td>22.7</td>
</tr>
<tr>
<td>Casual</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Years of work experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>6 – 15 years</td>
<td>39</td>
<td>40.6</td>
</tr>
<tr>
<td>16 – 43 years</td>
<td>33</td>
<td>34.4</td>
</tr>
<tr>
<td>Specialised Training *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Department</td>
<td>28</td>
<td>30.8</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>21</td>
<td>23.1</td>
</tr>
<tr>
<td>Mental Health Department</td>
<td>55</td>
<td>60.4</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>15.4</td>
</tr>
</tbody>
</table>

* Multiple endorsements allowed.

Table 15: Specialised Training within the Department

<table>
<thead>
<tr>
<th>Specialised Training *</th>
<th>Department</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MHD</td>
<td>ED</td>
</tr>
<tr>
<td>Emergency Training</td>
<td>Number</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>% within department</td>
<td>5.8</td>
</tr>
<tr>
<td>Mental Health Training</td>
<td>Number</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>% within department</td>
<td>98.1</td>
</tr>
<tr>
<td>Intensive Care Training</td>
<td>Number</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>% within department</td>
<td>3.8</td>
</tr>
<tr>
<td>Other Training</td>
<td>Number</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>% within department</td>
<td>13.5</td>
</tr>
</tbody>
</table>

* Multiple endorsements allowed.
5.2. Assault injuries

5.2.1. Workplace violence

All the participants (100%, N=95) stated they believed violence towards nurses occurred in their workplace (Question 9 in the survey). The highest proportion (45%) of nurses stated they believed most violence occurs during the evening shift, while 20% stated they believed violence towards nurses occurs during all shifts. Relatively few nurses believed that the night and morning shifts were the shift times during which violence mainly occurs (8% and 4% respectively) as Table 16 displays.

Table 16: Distribution of nurses who experienced workplace violence by shift time

<table>
<thead>
<tr>
<th>Shift Time</th>
<th>Number</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Evening</td>
<td>42</td>
<td>45</td>
</tr>
<tr>
<td>Night</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Unsure</td>
<td>21</td>
<td>23</td>
</tr>
<tr>
<td>All</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>93</td>
<td>100</td>
</tr>
</tbody>
</table>

5.2.1.1. Increase in workplace violence

The opinions of the nurses relating to the frequency and impact of workplace violence were measured using a five-point Likert-type scale. The individual scores could range from 1.00 to 5.00 (1= Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree). The mean rating of nurses is mentioned in the methodology chapter section 3.6.2.3. The mean scores of Questions 9.2 and 9.3 indicated nurses’ overall agreement of both statements: “Workplace violence had increased over the last five years” and “Workplace violence is worrying for me,” as shown in Table 17.

Table 17: Means and standard deviations of nurses pertaining to their perceived workplace violence

<table>
<thead>
<tr>
<th>According to nurses opinion:</th>
<th>N</th>
<th>Median</th>
<th>Mean¹</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.2  Workplace violence has increased over the last five years</td>
<td>97</td>
<td>4</td>
<td>3.89</td>
<td>.98</td>
</tr>
<tr>
<td>9.3  Workplace violence is worrying for me</td>
<td>97</td>
<td>4</td>
<td>4.04</td>
<td>.88</td>
</tr>
</tbody>
</table>

¹Means were calculated on a five-point Likert scale where: 1= Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, and 5=Strongly Agree.
5.2.2. Perpetrator and type of violence

5.2.2.1. Violence throughout nursing careers

All the participants (100%, n=91) had personally experienced verbal violence and most of them had personally experienced physical violence (94.3%, n=89) throughout their nursing careers (Survey Question 10). Rates for male and female nurses varied slightly. Physical violence was personally experienced by all male nurses (100%) and almost all female nurses (91.2%) throughout their nursing careers.

Rates for the three different departments were similar. All the intensive care nurses (100%) had personally experienced physical violence throughout their nursing careers and almost all ED nurses (95.6%) and MHD nurses (92.1%).

5.2.2.2. Verbal violence in the past 12 months

When the time scale under consideration was shortened to just the past 12 months, the rates of violence were almost as high as in the previous question, see Table 18. In the last 12 months, almost all of participants (99%, n=96) experienced an incident of verbal violence — all male nurses (100%), followed by female nurses (98.3%). All the participants from MHD and ICU (100%) experienced an incident of verbal violence in the last 12 months, but slightly less ED participants (96.1%). All the participants (100%, n=94) from the departments ED, ICU and MHD had witnessed a verbal violent incident in the last 12 months.

The verbal violence experienced by the participants was perpetrated mostly by patients and visitors (98% and 91% respectively). Verbal violence was also experienced from other nurses, doctors and hospital staff (55%, 45% and 34% respectively). Approximately one-quarter (26%) of nurses indicated that verbal violence can also be from nurses towards patients or visitors, as shown in the response to Survey Question 11, Table 18.

Patients were similarly verbally violent towards female and male nurses (98.2% and 97.2% respectively). In the same way, visitors were verbally violent towards both genders equally (91%). All the MHD participants (100%) experienced verbal violence in the last 12 months from patients, followed by ED and ICU (96% and 93.7% respectively). Rates of verbal abuse by visitors towards nurses compared with
patients in the different departments varied slightly, but nurses in all three departments were subjected to very high rates of verbal abuse from visitors and patients. The highest rate reported was in intensive care where participants experienced at least one incident of verbal violence from visitors (93.3%) or patients (93.7%) in the past 12 months. ED nurses experienced verbal violence from visitors (92.3%) and MHD nurses (89.5%) in the past 12 months.

Table 18: Distribution of nurses based on their experience of verbal and physical violence in the last 12 months

<table>
<thead>
<tr>
<th>In the last 12 months the nurses indicated that they:</th>
<th>Verbal violence</th>
<th>Physical violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Per cent Agree</td>
</tr>
<tr>
<td>11.1 Experienced a violent event</td>
<td>96</td>
<td>99</td>
</tr>
<tr>
<td>11.2 Witnessed a violent event</td>
<td>94</td>
<td>100</td>
</tr>
<tr>
<td>This workplace violence was from:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.3 Patients towards nurses</td>
<td>95</td>
<td>98</td>
</tr>
<tr>
<td>11.4 Visitors towards nurses</td>
<td>89</td>
<td>91</td>
</tr>
<tr>
<td>11.5 Nurses towards other nurses</td>
<td>84</td>
<td>55</td>
</tr>
<tr>
<td>11.6 Doctors towards nurses</td>
<td>80</td>
<td>45</td>
</tr>
<tr>
<td>11.7 Nurses towards patients or visitors</td>
<td>81</td>
<td>26</td>
</tr>
<tr>
<td>11.8 Hospital staff towards nurses</td>
<td>80</td>
<td>34</td>
</tr>
</tbody>
</table>

5.2.2.3. Physical violence in the past 12 months

Rates of physical violence towards nurses were as high in some cases, or slightly less than, the rates of verbal abuse. In the past 12 months, 84% of the nurses (n=91) reported that they had experienced a physically violent incident and almost all of them (98%, n=94) reported that they had witnessed a physically violent event in their workplace (see Table 18 responses to Survey Question 11).

The physical violence experienced by the participants was perpetrated mostly by patients and visitors (98% and 32% respectively).

100% of male nurses and 96.5% of female nurses had witnessed a physically violent workplace incident in the last 12 months. The physical violence was experienced mainly by male nurses (91.1%), followed by female nurses (78.9%) perpetrated mainly by patients (98%) and visitors (32%). A few nurses also experienced physical violence from other nurses and hospital staff (4% and 1% respectively); however, no physical violence from doctors towards nurses was indicated. In addition, several nurses (5%) indicated that physical violence occurs from nurses towards patients or visitors.
Most MHD participants (88.8%) had experienced a physically violent incident in the last 12 months, followed by ED and ICU participants (80% and 66.6% respectively). However, 100% of the ED and ICU participants had witnessed a physically violent workplace incident in the last 12 months, with slightly less having been witnessed by MHD participants (96.2%). Patients were physically violent towards both genders equally—about 98% (Female 98.1% and Male 97%), as too were visitors towards male nurses (34.6%) and female nurses (31.1%) in the last 12 months. Patients were mostly physically violent in MHD, followed by ED and ICU (100%, 95.4% and 92.8% respectively), while visitors were mainly physically violent in ED (57.1%) followed by MHD (25%) and the least in ICU (10%).

5.3. Effect of workplace violence

Nurses’ perceptions about the impact of a specific violent incident were measured using three aspects: i) personal ii) professional and iii) mental. The survey contained 9 statements overall about the impact of verbal and physical violence on nurses. Median, mean and standard deviations were calculated for each statement and are presented in Table 19 and Table 20, which summarise the responses to Survey Question 12. The calculation of mean responses for each item is similar to previous research see (Kynoch et al., 2011). The median and mean responses across all items were within the “Agree” category, based on the Table 2 categories of mean average scores for the impact of both verbal and physical violence on nurses as described above. All items are framed as a possible negative consequence of verbal and physical violence on nurses. The consistency of participant agreement with these statements is consistent with the finding that verbal and physical violence has wide-ranging impacts on the participant nurses.
5.3.1. Impact of verbal violence on nurses

Median, mean and standard deviations were calculated for each statement of the personal, professional and mental impacts of verbal violence on nurses as Table 19 shows. The median rating by the nurses of the personal, professional and mental impact statements was 4.

i) **Personal impact:** The computed mean ratings by the participants of two statements pertaining to personal impact of a specific violent incident on them ranged from 4.25 to 4.32, indicating agreement that they sustained negative impacts from verbal violence in the psychological and emotional aspects of their lives.

ii) **Professional impact:** The computed mean ratings of four statements pertaining to professional impact of a specific violent incident ranged from 3.98 to 4.37, indicating agreement that they sustained negative effects from verbal violence on their profession as nurses. The specific verbally violent incidents reduced the nurses’ abilities to offer effective care to patients and reduced their motivation to work. They also caused an increase in errors and relationships with staff to deteriorate.

iii) **Mental impact:** The computed mean ratings of three statements pertaining to the mental impact of specific verbal violence ranged from 3.85 to 4.06, indicating agreement that verbal violence has negative effects on nurses. Verbally violent incidents impact on nurses by causing repeated disturbing memories or thoughts of attack, repeated thoughts or the need to speak about an actual attack, and “super alertness” or watchfulness—always on guard. Overall, the computed mean rating of the verbal violence impact on nurses was 4.12. This indicates that the participating nurses agree, on average, that incidence of verbal violence affects their personal, professional and mental health in a range of ways.
Table 19: Nurses’ perceptions towards the impact of verbal violence on them

<table>
<thead>
<tr>
<th>Impact on nurses:</th>
<th>Verbal violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Personally impact:</td>
<td></td>
</tr>
<tr>
<td>12.1 Negative psychosocial effect</td>
<td>96</td>
</tr>
<tr>
<td>12.2 Negative emotional effect</td>
<td>97</td>
</tr>
<tr>
<td>Total personal impact</td>
<td>95</td>
</tr>
<tr>
<td>Professional impact</td>
<td></td>
</tr>
<tr>
<td>12.3 Reduces ability to offer effective care to patients</td>
<td>98</td>
</tr>
<tr>
<td>12.4 Reduces motivation to work</td>
<td>97</td>
</tr>
<tr>
<td>12.5 Increases potential to make errors</td>
<td>97</td>
</tr>
<tr>
<td>12.6 Negatively impacts relationships with staff</td>
<td>97</td>
</tr>
<tr>
<td>Total professional impact</td>
<td>97</td>
</tr>
<tr>
<td>Mental impact</td>
<td></td>
</tr>
<tr>
<td>12.7 Repeated disturbing memories or thoughts of attack</td>
<td>98</td>
</tr>
<tr>
<td>12.8 Repeatedly thinking or talking about the attack</td>
<td>97</td>
</tr>
<tr>
<td>12.9 Being “super alert” or watchful and on guard</td>
<td>97</td>
</tr>
<tr>
<td>Total mental impact</td>
<td>97</td>
</tr>
<tr>
<td>Overall impact on nurses</td>
<td>95</td>
</tr>
</tbody>
</table>

5.3.2. Impact of physical violence on nurses

Median, mean and standard deviation were calculated for each statement about the personal, professional and mental impacts of physical violence on nurses, see Table 20. The overall mean for the effect of verbal violence on nurses was 4.38, indicating agreement that physical violence impacts on nurses’ personal, professional and mental health.

i) **Personal impact:** The mean ratings by the nurses of two statements pertaining to personal impact ranged from 4.48 to 4.54, indicating agreement to high agreement that nurses experience negative impacts of physically violent incidents on the psychological and emotional aspects of their lives. The median rating of the personal statements pertaining to personal impact on them was 5, which was the highest possible score for this question with a “Strongly Agree” perception.

ii) **Professional impact:** The mean ratings of four statements pertaining to professional impact ranged from 4.10 to 4.56, indicating agreement to high agreement that nurses experience negative effects of physically violent incidents. These incidents re-
duce a nurse’s ability to offer effective care and, lower their motivation to work, increase errors and weaken their relationships with other staff. The overall median rating of the professional statements of professional impact was 5.

iii) Mental impact: The mean ratings of three statements pertaining to the mental impact of physical violence ranged from 4.19 to 4.40, indicating agreement that nurses experience negative effects from physical violence. Physically violent incidents cause repeated disturbing memories or thoughts of attack, repeated thinking or talking about an attack and being “super alert” or watchful—always on guard. The overall median rating of the mental statements on mental impact was 4.

The overall mean for the effect of verbal violence on nurses was 4.38, indicating agreement that physical violence impacts on nurses’ personal, professional and mental health.

Table 20: Nurses’ perceptions towards the impact of physical violence on them

<table>
<thead>
<tr>
<th>Impact on nurses:</th>
<th>Physical violence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Median</td>
</tr>
<tr>
<td>Personal impact:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.1 Negative psychosocial effect</td>
<td>94</td>
<td>5</td>
</tr>
<tr>
<td>12.2 Negative emotional effect</td>
<td>95</td>
<td>5</td>
</tr>
<tr>
<td>Total personal impact</td>
<td>93</td>
<td>5</td>
</tr>
<tr>
<td>Professional impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.3 Reduces ability to offer effective care to patients</td>
<td>95</td>
<td>5</td>
</tr>
<tr>
<td>12.4 Reduces motivation to work</td>
<td>95</td>
<td>5</td>
</tr>
<tr>
<td>12.5 Increases potential to make errors</td>
<td>95</td>
<td>5</td>
</tr>
<tr>
<td>12.6 Negatively impacts relationships with staff</td>
<td>93</td>
<td>4</td>
</tr>
<tr>
<td>Total professional impact</td>
<td>92</td>
<td>5</td>
</tr>
<tr>
<td>Mental impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.7 Repeated disturbing memories or thoughts of attack</td>
<td>95</td>
<td>4</td>
</tr>
<tr>
<td>12.8 Repeatedly thinking or talking about the attack</td>
<td>95</td>
<td>4</td>
</tr>
<tr>
<td>12.9 Being “super alert” or watchful and on guard</td>
<td>95</td>
<td>5</td>
</tr>
<tr>
<td>Total mental impact</td>
<td>95</td>
<td>4</td>
</tr>
<tr>
<td>Overall physical violence impact on nurses</td>
<td>89</td>
<td>5</td>
</tr>
</tbody>
</table>
5.4. **Management of workplace violence**

Workplace violence can be addressed by nurses and/or by hospital management.

5.4.1. **Management of violence by nurses**

Nurses cope with verbal and physical violence in different ways. The instrument contained twelve statements regarding the methods nurses use to manage aspects of verbal violence (section 5.4.1.1.) and physical violence (section 5.4.1.2.) in their workplace.

5.4.1.1. **Nurse management of verbal violence**

The survey contained 12 statements regarding the methods nurses use to manage aspects of verbal violence in their workplace. Table 21 (Survey Question 13) shows the median, mean and standard deviations that were calculated for all participants for each statement.

The mean ratings for 12 possible techniques they might use to manage violence varied from 2.03 to 4.41, indicating that some management methods were perceived as more effective, or were preferred over other methods. Taking no action was perceived as inadequate. However, low-level interventions were preferred over high-level or formal interventions. Nurses indicated general disagreement with the option to “take no action” (mean 2.03, median 2) in response to a verbal abuse incident. However, they did not prefer formal interventions. There were generally neutral views regarding completing a compensation claim, transferring to another position or pursuing prosecution (mean 3.06, 2.62 and 2.83 respectively). Low-level, or informal interventions, were preferred. The nurses expressed agreement with the majority of the statements towards managing verbal violence with a median of 4, and a mean that varied from 3.52 to 4.41 for possible techniques such as: asking the offender to stop, talking to friends/family for support, talking to a colleague for advice, seeking counselling, trying to defend themselves, completing an incident form, reporting to a senior staff member and reporting to hospital security. Overall, the mean rating for nurses’ management
of workplace verbal violence was 3.55, indicating agreement that nurses should act to curb verbal violence.

Table 21: Nurses’ perceptions towards the management of verbal violence

<table>
<thead>
<tr>
<th>Management of verbal violence</th>
<th>Verbal violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1 Take no action</td>
<td>N</td>
</tr>
<tr>
<td>13.2 Ask the person to stop</td>
<td>97</td>
</tr>
<tr>
<td>13.3 Talk to friends/family for support</td>
<td>95</td>
</tr>
<tr>
<td>13.4 Talk to colleague for advice</td>
<td>97</td>
</tr>
<tr>
<td>13.5 Seek counselling</td>
<td>94</td>
</tr>
<tr>
<td>13.6 Try to defend themselves</td>
<td>95</td>
</tr>
<tr>
<td>13.7 Complete an incident form</td>
<td>96</td>
</tr>
<tr>
<td>13.8 Complete a compensation claim</td>
<td>95</td>
</tr>
<tr>
<td>13.9 Report to a senior staff member</td>
<td>97</td>
</tr>
<tr>
<td>13.10 Report to Hospital security</td>
<td>94</td>
</tr>
<tr>
<td>13.11 Transfer to another position</td>
<td>95</td>
</tr>
<tr>
<td>13.12 Pursue prosecution</td>
<td>93</td>
</tr>
<tr>
<td>Overall management of verbal violence</td>
<td>90</td>
</tr>
</tbody>
</table>

5.4.1.2. Nurse management of physical violence

Table 22 shows the mean ratings of 12 statements regarding the management of physical violence, in response to Survey Question 13. The rating ranged from 1.63 to 4.60, indicating responses from disagreement to high agreement. Taking no action was not a preferred method. The mean rating towards the “take no action” was 1.63.

However, the nurses agreed with a majority of proposed management options with the mean ranging from 3.52 to 4.41. The overall mean rating of options for management of physical violence in their workplace was 3.88. This indicated nurse agreement towards the suggested methods they might use to manage physical violence incidents.
### Table 22: Nurses’ perceptions towards the management of physical violence

<table>
<thead>
<tr>
<th>Management of physical violence</th>
<th>Physical violence</th>
<th>N</th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1 Take no action</td>
<td></td>
<td>93</td>
<td>1</td>
<td>1.63</td>
<td>.96</td>
</tr>
<tr>
<td>13.2 Ask the person to stop</td>
<td></td>
<td>95</td>
<td>5</td>
<td>4.52</td>
<td>.66</td>
</tr>
<tr>
<td>13.3 Talk to friends/family for support</td>
<td></td>
<td>94</td>
<td>4</td>
<td>4.16</td>
<td>.96</td>
</tr>
<tr>
<td>13.4 Talk to colleague for advice</td>
<td></td>
<td>96</td>
<td>5</td>
<td>4.44</td>
<td>.69</td>
</tr>
<tr>
<td>13.5 Seek counselling</td>
<td></td>
<td>94</td>
<td>4</td>
<td>3.89</td>
<td>1.03</td>
</tr>
<tr>
<td>13.6 Try to defend themselves</td>
<td></td>
<td>95</td>
<td>5</td>
<td>4.41</td>
<td>.69</td>
</tr>
<tr>
<td>13.7 Complete an incident form</td>
<td></td>
<td>95</td>
<td>5</td>
<td>4.49</td>
<td>.79</td>
</tr>
<tr>
<td>13.8 Complete a compensation claim</td>
<td></td>
<td>95</td>
<td>4</td>
<td>3.74</td>
<td>1.13</td>
</tr>
<tr>
<td>13.9 Report to a senior staff member</td>
<td></td>
<td>96</td>
<td>5</td>
<td>4.60</td>
<td>.58</td>
</tr>
<tr>
<td>13.10 Report to hospital security</td>
<td></td>
<td>94</td>
<td>5</td>
<td>4.38</td>
<td>.81</td>
</tr>
<tr>
<td>13.11 Transfer to another position</td>
<td></td>
<td>94</td>
<td>3</td>
<td>2.91</td>
<td>1.12</td>
</tr>
<tr>
<td>13.12 Pursue prosecution</td>
<td></td>
<td>94</td>
<td>4</td>
<td>3.55</td>
<td>1.17</td>
</tr>
<tr>
<td><strong>Overall management of physical violence</strong></td>
<td></td>
<td>92</td>
<td>4</td>
<td>3.88</td>
<td>.45</td>
</tr>
</tbody>
</table>

### 5.4.2. General workplace violence management

The perceptions of the nurses about general workplace management strategies, support, workload and autonomy, in relation to the issue of workplace violence rather than specific incidents of violence, included statements addressing:

i) management strategies

ii) available services to nurses

iii) personal support services for nurses in hospital support

iv) workload in department

v) autonomy at work.

The survey contained 30 statements concerning these subthemes, see Survey Question 15. Respondents’ median, mean and standard deviations were calculated for each statement and are presented in Table 23.
5.4.2.1. Management strategies

The mean ratings of four statements on perceived general workplace management strategies ranged from 3.82 to 4.58, indicating agreement to high agreement with general workplace management strategies. Nurses agreed that the hospital should report violence to police in each instance (mean 3.82) and should have workplace violence policies (mean 4.14). However, nurses expressed high agreement with the statement that the hospital should involve nurses in developing workplace violence policies (mean 4.49) and that nurses should report violence in each instance (mean 4.58). Overall, the nurses agreed (mean 4.27) that general management strategies should be implemented in their hospital.

5.4.2.2. Available services for nurses

The mean ratings on six statements about ways in which their hospital should provide available services for nurses ranged from 4.04 to 4.68, indicating agreement to high agreement about the need for support services. Nurses agreed that the hospital should provide consultation after an incident (mean 4.48); the hospital should allow use of medication to calm aggressive patients (mean 4.41) and that the hospital should allow the use of mechanical restraints (mean 4.04). Nurses were in high agreement about the need for hospitals to be proactive in reducing violence. The hospital should provide training on violence management (mean 4.62); the hospital should encourage nurses to attend aggression management training (mean 4.68) and the hospital should allow access to policies addressing workplace violence (mean 4.61). Overall, the nurses agreed (mean 4.48) on the ways their hospital should provide services for nurses to address workplace violence.
5.4.2.3. **Support services in hospital**

Opinions about how hospital services should support nurses are indicated by responses to 13 statements. The responses varied only slightly from 4.52 to 4.68. Nurses were in high agreement that all hospital services should support nurses in their workplace. The nurses were also in high agreement that the support services should provide opportunities for education (mean 4.54) and training (mean 4.63) to address violence; provide resources for resolving problems (mean 4.59) and encourage new ideas to deal with violence (mean 4.56). In addition, the nurses were in high agreement that clear guidance was needed on how to deal with violence (mean 4.63); that the needs of the department needed assessing (mean 4.61); that nurses should work under safe conditions (mean 4.62) and should feel safe in their work environment (mean 4.68). High agreement was also obtained regarding allowing nurses to manage patient care adequately and effectively (mean 4.58); empowering nurses to accomplish their work in an effective manner (mean 4.64), including sharing information (mean 4.52) and feedback (mean 4.59), and receiving support from colleagues and supervisors after an incident (mean 4.60). Overall, the nurses were in high agreement regarding the ways that hospital services should support nurses in their workplace (mean 4.59).

5.4.2.4. **Workload in departments**

Nurses believed that the heavy workload in their departments affected both their performance and overall levels of violence. They were ambivalent, however, about the ability of existing processes to address overly heavy workloads. Four statements about workloads received mean ratings of 3.25 to 3.69, indicating attitudes ranging from ambivalence to agreement about how workload issues are addressed in their departments. Nurses were ambivalent about the processes that are in place for dealing with workload issues (mean 3.25). However, nurses agreed that workload negatively affects their ability to manage patient care (mean 3.65) and also contributes to violence towards nurses (mean 3.67). In addition, nurses agreed that staff did not have sufficient time to complete their work (mean 3.69). Overall, nurses agreed that workloads impact on their departments (mean 3.56).
5.4.2.5. Autonomy at work

Nurses are doubtful that they have sufficient autonomy at work, but they were satisfied that if they had autonomy to make decisions about the management of violent patients, they would be capable of reducing workplace violence. The mean ratings of three statements about their autonomy ranged from 2.88 to 3.61. Nurses were neutral to slightly unsatisfied about the autonomy they have to manage violence at work (mean 2.88).

However, they agreed about their ability to make necessary decisions related to patient care (mean 3.54) and that autonomy contributes to reducing workplace violence (mean 3.61). Overall, the nurses were neutral about their autonomy at work (mean 3.35).
Table 23: Nurses’ perceptions towards management strategies, available services, support services, workload and autonomy in the workplace

| Management strategies, available services, support services, workload and autonomy | Level of agreement |
|---|---|---|---|---|
| **Management strategies:** | N | Median | Mean | SD |
| 15.1 Hospital has workplace violence policies | 97 | 4 | 4.14 | .85 |
| 15.2 Hospital should involve nurses in developing workplace violence policies | 97 | 5 | 4.49 | .64 |
| 15.3 Nurses should report violence in each instance | 97 | 5 | 4.58 | .69 |
| 15.4 Hospital should report violence to police in each instance | 95 | 4 | 3.82 | 1.00 |
| **Total management strategies:** | 94 | 4 | 4.27 | .52 |

| Available services to nurses: | N | Median | Mean | SD |
| 15.5 Hospital should provide training on violence management | 97 | 5 | 4.62 | .71 |
| 15.6 Hospital should provide consultation after an incident | 96 | 5 | 4.48 | .66 |
| 15.7 Hospital should allow using of medication | 94 | 5 | 4.41 | .71 |
| 15.8 Hospital should allow using mechanical restraint | 96 | 4 | 4.04 | 1.03 |
| 15.9 Hospital should encourage nurses to attend aggression management training | 96 | 5 | 4.68 | .58 |
| 15.10 Hospital should allow access to policies addressing workplace violence | 96 | 5 | 4.61 | .60 |
| **Total available services to nurses:** | 94 | 5 | 4.48 | .54 |

| Personal support services for nurses in hospital: | N | Median | Mean | SD |
| 15.11 Should provide opportunities for education | 96 | 5 | 4.54 | .63 |
| 15.12 Should ensure nurses work under safe conditions | 97 | 5 | 4.62 | .69 |
| 15.13 Should provide training to address violence | 96 | 5 | 4.63 | .60 |
| 15.14 Should allow nurses to manage patient care adequately and effectively | 95 | 5 | 4.58 | .62 |
| 15.15 Should encourage new ideas to deal with violence | 95 | 5 | 4.56 | .63 |
| 15.16 Should allow sharing information and feedback | 94 | 5 | 4.52 | .65 |
| 15.17 Should provide resources for resolving problems | 94 | 5 | 4.59 | .61 |
| 15.18 Should show clear guidance about violence | 94 | 5 | 4.63 | .62 |
| 15.19 Should assess the needs of the department | 95 | 5 | 4.61 | .60 |
| 15.20 Should facilitate support from colleagues after an incident | 94 | 5 | 4.59 | .62 |
| 15.21 Should provide support from supervisors after an incident | 93 | 5 | 4.60 | .61 |
| 15.22 Should empower nurses to accomplish work in an effective manner | 94 | 5 | 4.64 | .62 |
## Chapter 5: Survey Findings

### Management strategies, available services, support services, workload and autonomy

<table>
<thead>
<tr>
<th>Management strategies, available services, support services, workload and autonomy</th>
<th>Level of agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td><strong>Should allow nurses to feel safe in their work environment</strong></td>
<td>94</td>
</tr>
<tr>
<td><strong>Total personal support services for nurses in hospital:</strong></td>
<td>93</td>
</tr>
<tr>
<td><strong>Workload in my department:</strong></td>
<td></td>
</tr>
<tr>
<td>15.24 Negatively affects my ability to manage patient care</td>
<td>96</td>
</tr>
<tr>
<td>15.25 Contributes to violence towards nurses</td>
<td>94</td>
</tr>
<tr>
<td>15.26 Nurses do not have sufficient time to complete their work</td>
<td>94</td>
</tr>
<tr>
<td>15.27 There is a process in place that deals with workload issues</td>
<td>95</td>
</tr>
<tr>
<td><strong>Total workload in my department:</strong></td>
<td>94</td>
</tr>
<tr>
<td><strong>Autonomy at work:</strong></td>
<td></td>
</tr>
<tr>
<td>15.28 Nurses have the ability to make necessary decisions related to patient care</td>
<td>96</td>
</tr>
<tr>
<td>15.29 Nurses’ autonomy contributes to reducing workplace violence</td>
<td>95</td>
</tr>
<tr>
<td>15.30 Nurses are satisfied with their authority to manage violence at work</td>
<td>95</td>
</tr>
<tr>
<td><strong>Total autonomy at work:</strong></td>
<td>95</td>
</tr>
<tr>
<td><strong>Overall management strategies, available services, support services, workload and autonomy</strong></td>
<td>87</td>
</tr>
</tbody>
</table>
5.5. **Implementation of general management strategies**

Table 24 illustrates nurse perceptions about the implementation of workplace management strategies, available services and support services, see Survey Question 15. The survey contained 23 statements relating to nurses’ perceptions about the implementation of:

i) management strategies

ii) available services to nurses

iii) support services for nurses in their hospital.

The frequency and percentage of the nurses’ responses were calculated for each statement from the responses codes: “Yes,” “No,” “Sometimes” and “Do not know”.

### 5.5.1. Implementation of management strategies

Fewer than half of the nurses (47.3%) reported that their hospital had implemented workplace violence policies. Another 36.3% believed workplace violence policies were sometimes implemented and 12% did not know about workplace violence policies. In addition, almost half of the nurses (44.4%) did not know if their hospital involved nurses in developing workplace violence policies.

Only 26.4% of nurses stated that they reported each incident of workplace violence, while 23% said they did not report each incident. The largest percentage of nurses (44%) agreed that incidents were sometimes reported. A significant proportion (30%) of nurses said their hospital did not report violence to police in each instance, 27.8% said reports were made to police sometimes and 26% did not know if incidents were reported to police or not. Only 15.6% of nurses said that violence was reported to police in each instance.
5.5.2. Implementation of available services for nurses

Training and support were reported to be patchy. Most of the nurses (83.7%) said their hospital provided training on violence management. However, 43.5% of nurses said that sometimes the hospital provided consultation after an incident, while 28.3% agreed that post-incident consultations were provided and 15.2% said post-incident consultation was not provided. When asked about the use of medication to calm violent patients, about half of the nurses (48.9%) reported that medications were used, while 45.6% said medications were used sometimes. Most of the nurses (53.3%) reported that the hospital sometimes allowed them to use mechanical restraints for violent patients. However, 22.8% said mechanical restraints were used and 18.5% said mechanical restraints were not used. The majority of nurses (81.5%) said their hospital encouraged them to attend aggression management training. Most of the nurses knew that their hospital allowed them access to hospital violence policies, but 20% of nurses did not know if their hospital allowed them access to policies addressing workplace violence.

5.5.3. Implementation of personal support services

Just more than half of the nurses (51.1%) reported that their hospital provided opportunities for education about coping with violence, while 35.6% reported opportunities for education only happen sometimes.

Most of the nurses (70%) said the hospital provided training to address violence. However, only 29.9% of nurses said their hospital provided resources for resolving problems, 39.1% said the hospital sometimes provided resources for resolving violence problems and 13.8% said the hospital did not provide resources for solving violence problems.

New ideas from nurses for dealing with violence are not generally welcomed. Only 20.5% said the hospital encouraged new ideas to address the problem, 31.8% of nurses said the hospital sometimes encouraged new ideas and 25% of nurses reported that their hospital does not encourage new ideas to deal with violence.
Just fewer than half of the nurses (47.1%) reported that their hospital showed clear guidance about violence, 20% said clear guidance was given and 10.4% said clear guidance was not given.

Opinions varied on whether the hospital assessed the needs of the department, with 40.9% of nurses saying the hospital sometimes assessed the needs of their department, 33% said the hospital always assessed the department’s needs and 15.9% said the hospital did not assess departmental needs at all.

Opinions were also varied about whether the hospital ensured nurses worked under safe conditions. About one-third of nurses (34.4%) said that the hospital ensured nurses worked under safe conditions, while 48.9% said the hospital sometimes ensured staff worked under safe conditions.

Less than one-third of nurses (30%) said the hospital allowed them to feel safe in their work environment, while 54.5% of nurses said that sometimes the hospital allowed them to feel safe at work and 12.2% said it did not allow them to feel safe.

Most of the nurses reported that their hospital allowed them to manage patient care adequately and effectively, but 37.1% said their hospital sometimes allowed them to manage patient care adequately and effectively.

Less than one-third of nurses (31.8%) said the hospital empowered them to accomplish work in an effective manner, while (51.1%) stated that this only occurred sometimes.

Almost one-fifth of nurses said the hospital did not allow information sharing and feedback. Another 34.5% of nurses said the hospital sometimes allowed sharing of information and feedback; however, 29.9% said the hospital allows sharing of information and feedback, but 17.2% stated that it doesn’t.

Hospital support was more reliable than support from supervisors following incidents of violence. Hospital support was offered according to 40.9% of nurses, while 47.7% said hospital support was sometimes offered. However, support from supervisors after an incident was offered according to 36.8% of the nurses, while 43.7% nurses said supervisors sometimes provided support and 10.3% of nurses said it did not happen.
## Table 24: Nurses’ perceptions towards implementation of management strategies, available services and support services at workplace

<table>
<thead>
<tr>
<th>Management strategies, available services and support services</th>
<th>Implementation</th>
<th>Number</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management strategies:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.1 Hospital has workplace violence policies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.2 Hospital should involve nurses in developing workplace violence policies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.3 Nurses should report violence in each instance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.4 Hospital should report violence to police in each instance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available services to nurses:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.5 Hospital should provide training on violence management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.6 Hospital should provide consultation after an incident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.7 Hospital should allow using of medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.8 Hospital should allow using mechanical restraint</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.9 Hospital should encourage nurses to attend aggression management training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.10 Hospital should allow access to policies addressing workplace violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal support services for nurses in hospital:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.11 Should provide opportunities for education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.12 Should ensure nurses work under safe conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.13 Should provide training to address violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.14 Should allow nurses to manage patient care adequately and effectively</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.15 Should encourage new ideas to deal with violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.16 Should allow sharing information and feedback</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.17 Should provide resources for resolving problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.18 Should show clear guidance about violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.19 Should assess the needs of the department</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.20 Should facilitate support from colleagues after an incident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.21 Should provide support from supervisors after an incident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.22 Should empower nurses to accomplish work in an effective manner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.23 Should allow nurses to feel safe in their work environment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.6. **Support during and after violent incidents**

Nurses were asked about the support they are given during and after incidents of violence.

**5.6.1. Support during incidents of verbal violence**

Nurses generally found that their manager, colleagues, family and friends supported them adequately during and after incidents of verbal violence. Hospital support was found to be less adequate. Survey participants were asked to comment on four statements regarding the support available during a specific verbally violent incident in the workplace. Table 25 shows the median, mean and standard deviations that were calculated for each statement from the responses to Survey Question 14. The mean ratings of four statements refers to the support they have received during a specific incident of verbal violence, and ranged from 2.85 to 4.07, indicating views that ranged from neutral to agreement. Nurses reported they felt least supported (mean 2.85) by hospital management. The Cronbach α for this group is mentioned in the methodology section 3.6.2.5. However, in the other three statements (14.2-14.4) the nurses agreed more strongly with statements about the support they received from managers (mean 3.50), colleagues (mean 4.04), family and friends (mean 4.07). Overall, the nurses agreed that they had received support during a specific verbally violent incident (mean 3.61).

<table>
<thead>
<tr>
<th>Support during violence incident</th>
<th>Verbal violence</th>
<th>N</th>
<th>Median</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.1 The incident was well managed by the hospital</td>
<td>94</td>
<td>3</td>
<td>2.85</td>
<td>1.08</td>
<td></td>
</tr>
<tr>
<td>14.2 My manager supported me</td>
<td>96</td>
<td>4</td>
<td>3.50</td>
<td>1.05</td>
<td></td>
</tr>
<tr>
<td>14.3 My colleagues supported me</td>
<td>96</td>
<td>4</td>
<td>4.04</td>
<td>.78</td>
<td></td>
</tr>
<tr>
<td>14.4 My family/ friends supported me</td>
<td>95</td>
<td>4</td>
<td>4.07</td>
<td>.77</td>
<td></td>
</tr>
<tr>
<td>Overall support during violence incident</td>
<td>94</td>
<td>4</td>
<td>3.61</td>
<td>.61</td>
<td></td>
</tr>
</tbody>
</table>
5.6.2. Support during incidents of physical violence

Nurses generally agreed that their hospital, manager, colleagues and family and friends were generally supportive during physically violent incidents. The survey contained four statements regarding support received during a specific physically violent incident in the workplace. Table 26 illustrates the median, mean and standard deviations that were calculated for each statement, based on responses to Survey Question 14. The mean ratings were 3.18 to 4.21, indicating a specific incident of physical violence that was well managed by the hospital (mean 3.18). However, the nurses agreed that during a specific incident of physical violence the manager (mean 3.80), colleagues (mean 4.21), or family and friends (mean 4.11) supported them. Overall, the nurses agreed that they received support during a specific incidence of physical violence (mean 3.82).

Table 26: Support during physical violence incident

<table>
<thead>
<tr>
<th>Support during violence incident</th>
<th>Physical violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>14.1 The incident was well managed by the hospital</td>
<td>94</td>
</tr>
<tr>
<td>14.2 My manager supported me</td>
<td>93</td>
</tr>
<tr>
<td>14.3 My colleagues supported me</td>
<td>94</td>
</tr>
<tr>
<td>14.4 My family/ friends supported me</td>
<td>93</td>
</tr>
<tr>
<td>Overall support during violence incident</td>
<td>93</td>
</tr>
</tbody>
</table>
5.7. Result of statistical tests

The exploratory research question number four from section 1.3.2 asked:

*Are there any differences in nurses’ perceptions of workplace violence in a regional public hospital based on their selected demographic characteristics (age, gender, ethnic background, level of education, work experience, working status and department)?*

This research question was tested by one-way ANOVA, also known as an F-test. In addition, *t*-tests were used to explore whether any significant differences existed in the responses of the nurses based on their demographic profiles.

One-way ANOVA tests were used for comparing the differences between means of more than two groups and *t*-tests were applied for comparing the differences between the means of two groups. The one-way ANOVA and *t*-tests have shared assumptions of independence of participants, normality and equality of variances. All survey respondents completed the survey only once, ensuring that in all comparisons of means, individuals only occurred in one of the comparison samples, supporting the assumption of independence. Prior to application of the *t*-test or ANOVA (F-test) methods, the Levene’s test for equality of variance between comparison groups and the Shapiro-Wilk’s (W) test of Normality were performed for each statistical test (Field, 2013; Pallant, 2013). In each case, no significant deviation from equality of variance or normality was found, so assumptions were not violated. Therefore, non-parametric equivalent tests for the ANOVA and *t*-tests (Kruskal-Wallis and Mann-Whitney test respectively) were not used.

Analysis of perceptions of responses to individual survey items were related to two main themes:

i) Perceptions related to a specific violent incident, including the impact, management and support of nurses during and after a specific incident of verbal or physical violence (Survey Question 12-14).

ii) Perceptions related to general workplace management strategies, support services, workload and autonomy (Survey Question 15).

The mean responses within these two main themes were compared for a range of demographic variables. The themes were measured based on combined (average)
Likert scale scores across the survey items for each participant. Combined scores were created for perceptions related to each theme separately. Prior to combining survey items to produce combined individual scores within each theme, Cronbach’s alpha ($\alpha$) was used to assess the reliability of the Likert scales (Field, 2013). Cronbach $\alpha$ values were between 0.708 and 0.942 for all scales of the survey items, except the verbal support scale, for which Cronbach $\alpha$ values was 0.567 as discussed in more detail in the methodology, see section 3.6.2.5.

5.7.1. Statistical tests related to specific incident

The nurses’ perceptions regarding the impact, management and support of a specific violent incident were analysed based on aspects of physical and verbal violence. The nurses’ perceptions were captured in response to individual survey items and were combined to create three general themes:

i) impact of verbal and physical violence on nurses

ii) management strategies to support nurses who experience verbal and/or physical violence

iii) support during incidents of verbal and/or physical violence.

For incidents of both verbal and physical violence, mean responses within these themes were compared for a range of demographic variables. The impact theme was measured based on combined (average) Likert scale scores for nine survey items for each participant. Management was the combined score across 12 survey items, and support was the combined score across four survey items.

Table 27 shows the mean responses for each of four demographic variables: Age Groups, Years of Work Experience, Departments and Level of Education, with more than 2 groups. ANOVA’s were used to statistically compare mean responses between groups within each demographic variable and within each theme (Impact, Management and Support) separately. Table 28 shows the mean responses for each of the three demographic variables: Gender, Background and Work Status, with only two groups for which $t$-tests were used to compare means.

For all ANOVA and $t$-test analyses, no significant differences were found between any category means ($p>0.05$) within any of the demographic variables (age,
gender, ethnic background, level of education, work experience, working status and department) as presented in Appendix U (ANOVA Tests and t-Tests). The smallest $p$-value for any of the ANOVA results was for nurses’ perceptions regarding the management of verbal violence based on their age group ($p = 0.15$). The smallest $p$-value for any of the $t$-test results was for nurses’ perceptions regarding the impact of verbal violence based on their work status group ($p = 0.05$). The fact that no significant differences were found between any category means ($p > 0.05$) any of the demographic variables show the high level of violence that nurses experienced in their workplace.

For all seven demographic variables the mean perceptions for impact, management and support related to both verbal and physically-specific violent incidents were at least 3.41 in Table 27. Therefore, there were no mean scores within the Strongly Disagree or Disagree ranges based on the categories and means average scores of Table 2. The mean perceptions for impact, management and support related to physically violent incidents across all the seven demographic variables were at least 3.64. Therefore, the average responses were within the agree perception as shown in Table 2. The mean perceptions for impact related to both verbal (lowest mean 3.96) and physical (lowest mean 4.27) violence were within the agree perceptions (Table 28) which imply that nurses agree verbal and physical violence impacts on them, management strategies to support nurses who experience verbal and/or physical violence are needed and that support during incidents of verbal and/or physical violence is required.
Table 27: F-test results for nurses’ mean perceptions regarding verbal and physical violence based on their demographic variables.

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Verbal Violence—Level of Agreement</th>
<th>Physical Violence—Level of Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Impact</td>
<td>Management</td>
</tr>
<tr>
<td>Age Groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 – 35 years</td>
<td>4.12 (.43)</td>
<td>31</td>
</tr>
<tr>
<td>36 – 50 years</td>
<td>4.12 (.79)</td>
<td>39</td>
</tr>
<tr>
<td>50 – 68 years</td>
<td>4.10 (.84)</td>
<td>23</td>
</tr>
<tr>
<td>Years of Work Experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>4.14 (.44)</td>
<td>23</td>
</tr>
<tr>
<td>6 – 15 years</td>
<td>3.97 (.86)</td>
<td>37</td>
</tr>
<tr>
<td>16 – 43 years</td>
<td>4.25 (.62)</td>
<td>33</td>
</tr>
<tr>
<td>Departments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHU</td>
<td>4.04 (.80)</td>
<td>55</td>
</tr>
<tr>
<td>ED</td>
<td>4.24 (.55)</td>
<td>24</td>
</tr>
<tr>
<td>ICU</td>
<td>4.25 (.49)</td>
<td>16</td>
</tr>
<tr>
<td>Level of Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>4.09 (.71)</td>
<td>57</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>4.17 (.76)</td>
<td>26</td>
</tr>
<tr>
<td>Diploma in nursing</td>
<td>4.21 (.54)</td>
<td>12</td>
</tr>
<tr>
<td>And Other certificate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 28: t-test results for nurses’ perceptions regarding themes within verbal and physical violence based on their demographic variables

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Verbal Violence—Level of Agreement</th>
<th>Physical Violence—Level of Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Impact</td>
<td>Management</td>
</tr>
<tr>
<td></td>
<td>Mean (Std. D)</td>
<td>N</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>4.18 (.70)</td>
<td>58</td>
</tr>
<tr>
<td>Male</td>
<td>4.05 (.69)</td>
<td>37</td>
</tr>
<tr>
<td>Background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immigrated to Australia</td>
<td>3.96 (.92)</td>
<td>17</td>
</tr>
<tr>
<td>Aboriginal and Australian Born</td>
<td>4.18 (.64)</td>
<td>73</td>
</tr>
<tr>
<td>Work Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-Time</td>
<td>4.05 (.75)</td>
<td>71</td>
</tr>
<tr>
<td>Part-Time and Casual</td>
<td>4.37 (.43)</td>
<td>23</td>
</tr>
</tbody>
</table>
5.7.2. Statistical tests related to general workplace violence management

The nurses’ perceptions regarding general workplace management strategies, support, workload and autonomy were captured in responses to individual survey items, and analysed. The mean responses were compared for a total of seven demographic variables. The mean responses were measured based on combined (average) Likert scale scores across 30 survey items for each participant.

The mean responses for each of the four demographic variables: Age Groups, Years of Work Experience, Departments and Level of Education, with more than two groups are displayed in Table 29. ANOVA was used to statistically compare means responses between groups within each demographic variable.

Table 30 shows the mean responses for each of three demographic variables: Gender, Background and Work Status, with only two groups for which t-tests were used to compare means. The mean perceptions of general workplace management strategies, support, workload and autonomy across all the seven demographic variables were between a mean of 3.84 to 4.17, which fell within the “Agree” band, see Table 29 and Table 30.

No significant differences were found between any group means (p>0.05) within any of the seven demographic variables for all ANOVA and t-test analyses. ANOVA’s smallest p-value results were: p = 0.41 for nurses’ perceptions regarding general workplace management strategies, support, workload and autonomy based on their departments. The t-test’s smallest p-value results were p = 0.37 for nurses’ perceptions regarding general workplace management strategies, support, workload and autonomy based on their gender. Therefore, none of the ANOVA or t-tests identified significant differences between means.
Table 29: F-test results for nurses’ level of agreement based on their demographic variables

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Level of Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
</tr>
<tr>
<td>Age Groups</td>
<td></td>
</tr>
<tr>
<td>22 – 35 years</td>
<td>4.22</td>
</tr>
<tr>
<td>36 – 50 years</td>
<td>4.30</td>
</tr>
<tr>
<td>50 – 68 years</td>
<td>4.19</td>
</tr>
<tr>
<td>Years of Work Experience</td>
<td></td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>4.20</td>
</tr>
<tr>
<td>6 – 15 years</td>
<td>4.22</td>
</tr>
<tr>
<td>16 – 43 years</td>
<td>4.32</td>
</tr>
<tr>
<td>Departments</td>
<td></td>
</tr>
<tr>
<td>MHU</td>
<td>4.21</td>
</tr>
<tr>
<td>ED</td>
<td>4.38</td>
</tr>
<tr>
<td>ICU</td>
<td>4.25</td>
</tr>
<tr>
<td>Level of Education</td>
<td></td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>4.28</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>4.17</td>
</tr>
<tr>
<td>Diploma in Nursing and Other Certificate</td>
<td>4.35</td>
</tr>
</tbody>
</table>

Table 30: Results of t-test for nurses’ level of agreement based on their demographic variables

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Level of Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>4.22</td>
</tr>
<tr>
<td>Male</td>
<td>4.31</td>
</tr>
<tr>
<td>Background</td>
<td></td>
</tr>
<tr>
<td>Immigrated to Australia</td>
<td>4.21</td>
</tr>
<tr>
<td>Aboriginal and Australian Born</td>
<td>4.28</td>
</tr>
<tr>
<td>Work Status</td>
<td></td>
</tr>
<tr>
<td>Full-Time</td>
<td>4.23</td>
</tr>
<tr>
<td>Part-Time and Casual</td>
<td>4.31</td>
</tr>
</tbody>
</table>

The exploratory research Question 4 was formulated to test whether there were any statistical differences in nurses’ perceptions towards workplace violence. This research question is divided into two sections and determines the nurses’ perception of impact, management and support of i) a specific violent incident and ii) services or managements strategies that are generally available in the hospital.

Exploratory research Question 1: aimed to determine whether the nurses, based on their age groups, gender, background, level of education, work experience, working status and department would differ in their perceptions towards three aspects of verbal and physical violence: impact of violence, management of violence and support in a specific violent incidence (as shown in section 5.4.1).
Exploratory research Question 2: aimed to determine whether the nurses in different age groups, gender, background, level of education, work experience, working status and department would differ in their perceptions towards general workplace management strategies, support, workload and autonomy (as discussed in section 5.4.2).

The mean ratings of the nurses across all seven demographic variables in each aspect of verbal and physical violence, including general workplace management strategies, support, workload and autonomy, were calculated. The means were then used in the ANOVA, see Table 27 and Table 29 and t-tests scores, see Table 28 and Table 30, to determine whether statistically significant differences existed between the nurses according to their demographic variables.

No statistically significant differences in the mean ratings of the nurses across all their demographic variables were found. This indicates that there were no differences in perceptions about the impact, management and support services in a specific incident of verbal and physical violence or about general workplace management strategies, support, workload and autonomy, based on their demographic variables.

5.8. Factors of workplace violence

Short answer questions in the survey yielded comments from nurses about the factors they believe contribute to workplace violence. Nurses who answered the open question 13A of the online and printed survey: “What are the reasons for workplace violence?” provided a large number of reasons that could be divided into four main categories. The four categories were grouped using thematic analysis and developing subthemes including: social factors, hospital factors, personal factors and factors of horizontal violence, as discussed below.

5.8.1. Social factors

Nurses suggested a large number of social factors contribute to workplace violence. These ranged from the level of violence in the general community to personal characteristics such as impatience, poor communication and lack of respect:

“Domestic violence” (Online ED2, ED74)
“Culture of violence” (MHD32)
“Normalisation of violent and aggressive behaviours” (MHD10)
“General acceptance of workplace bullying” (MHD53, ICU94)
“Impatience” (ICU97)
“Sense of entitlement” (Online MHD6)
“Poor communication” (MHD47)
“Lack of respect” (MHD4, ED58, ICU83, ICU97)
“Lack of education” (ED58)
“Generally rude people” (ED78)
“Poor manners” (ICU97)
“Police using hospital as a perceived ‘dumping’ ground for antisocial behaviours from people” (Online ED2)
“People are relying more on the QPS, QAS & health departments to control bad behaviours” (Online ED2)
“Unfair expectations of what nurses can do for patients” (ED69)
“High and unrealistic expectations from community on what warrants emergency treatment or expectation from health care facility” (Online ED3, MHD45, ED780, ICU88)
“Lack of discipline in society” (ICU92)

An interesting finding, in addition to the predictable comments about social malaise, is that nurses feel hospitals are being used by government agencies, for example, the police service and ambulance services, to ‘dump’ difficult individuals whose behaviour they cannot control.

5.8.2. Hospital factors

The hospital factors are divided into three categories: general management, environment and workload.

5.8.2.1. General management

The range of hospital factors that influence the frequency and severity of violence towards nurses is extensive. These hospital factors include lack of nurse training and leadership, medical errors such as misdiagnosis or prescribing inappropriate medications, lack of communication with patients’ families, restriction of patients’ freedoms and the general lack of sanctions, or application of sanctions, to patients who are violent:

“Skill mix is being compromised” (Online ED2)
“Inexperienced staff or staff with not appropriate training” (MHD20, MHD46)
“Leadership is not available” (Online ED2)
“Under-medicating of patients” (Online MHD8, Online MHD9, MHD31, MHD46, MHD55)
“Inappropriate admissions” (Online MHD8, MHD35)
“Inadequate treatment, wrong medications and wrong diagnosis” (MHD35, MHD36, MHD50)
“Poor or no management plans” (Online MHD8, MHD11, MHD41, MHD46)
“Poor management of client by treating team” (MHD53)
“Carers/partners/family/significant others not informed as necessary” (Online ED2)
“Limitation on freedom of movement or restrictions of patients freedoms” (MHD30, MHD32, MHD41, MHD54)
“There are no consequences for violence and aggression from patients. The majority of patients are aware of this fact and therefore don’t care what they do to staff” (MHD44, MHD53)

Overall, nurses blame individuals, the hospital, other professionals, failures in communication and lack of sanctions for the incidence of violence in the workplace.

5.8.2.2. Environment

Nurses suggested several environmental factors that might be related to workplace violence, such as lack of security, restricted smoking regimes and insufficient space in the ward:

“Lack of security” (ED69)
“High emotional level experienced within the emergency department” (Online ED2)
“High levels of intensity and stress from patients and family” (ED76)
“ED as the 'front-line’” (Online ED2)
“Mental health wards are now all locked” (Online MHD7)
“Insufficient floor space or overcrowding resulting in cramped conditions for the number of patients accommodated in the unit” (Online MHD7, Online MHD10)
“Restricted smoking regime in HDU” (Online MHD7, MHD30, MHD55)
“Cigarette smoking regime is only hourly and MH patients are not allowed outside in between these times which increased aggression” (Online MHD7)

Environmental factors combined with a high workload might impact on workplace violence.
5.8.2.3. **Workload**

High workloads were found to be a cause of violence in the wards due to doctor delays in seeing patients, long waiting times and a reduction in the number of nurses:

“Shifts are getting busier” (Online ED2, ICU96)
“Long waiting times til treatment by doctor” (Online ED3, MHD40 ED61, ED62, ED67, ED69 ED74, ED780, ICU96)
“Delay in seeing doctors” (MHD30)
“Increase and high workload” (ED57, ICU96)
“Nursing staff are being reduced or lack of staff” (Online ED2, MHD47, ED69, ICU89)

Overall, nurses suggested several reasons that contribute to violence in their workplace, including social factors, hospital factors, environmental factors and high workloads in the wards.

5.8.3. **Personal factors**

The personal factors consist of “Nurses’ and doctors’ factors” and “Patients’ factors” as described below:

5.8.3.1. **Nurses’ and doctors’ factors**

Nurses suggested that both they and the doctors as individuals contribute to violence, due to their working extra hours, communicating ineffectively and feeling frustrated.

“Nursing & medical staff that suffer from fatigue (mainly due to shift work & overtime)” (Online ED2)
“Lack of sleep” (ICU96)
“Working too many extra hours and tired” (MHD11)
“Stress” (ICU89, ICU91)
“Poor communication of prescribed treatment and changes by doctors” (MHD36)
“Doctors contradicting nurse/ward policies” (MHD46)
“Inappropriate referrals to mental health” (MHD36)
“Nurses frustrated by unsafe staffing levels, nursing and medical skills and level of care providers” (ED61)
“Having to look after idiots” (ED64)
“Nursing staff made feel they are wrong for excluding an aggressive patient” (MHD3)
The individual factors and patient factors are suggested to increase workplace violence.

5.8.3.2. Patients’ factors

Patients are the main cause of violence in the workplace due diverse reasons, such as personality disorders, pain, fear, stress, psychosis, confusion and drug and alcohol abuse:

“Patients are unwell” (Online ED2, MHD47)

“Personality disorders” (Online ED2, Online MHD7, MHD9)

“Mental health disorders or illness” (Online ED3, Online MHD7, Online MHD10, MHD9, MHD17, MHD21, MHD39, MHD48 ED61, ED63) “resulting in delusions of persecution, and misinterpretation of actions.” (Online MHD10)

“Current condition (sepsis, hypoxic, encephalopathies, pain, fear, panic and stress, dementia or delirium)” (Online ED2, MHD5, MHD15, MHD20, ED58, ED61, ED67, ED74, ICU83, ICU86, ICU97, ICU98)

“Psychosis” (Online MHD6, MHD5, MHD30, MHD31, MHD37, MHD45, MHD54)

“Antisocial behaviours” (MHD17, MHD18, MHD21, MHD35, MHD37)

“Poor problem-solving” (MHD37)

“Confused patients” (MHD45 ED78, ICU94) “from either drugs or having been ventilated or disorientation” (ED78, ICU95, ICU97)

“Head injuries” (ICU83)

“Patients’ social issues or family issues” (Online ED2, ED74, ICU86)

“Poor access to personal space and care of belongings” (MHD37)

“Emotions (grief, anger) or aggressive personalities” (Online MHD6, MHD11, MHD15, MHD31, MHD37, MHD52)

“Carers/partners/family/significant others are concerned” (Online ED2)

“Impaired cognitive ability” (ED62)
“Drug abuse” (Online MHD6, Online MHD10, MHD5, MHD8, ED57, ED59, ED61, ED74, ICU91, ICU94, ICU97, ICU98)

“Alcohol abuse” (Online ED3, MHD8, ED59, ICU91, ICU97)

“Illlicit substances abuse” (Online ED3, Online MHD4, MHD9, MHD32, MHD45, ED61)
“Drug or Alcohol intoxication” (Online ED2, Online MHD6, MHD15, ED62, ED69, ED78, ICU84)

“Withdraw from drug” (Online MHD7, MHD7, ICU98)

“Misunderstanding or misinterpretation of communications” (MHD12, MHD18, MHD36, MHD49, MHD54, ED59)

“Scared visitors or patients facing the unknown” (ICU93)

“Expectation of patients to be seen immediately” (ED82)
“Patients’ expectations to be ‘now’” (ED68)
“Patients’ inability to accept the word ‘No’” (MHD49)
“Demanding patients” (MHD31)

“Noncompliance with treatment or treatment refusal” (Online ED3, Online MHD6, MHD20, MHD30)

“Patients unhappy regarding hospitalisation” (MHD7, MHD11, MHD41, MHD55)

“Socioeconomic status of consumers” (MHD54)
“Sense of entitlement” (Online MHD6, MHD39)

“Patients not getting their perceived needs” (Online MHD6, MHD33, ICU84)

“Patients experiencing a sense of frustration” (MHD13, MHD37, ICU87)

“Racism” (Online MHD6)
“Patients transferred from jail” (Online MHD7)
“Sometimes violence is planned or without reason” (MHD6, ED73)
“Bad behaviour” (ICU87)
“Poor impulse control” (MHD39, MHD40)
“Poor social skills or social isolation” (ICU83, ICU98)
Nurses suggested a large number of patients’ factors that contribute to workplace violence. These ranged from personality issues such as fear, grief and stress or mental disease to patients’ attitudes such as racism and sense of entitlement.

5.8.4. Horizontal factors

Nurses also mentioned causes of horizontal violence, which is due to staff burn out.

“Violence from other staff factors associated with burn out” (Online ED2, MHD52)

5.9. Solutions for workplace violence

5.9.1. Nurses’ suggestions of managing violence

Nurses provided many suggestions for managing, reducing or preventing workplace violence. These suggestions are based on the open questions: 16A and 16B in the survey: “What are the most important measures that would prevent and manage violence in your workplace?” These suggestions can be divided into six main potential solutions: (1) social, see section 5.9.1.1; (2) personal, see section 5.9.1.2; and (3) hospital, see section 5.9.1.3. These solutions included strategies that can be implemented in three stages: (A) General management strategies (B) During-incidence management (C) Post-violent incidence management (that the hospital can manage) (4) Environment of workplace, see section 5.6.4.4 (E) Workplace violence policy, see section 5.6.4.5 and (F) Workplace support, see section 5.6.4.6, as presented in Table 31. Each of these potential solutions is supported by evidence from the nurses.
### Table 31: Management factors of workplace violence

<table>
<thead>
<tr>
<th>Social General management strategies</th>
<th>During-incidence management</th>
<th>Post-incidence management</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Education of the society</td>
<td>(1) De-escalating</td>
<td>(1) Press charges against offenders</td>
</tr>
<tr>
<td>(2) Warning and awareness of the society</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Management of abuse substances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal (1) Improve communication</td>
<td>(2) Patient discharge</td>
<td>(2) Seclusion of patients</td>
</tr>
<tr>
<td>(2) Nurse attitudes</td>
<td>(3) Limiting access to the ward</td>
<td>(3) Restraints</td>
</tr>
<tr>
<td>(3) Nurse skills</td>
<td>(4) Communication with patients</td>
<td>(4) Sedating medication</td>
</tr>
<tr>
<td>Hospital (1) Patient admission</td>
<td>(5) Patient review</td>
<td>(5) Treatment of patients</td>
</tr>
<tr>
<td>(2) Patient discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Limiting access to the ward</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Communication with patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Patient review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) Care and treatment of patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7) Medication management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8) Education and training of staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9) Team work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment (1) Ward layout</td>
<td>(1) Workplace violence policy</td>
<td></td>
</tr>
<tr>
<td>(2) Working guidelines</td>
<td>(2) Act according to policy</td>
<td></td>
</tr>
<tr>
<td>(3) Modify ward rules</td>
<td>(3) Access to the policy</td>
<td></td>
</tr>
<tr>
<td>(4) Safe environment</td>
<td>(4) Knowledge about the policy</td>
<td></td>
</tr>
<tr>
<td>(5) Police officer present or access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) Security officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7) Workload</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8) Ward equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy (1) Workplace violence policy</td>
<td></td>
<td>(7) Enable reporting of workplace violence</td>
</tr>
</tbody>
</table>
5.9.1.1. Social potential solutions

Nurses advised on three strategies targeting the society for management of workplace violence: education, warning and awareness and management of abuse substances.

1) Education of the society:

“Education to public on zero tolerance” (MHD45)
“Society should continue to frown upon verbal or physical violence to hospital staff” (ICU83)

2) Warning and awareness of the society:

“Government warnings on television. Warning general public about new regulations regarding serious assault. Increase awareness” (ICU84)
“To inform public; reinforce the legal outcome with assault” (MHD45)
“People realising there are consequences and violence is not tolerated” (ED65)

3) Management of abuse substances:

“Better management of abusive substances in community of better respect and social awareness taught in families and community” (ICU83)

5.9.1.2. Personal potential solutions

Personal potential solutions include suggested ways that nurses should perform in order to manage workplace violence: improve communication, nurse attitudes and nurse skills.

1) Improve communication:

“Communication with staff” (MHD38)

2) Nurse attitudes:

“Be alert” (MHD11)
“Precautions” (MHD42)
“Punitive attitude or combative attitude” (MHD46)
“Altering people perception of professional care” (ED58)

3) Nurse skills:

Page 189
“Skill mix of nursing staff” (MHD33)

5.9.1.3. **Hospital potential solutions**

Hospital management of workplace violence included three main strategies that nurses suggested to manage, reduce or avoid violence in the wards. These strategies are: (A) General management strategies; (B) During-incident violence management; (C) Post-incident violence management.

**(A) General management strategies**

Nurses suggested many general management strategies, which include: patient admission, patient discharge, limiting access to the ward, communication with patients, patient review; team work, medication management, education and training of staff and treatment of patients.

1) Patient admission:

   “More rigorous admission criteria” (Online MHD8)
   “Better screening process for admission” (MHD8, MHD34, MHD35)
   “Intoxicated or drug-addled people should not be admitted onto the ward” (MHD10)
   “Drunk tank” so QPS and QAS have other option to take patients to safe place” (MHD10, ED78)

2) Patient discharge:

   “Patients are not kept longer than necessary” (MHD41)
   “Zero tolerance of violence unless they are genuinely psychotic. All others, can be discharged home or to the watch-house” (MHD32)
   “Violent clients should be charge and discharged ASAP” (MHD10)

3) Limiting access to the ward:

   “Patients or visitors have a general attitude that they have a right to be in the department. Do not allow people such in or out accesses” (ED80)
   “Remove visitors who are violent or abusive towards staff” (ICU88)

4) Communication with patients:

   “Effective communication” (MHD11, MHD20, MHD36 MHD42, MHD46, ICU89)
“Good communication between patients and nurses or doctors”
(MHD41, ICU90)  
“Treat patients with respect and non-judgemental attitude” (Online MHD1, MHD4 MHD50, ED58)

5) Patient review:

“Timely or regular review of patients by doctors and treatment”
(MHD20, MHD30, MHD36)  
“More frequent review of patients by medical officer” (online MHD1, online MHD8)  
“Reduce waiting time” (ED58)

6) Care and treatment of patients:

“Increase care quality” (ED58)  
“Effective Assessment & counselling for patients” (Online MHD6)  
“Effective holistic nursing care” (Online MHD6)  
“Treatment of patient in the first instance” (Online MHD6)  
“Early illness intervention” (ICU83, ICU90)  
“More rigorous treatment plans” (Online MHD8, ICU83)  
“Addressing patients as individuals always. Addressing the needs of family and friends” (ICU92)  
“Building therapeutic relationships with patients” (Online MHD1, MHD4)  
“Agreement with patient of other suitable options” (Online MHD1).  
“Including patients in treatment plans rather than deciding by doctors then nurses must enforce them” (MHD41)

7) Medication management:

“Optimisation of medication management” (online MHD1, online ED8, MHD1, MHD4 MHD6, MHD11, MHD39, MHD55)  
“Adequate PRN medications given faster with particular patients” (online MHD9, MHD30, MHD31, MHD41)  
“Effective use of medication in the right context” (online MHD6).  
“Adequate medication and treatment” (MHD35, ICU83)

8) Education and training of staff:

“Education staff on good communication” (ED58)  
“Professional development and further education” (Online MHD1).  
“Adequate and regular training in violence” (Online ED2, MHD20, MHD41)  
“More training scenarios and de-escalations and techniques hospital wide not just MH and coverage with what nurses can do to avoid violence” (MHD54)
“Appropriate de-escalation training” (MHD37).
“Appropriately trained mental health specific staff” (Online MHD7)
“Better trained younger nurses who can competently understand English” (MHD53)
“Better education for doctors to realise the importance of sufficient PRN for mental health patients” (MHD18)
“Promoting health of workplace” (ICU84)

9) Team work:
“Effective team work” (ED58, ICU89)
“Collaborative problem-solving” (MHD13)

(B) During-violent incident management

Potential solutions of during-violent incident management include de-escalating techniques, seclusion and restraint of patients, using sedating medication and conditional treatment.

1) De-escalating:
“De-escalating techniques” (MHD5, MHD11, MHD12, MHD31, MHD50, ED63)

2) Seclusion of patients:
“Seclusion” (MHD11 MHD55)
“Seclusion for short period if required” (Online MHD1)

3) Restraints:
“Effective use of restraints” (Online MHD6, MHD12, MHD15, ICU83)
“Use of mechanical restraint” (MHD1, ICU95)
“Use of chemical restraint” (MHD1, MHD40, MHD53 ICU95)
“Use force when necessary” (MHD53)
“Medical restraint if suitable follow-up by QPS (Queensland Police Service) for all assaultive acts against staff” (MHD30)

4) Sedating medication:
“More or sufficient sedating medication” (MHD8, MHD15, ICU91)
“Adequate sedation in emergency department (where it is safe to monitor) to reduce arousal before people arrive in the ward and become assaultive” (Online MHD10, MHD16)
“Utilisation of acute sedation guidelines before medical staff” (MHD2)
5) Conditional treatment of violent patients:

“Enforcement of no treatment if violent to staff” (ED63)

Nurses also advised on potential solutions for post-violent incident management.

(C) Post-violent incident management

The main two post-violent incident management strategies suggested by nurses were to press charges against offenders and have better access to debriefing and/or consulting services.

1) Press charges against offenders:

“Violent and aggressive client should be charged! Client who makes weapons (e.g. shivs, knives etc.) intend to harm people: charge them. People who use drugs on the wards: charge them. People who threaten to harm staff and family members: charge them!” (MHD10)

“Consequences for offenders—charging them criminally” (ED65)

“If nurses want to press charges for assault let them” (ED67)

2) Debriefing:

“Compulsory debriefing forums” (online ED7)

“Debriefing, better access to debriefing or counselling” (ICU84)

5.9.1.4. Environment of workplace

Nurses believe that by providing a better environment, it is possible to reduce the violence towards nurses. This includes providing larger area for patients, a safe environment for nurses and the presence of security in the ward.

1) Ward layout:

“Larger patient areas in wards” (online MHD8)

“More space regarding ward layout. Purpose built ward” (MHD46)

“Improved environment resources” (MHD37)

“Have nursing station (i.e. nurses to sit in safe zone)” (MHD16)

2) Working guidelines:

“Eliminate ambiguous work directions” (MHD37)

“Suitable strategies to address situations that arise quickly” (ICU90)

“Zero tolerance of drug-related aggression” (ED78)
“Adequate risk assessment” (MHD12)

3) Modify ward rules:
   “Not to ban cigarette smoking in MHD wards in January” (MHD55)
   “Increased opportunity for smokers” (Online MHD7)
   “Ability to let patients into open areas in secure environments” (Online MHD7)

4) Safe environment:
   “Ensure safe environment” (MHD4)
   “All measures in place for safe working environment” (ED66)
   “Make sure patients and other staff are safe” (MHD50)
   “Not exposing nurses to constant violence” (MHD53)

5) Police officer present or access:
   “Utilise of police if possible” (MHD34)
   “Police officer present in ED department” (ED57, ED75, ED79)
   “Police officer in department on weekends” (ED75)
   “Better access to QPS, direct line is not always answered” (ED79)

6) Security officer:
   “Higher presence of security in wards” (online MHD7, MHD34, MHD36)
   “Security Officers” (MHD12, ED57, ED63, ED68, ED80)
   “More security officers available to all areas of hospital full-time, not just ED” (ED78)
   “Security should be utilised to escort people from the hospital withdrawal of medical care” (MHD10)

7) Workload:
   “Adequate staffing” (MHD12, MHD39, ED78)
   “Reduce workloads” (online ED2, MHD5)
   “Increased staffing levels” (online MHD7, MHD15, MHD42)
   “Reduce and adequate nurse/patient ratios” (online ED2, ICU83)
   “Increasing nursing number which would decrease aggression from patients wait and feel of neglect” (ED76)
   “Decrease stress levels on staff by decreasing pressures on workload” (ICU91)
8) Ward equipment:

“Need Tasers” (online ED9)
“Proper shields / protective gear as used in ABM (=Aggressive behaviour Management) and other health facilities” (MHD3)
“Camera” (MHD21)
“Being able to videotape patients as police do” (ED57)

In addition to improving the environment, the nurses suggested acting according to the policy.

5.9.1.5. Workplace violence policy

Acting according to the policy, in addition to having clear policies and guidelines, improves policy access and knowledge; all which were found to be important in preventing violence at work.

1) Workplace violence policy:

“Clear policies and guidelines” (Online ED2, MHD37 and ICU89)
“Zero tolerance should be for verbal violence as well and consequences are enforced” (MHD40)
“Zero tolerance of violence unless they are genuinely psychotic. All others, can be discharged home or to the watch-house” (MHD32)

2) Act according to policy:

“Follow through with policies” (ED67)
“Absolute zero tolerance of violence” (Online ED7, ED58, MHD44, ICU92)
“Signs say violence will not be tolerated. But then it seems to be an expectation from management that it is tolerated” (Online ED3)
“Justice System accepting that mental illness is not an excuse for violence” (MHD33)
“Legal action of those in a capacity to make decision. Carrying out of action to those who assault” (ICU84)

3) Access to the policy:

“More guidelines accessible to be able to decline angry patients” (MHD15)

4) Knowledge about the policy:

“Knowing of policies and procedures of the ward” (MHD11)
5.9.1.6. **Workplace support**

By increasing support for nurses from managers, doctors, the hospital and other services, nurses believe it would improve their ability to better manage violence, as well as increase their reporting of violence.

1) Unsupported nurses:

“Staff are unable to seek support form family as the issues they face would frighten them (weapon, threats to family etc.) and confidentiality. Staff are unable to communicate to the media due to code of practice and confidentiality. Staff are verbally abused and accused of horrid (= horrible) crimes. (Rape, paedophilia etc. on a daily basis) and are powerless to act” (MHD32)

2) Support from doctors:

“Doctors to assist in medication” (MHD34)
“Doctors listening to nurses opinions” (MHD53)
“Doctors understanding” (MHD53)
“If doctors listened to nurses and provided adequate medical management of patients and placed in correct ward for better management” (MHD54)
“Support from doctors regarding use of chemical and mechanical restraints” (ICU97)

3) Support from managers:

“Managers support staff to utilise polices and met compromise patients' staff safety” (MHD37)
“Improved recognition by managers” (MHD37)

4) Support from the hospital:

“Support from hospital management” (Online ED2, ICU89, ICU92)
“Better support” (ED80)
“More support from hospital management in the reduction of violence within the workplace” (online ED3, online ED7)
“Backing nursing staff on decisions to remove people from the department if behaving in a violent or threatening manner. Feel there is more support on the floor for persons exhibiting violent behaviour than for QLD health staff” (Online ED3)

5) Support from police:

“Police support” (ED58)
6) Autonomy of nurses:

“Letting the nurses more control” (MHD53)

7) Enable reporting of workplace violence:

“Being able to feel empowered and supported about reporting at work and to the police” (MHD40)
“Better reporting of incidents to accurately assess how often it occurs” (ED69)

Nurses have advised on who they believe should provide them with support.

5.9.2. Required to provide support

Nurses suggested several options for possible hospital or outside support following a violent incidence. These suggestions are based on Question 14A of the survey: “Others who should provide nurses support, please describe.”

5.9.2.1. Support within the hospital

The support was divided into counselling and debriefing support services, as well as staff and other services support.

(1) Counselling and debriefing support services:

“Social workers within the department” (Online ED2)
“Professional debriefing after incidents” (MHD8)
“Counsellors” (MHD12, ED61)
“Legal advice and psychologist” (MHD34)

However, nurses mentioned current problems with counselling services: “Improved access to counselling and debriefing currently all support services are outsourced and off-campus and a culture that supports debriefing after event” (ICU84).

(2) Support from staff:

“NUM should meet with injured staff member and show support” (online MHD9)
“Higher management” (ICU89)
“Clinical directors” (MHD10)
“Non-clinical staff” (MHD11)
“Support from doctors” (ICU97, MHD11)
(3) Support from other services:

“Security in cases of violence physically” (MHD41)
“Workplace health and safety” (ED61)

5.9.2.2. Support from outside of the hospital

Nurses advised that support is needed also from variety of bodies outside of the hospital, including:

“Provision of external supports” (MHD37)
“Private Counsellors” (ED80)
“Union for legal support” (ED61)
“QPS” (MHD10, MHD12 and MHD30)
“Government and media” (58ED)
“Patient’s family” (ICU97)
“Society should continue to frown upon verbal or physical violence to hospital staff” (ICU83)

Summary

In this chapter the findings of the quantitative survey were presented and organised into nine sections. The numerical quantitative data were presented first, followed by the questionnaire open-ended qualitative data. The first section presented the descriptive demographic profile of 98 nurses who participated in the survey. The second section reflected the assault injuries and the high occurrence of verbal and physical workplace violence that nurses experienced in their wards, both throughout their nursing careers and in the last 12 months. In the third section, the presented evidence regarding the effects of a specific violent incident on nurses was measured based on personal, professional and mental aspects. The effects and management of verbal and physical violence in the workplace were then discussed in the fourth section. This included the management of specific incidents by nurses, as well as general workplace violence management. Management implementations were presented in the fifth section.
The sixth section provided evidence regarding support during and after incidents of verbal and physical violence, and the nurses’ opinions of who should provide them with support was then presented. The seventh section presented the results of the statistical testing. The test results proved that there was no statistical difference in nurses’ perceptions towards workplace violence when their demographic variables were tested: age, gender, background, level of education, work experience, working status and department.

The qualitative section of the questionnaire presented the open-ended survey questions and included the last two sections: factors and solutions for workplace violence. The nurses suggested several factors that contribute to workplace violence, including: social, hospital personal and horizontal factors. The solutions for workplace violence were fully canvassed in the last section and included nurses’ suggestions for preventing, reducing and managing workplace violence: personal, hospital, environmental, policy and support.

Chapter 6 discusses the research questions in relation to the significant findings of the qualitative focus groups interviews, results of the quantitative survey and relevant literature.
CHAPTER 6: DISCUSSION

This chapter has five sections based on the Occupational Health Framework (Levin et al., 1998). The first section discusses the findings regarding assault injuries, the second section discusses the effect of workplace violence, the third section presents the factors affecting violence and nurses’ suggestion for preventing violence in their workplace, the fourth section discusses the support provided to nursing staff during and after a violent incident and the final section presents the differences in perceptions of workplace violence. The study was gathering data at one regional hospital in one year, as this scope could be achieved within the framework of a doctoral program of study. The following section relates the findings from the study to these themes.

6.1. Research findings and conceptual framework

The Occupational Health Framework by Levin et al. (1998) was used to explore contributing factors, consequences and solutions to ED nurse assault in the United States. This framework was useful to better understand workplace violence by exploring the factors that contribute to both the assault injuries and to seek possible solutions. Levin’s framework assisted this study in applying the research findings to the conceptual framework. The conceptual framework consists of four main themes: factors causing workplace violence, assault injuries, the effect of workplace violence and possible solutions. The findings from the three focus groups were supported by this theoretical framework. Nurses described the assault injuries from patients and visitors in their workplace and then described the effects of workplace violence on them, and on the witnesses of patient assaults. Nurses also described horizontal violence. The nurses discussed a variety of factors that contribute to incidents of verbal and physical violence in their workplace. These factors included social, hospital and personal factors (including patient and nurse factors). During the focus group interviews, the nurses made a lot of suggestions for managing or reducing violence in their workplace, including general management of violence and management practices during and post-violent incidents.
6.1.1. Factors

There are several factors that were found to contribute to assault injuries, effects of workplace violence and solutions to workplace violence, see

Figure 1 in section 2.6. The factors include social, hospital and personal factors. Social factors that contribute to vertical violence within the hospital include the social changes in which violence is more expected or accepted, and the overall disappointment with the Mental Health System in Australia.

Hospital factors that contribute to vertical violence within the hospital consist of hospital management factors and hospital environment factors. Hospital management factors relate to the increase in nurse workloads, reduction in the number of experienced staff, long waiting lists for, and delays in, treatment, medical errors and conflicting information given by different staff. Hospital environment factors include several hospital environments that contribute to violence—stressful and confining environments, as well as dynamic, frustrating, negative and unsafe environments.

The second factor that contributes to workplace violence is personal factors. Personal factors consist of nurses’ factors and patients’ factors. Nurses’ factors related to the nurses’ attitudes towards patients and their ability to manage heavy workloads. Patients’ factors related to personality issues and patient attitudes, including patients who lack of understanding of the healthcare system, substance-dependent patients, mentally disturbed and confused patients and patients who are hospitalised against their will. In addition, there are two factors that influence horizontal violence—teams who are not interactive and staff who are very busy or stressed. These three factors contributed to both assault injuries and effects of workplace violence.

6.1.2. Assault injuries

Assault injuries refers to the occurrence rate of vertical violence—incidents of verbal and physical violence that the nurses experienced or witnessed from both patients and visitors. The patients were mainly physically and verbally violent while
visitors were mainly verbally violent. The location of workplace violence and the increases in violence are also discussed. Assault injuries also refer to horizontal violence, which relates to the occurrence of verbal and physical violence from other staff, such as nurses, doctors and hospital staff.

6.1.3. Effects of workplace violence

Effects of workplace violence relate to the effect of violence on nurses’ personal lives and their professional ability to provide care and services for patients. The effects of workplace violence consist of the emotional and physical impact of violence on nurses, impacts on their personal life, job dissatisfaction, reduced work productivity and professional dilemmas. Workplace violence causes nurses to react in various ways, such as feeling stressed, unsafe, fearful, intolerant, desensitised, cynical and hypervigilant. Workplace violence also had an impact on nurses’ interactions with patients and visitors, on less-experienced nurses and on nurses’ decisions to remain in their profession.

6.1.4. Solutions for workplace violence

Solutions for workplace violence are taken from the nurses’ suggestions regarding management and prevention of violence in their departments. The nurses suggest several solutions to manage violence, including general management of workplace violence and management of violence during and post incidence. Management of workplace violence refers to the workplace policy, support and strategies of the hospital. Workplace policy relates to increasing nurses’ knowledge about workplace policy and the implementation of a workplace violence policy. The support refers to the need to increase hospital support by utilising resources for nurses, providing hospital support services and increasing support from co-workers and managers. The hospital management strategies involve three components: general management and during and post-management of violent incidents.
6.1.4.1. General management strategies

General management strategies refer to the four levels of management within society and the hospital, and the nurses’ and patients’ levels. The general management within society includes education of the community and better support for the mental health patients. Hospital general management relates to implementing policies, charging people with assault, communicating more effectively, educating and training nurses, increasing security, providing a waiting-time screen, excluding aggressive families and visitors and shortening the overall waiting time. The nurses’ level of general management includes allocating staff, calming patients by contacting their families, taking responsibility of and caring for patients, explaining the situation to patients, following through on promises, being consistent according to the ward rules, acting assertively, increasing awareness, de-escalating violence and improving communication among staff. There is also holding patients and visitors responsible for their behaviour.

6.1.4.2. During-incident management

Management of violence during an incident refers to the hospital and nurses’ level of managing violence during the event. At the hospital level, there is seclusion of patients and use of medication. At the nurses’ level, there is changing staff during the shift, protecting oneself first, using medication, asking for a break or stopping work during the shift.

6.1.4.3. Post-incident management

Post-incident management refers to hospital and nurses’ level of management after the incident. The hospital level consists of pressing charges and contacting the police, providing counselling services for staff, enabling debriefing after the incident, calling the police, enabling nurses to report on the violent incident and providing support and caring for assaulted staff. The nurses’ level relates to personally complaining about the offenders and reporting the violent incident.
Nurses cope with verbal and physical violence in different ways. According to Celik et al. (2007, p. 362) findings: “Among the coping methods with verbal and physical abuse, the choice of ‘do nothing’ was found to be a method the verbally abused nurses used more (70.5%) while ‘reporting the abusive behaviour and person to a manager (50.2%)’ was the more frequently used coping method by the nurses physically abused.”

Nurses mentioned a large variety of reasons (see chapter 4.) that cause violence in their hospital, and also offered reasons for the increasing hospital violence levels in comparison to the past. By addressing these reasons and following the nurses’ suggestions (mentioned in chapter 4), there is the possibility to reduce workplace violence towards nurses. In order to reduce violence and to have a better workplace environment, the hospital needs to deal with horizontal violence from staff towards nurses seriously if it intends to eliminate it. Simultaneously with addressing horizontal violence, the hospital should prevent vertical violence by following the nurses’ suggestions, improving hospital support services for empowering nurses, improving management’s dealing with violent events and increasing patient and visitor awareness of hospital workplace violence policies—and the consequences of violent behaviour.

The nurses also mentioned needing support from their departmental hospital managers to deal with a violent episode. It is important that the hospital provides support for nurses during the violent episode, as well provides nurses with education sessions and debriefing, allowing them to discuss their thoughts and feelings, the overall impact and the time needed to recover from the assault.

Nurses would then be able to understand that they are not alone in this situation and that their workplace is caring for their wellbeing, as well as providing them with a supportive workplace, through: implementing policy, improving management strategies to prevent violence, empowering nurses through education courses and improving hospital support services and the support from other staff. By implementing the nurses’ suggestions, there is the potential to improve the nurses’ abilities to care for patients and allow them to feel safer in their workplace. Nurses will be able to provide better caring for patients, and nurse workplace retention will increase. This will have
positive consequences for the industry; reduce the cost of compensation, decrease absenteeism and increase work productivity.

6.2. Assault injuries

The severity of violence reported in this study included nurses being verbally or physically injured by both patients and visitors. Verbal violence included intimidating nurses, swearing and threatening their families. The most severe verbal abuse reported was being threatened with a knife or with being stabbed with a pair of scissors. Physical violence was varied and included being pushed, punched and having a shoe tossed at the head.

Nurses also witnessed very high levels of violence towards other nurses. In the previous 12 months, all the participants had witnessed verbal violence towards other staff and most also witnessed physical violence towards other nurses.

The very high frequency of workplace violence found in this study is comparable with findings in studies overseas, such as in Texas, Iran and Turkey (Anderson & Parish, 2003; Esmaeilpour et al., 2011; Pinar & Ucmak, 2011). However, other international studies found much lower rates of violence, with about two-thirds of nurses experiencing verbal violence and one-third of nurses experiencing physical violence (Celik et al., 2007; Hahn et al., 2013; Nolan et al., 2001; Spector et al., 2014). The rates of violence found in this study are higher than rates reported in previous national and state studies conducted in Australia (Farrell et al., 2006; Hodge & Marshall, 2007; Roche et al., 2010) and Queensland (Crilly et al., 2004; Hegney et al., 2006; Hegney et al., 2003; Hegney et al., 2010). For example, 53.4% (n=309) of nurses in a public sector Queensland hospital experienced violence in the previous three months (Hegney et al., 2010) and 70% (n=50) of nurses reported experiencing violence in the previous five months (Crilly et al., 2004).

The differences between this study’s findings and other studies’ findings could be explained in several ways. First, different definitions of verbal and physical violence might explain the differences between the findings in the different studies (Alexy & Hutchins, 2006). For example, Luck et al. (2006b) argued that it is difficult to compare studies, statistical data, types and level of violence due to lack of a consistent
definition of violence, which also makes it difficult to address this problem. For example, in a study conducted by O'Connell et al. (2000) the definition of aggressive behaviours included intimidation, verbal and physical aggression and that “there were no studies identified in the literature that specifically included ‘intimidation’ as an aggressive behaviour” (p.608). Other studies did not include verbal or physical violence in the survey instrument, but used the definitions of “threat” and “assault” (Privitera, Weisman, Cerulli, Tu, & Groman, 2005). In another study, “physical violence” was defined, but not “verbal violence” and other definitions were used such as “threat of violence” and “emotional abuse” (Roche et al., 2010). Other studies used the term “verbal violence” and “both verbal and physical” (Crilly et al., 2004) but did not check “physical violence” incidences separately from “verbal violence”.

Second, differing timeframes in the questions, varying from the previous 3, 5 or 12 months could also explain the differences between this study and other studies findings. For example, a study conducted by Hegney et al. (2010) examined the experience of workplace violence within the last 3 months, while Crilly et al. (2004) examined over a period of 5 months. Other studies revealed the exposure to violent incidents in the last 12 months (AbuAlRub et al., 2007; Hahn et al., 2012; Talas et al., 2011).

Third, differing locations of the hospitals nationally and internationally (Spector et al., 2014) could justify the differences between this study and other studies findings. Fourth, differences between the environmental settings and individual differences between the nurses (Chen et al., 2013) might also give explanation to these differences. As well as the higher rates in the most recent study may also be partially supported by increasing rates of violence over time.

Some of the differences may be explained by the different hospital departments where the research was conducted. For example, a survey of 1400 ED nurses in the United States (Lee, 2001) revealed that 97% of the participants experienced verbal violence from patients and 87% experienced physical violence more than five times per year. Another large study of 2,495 medical professionals showed that staff who work in the hotspot departments, such as emergency and intensive care, experienced the highest levels of workplace violence in the previous 12 months than other hospital wards: ED 73.9% and ICU 58.8% (Hahn et al., 2012). However, Chen et al. (2013)
reported that frequency of violence in outpatient units and emergency rooms was 2.25 times higher than in ICUs. Itzhaki et al. (2015) found that 88.1% of the nurses in one of the mental health centres in Israel reported verbal incidents and 58.4% of the participants reported physical incidents in the previous 12 months. The variations between results in different hospital departments in the types of perpetrator found in this study are explored in the following section.

### 6.2.1. Variances in workplace violence

The variances between departments and regions of countries are discussed in the following sections. Nurses working in emergency, intensive care and mental health departments report differing frequency and severity of workplace violence.

#### 6.2.1.1. Variances between departments

There were no differences between wards in this study based on the ANOVA test because of the ceiling effect. Every nurse (N=98) in the survey who was working in mental health or intensive care reported experiencing verbal violence in the previous 12 months. Almost all the ED nurses in the survey (96.1%) reported experiencing verbal violence in the previous 12 months. The frequency of physical violence rates ranged from 66.6% to 88.8% of nurses in the three departments in the previous 12 months. The highest number of nurses subjected to violence was staff in the MHD, where 88.8% of nurses experienced physical violence in the previous 12 months. The ED nurses were also exposed to physical violence, with 80% reporting an incident in the previous year. The intensive care nurses reported experience of 66.6% physical violence in the previous 12 months. The rates of violence in this study are higher than those found in Lau, Magarey, and McCutcheon (2004), a study of psychiatric and EDs where the incidence of nurses' exposure to violence ranged from 60% to 90%. Schnieden and Marren-Bell (1995) suggested workplace pressure as the main factor associated with the rates of violence in ‘high risk’ units, such as intensive care, emergency and mental health.
Given the comments of the focus group nurses that verbal and physical violence occurs on a daily basis, it is not surprising that every nurse in the survey group reported verbal abuse and almost all reported experiencing physical violence in the previous year. The high level of workplace violence that perceived by the participants can be related to response bias, where those who participate have specifically interest in the topic.

The perpetrators of violence were mostly patients, followed by visitors (including relatives of patients). Patients were more verbally and physically violent towards nurses than visitors. Visitors were more verbally and less physically violent towards nurses, as reflected in the interviews and survey findings.

The findings of the survey show the very high extent of violence the nurses experienced. Verbally violent incidents were perpetrated mostly by patients (98%) and visitors (91%), and incidents of physical violence were perpetrated mostly by patients (98%) and visitors (32%) in the previous 12 months. These findings are disturbing because nurses are beside the patient’s bed and are caring for their patients. In addition, it could be disturbing to experience violence from patients more than visitors—because visitors do not stay permanently in the wards, and it is possible to tell the aggressive visitors to leave the ward if they are violent towards the staff. However, patients are in the wards during their hospitalisation and nurses do not have the authority to ask aggressive patients to leave the ward.

These findings are consistent with previous studies conducted in Australia that found patients are the primary source of violence towards nurses and are more likely to be physically violent, followed by visitors, who are mainly verbally violent (Farrell et al., 2006; Lyneham, 2000; O’Connell et al., 2000; Roche et al., 2010). Hegney et al. (2006) found patients committed the highest amount of violence (74.8%) in public hospitals compared to visitors or relatives (44.9%) in 2004.

The findings of this study had a ceiling effect. Given the high rates of workplace violence, the time scales being used for the questionnaire may have needed to be shortened substantially to gather more accurate data, for example, by gathering data on the “previous month” or even the “previous week” to capture the true frequency and severity of the problem. An alternative data-gathering method may need to be
tralled, such as asking nurses to complete a daily diary of verbal and physical violence from patients and visitors, to more accurately qualify and quantify the problem. Alternative data-gathering methods may also be required to qualify and quantify the severity of the violent incidents because of the reporting by participants of life-endangering situations. Monitoring of ‘high risk’ units such as intensive care, mental health and emergency with closed-circuit television cameras may be warranted to gather more accurate data. Installation of security cameras may also be warranted to enable security staff to respond in a timely manner to ensure the safety of hospital staff during violent incidents. The variations can be seen not just between departments, but also among regions of countries.

6.2.1.2. Variances between regions

The frequency and severity of workplace violence found in this study are consistent with previous studies conducted in English speaking countries. In these countries, physical violence was mainly perpetrated by patients rather than hospital visitors of family and friends. In countries in the Middle East, physical violence was perpetrated more often by relatives visiting patients than by the patients themselves (Gimeno et al., 2012; Hahn et al., 2012; Magnavita & Heponiemi, 2011; McKenna et al., 2004; Ryan & Maguire, 2006; Spector et al., 2014). Spector et al. (2014) suggested that the different rates of violence and the variation in perpetrators observed in European and Middle Eastern countries might be due to cultural values, because European cultures are more individualistic and Middle Eastern cultures are more collectivist in nature. Spector found that “individualists might tend to navigate their healthcare by themselves or with the help of a small number of nuclear family members” whereas “collectivists are more likely to receive help from a broader network of extended family members and friends who might accompany the ill person as they receive treatment and thus have more contact with nurses that provides opportunities for violence” (Spector et al., 2014).

This explanation of cultural differences might contribute to the variation in this research results. Patients in English speaking cultures appear to be more likely to have independent agency in seeking treatment and appropriate care for themselves. If they
have a desperate need they could, therefore, be more likely to lash out with verbal and physical violence towards nursing staff. In Middle Eastern countries the culture is more strongly family-oriented and the relatives take a more hands-on role in a patient’s hospital care. If the family becomes upset about treatment of a patient, they may be more likely to become aggressive towards staff, advocating for the patient. In addition, patients in Middle Eastern cultures may feel less need to use verbal abuse or physical violence to fight for their needs because their family and friends around them advocate for their needs. Further research would be necessary to validate the differences observed.

### 6.2.2. Time of occurrence

The highest proportions of nurses (45%) believed most of the violence occurred during the evening shift. A lower proportion of nurses (20%) believed violence towards nurses occurred during all shift times. Relatively few nurses (8%) believed that most of the violence towards nurses occurs during the night shift and even fewer (4%) believe most of the violence towards nurses occurs during the morning shift. These findings concur with the Crilly et al. (2004) study of 71 ED nurses in Queensland. Crilly et al. (2004) found that 37% of the violence occurred during the evening shift compared with only 20% during the day shift. Pich et al. (2011) also found that the afternoon shift was the peak time for workplace violence, particularly on weekends and during winter. This study’s findings that violence occurs at high rates during all shifts may indicate an increase in violence against nurses overall. This will be discussed in the following section.

### 6.2.3. Increase of workplace violence

The very high levels of workplace violence reported in this study may be explained by escalating frequency and severity of violence towards nurses. Severity of violence refer to verbal versus physical violence, degree of violence and the increase in level of violence experienced over the past five years of time within the same population as was perceived by the nurses who participated in the focus groups and this survey. The survey findings suggest that nurses’ perception of workplace violence had
increased over the past five years and that the change was worrying to them. The survey findings validate the focus group findings that violence from patients and visitors is escalating over time. These findings are also validated by studies that all found increases in the incidence and severity (as physical versus verbal) of violence against nurses (Farrell et al., 2006; Hodge & Marshall, 2007; Wilkes et al., 2010). Crilly et al. (2004) also reported high and increasing levels of violence in EDs (53% verbal and 26% both verbal and physical violence) in his Queensland study.

Hegney et al. (2006) also found increasing violence, particularly in the public sector. Hegney’s findings showed a significant increase in the proportion of reported incidents involving patients or visitors between 2001 and 2004. In 2001, 63% of nurses reported being subjected to violence from patients, compared with 33.8% from visitors. In 2004, these rates had risen to 74.8% of nurses reporting being subjected to violence from patients, compared with 44.9% from visitors. However, an increase in reporting may not equate to an increase in incidence as it is likely that there are multiple factors that could be related to increased reporting, such as changes in policies that emphasise reporting violence, or as Hegney et al. (2006) stated: “an increase in actual workplace violence, or awareness of what workplace violence is, cannot conclusively be stated” (p.230).

The nurses who participated in this study have indicated increased incidence together with underreporting. The perception of the nurses who participated in this study provided several reasons for these increases in violent incidences over a period of time within the same population which include changes in the community for example, with people feeling entitled to be more demanding; people being more questioning of authority; people feeling angrier and more stressed; nurses being more accepting of bad behaviour; people engaging in more high-risk behaviours; more mental health patients in the hospital’s ward and greater drug and alcohol use within the community.

Increases in violent incidences over a period of time within the same population was perceived by the participated nurses due to increasing workloads for nurses. Nurses said that the increasing workload in their wards impacted on violence because shifts were busier and staff had less time with each patient. This means patients became
more aggressive and frustrated because nurses had less time to address their needs. These findings are in agreement with the qualitative findings in Hegney et al. (2006) that “some nurses noting that abuse from relatives was linked to the nurse’s inability to provide the expected level of care to a patient because of workload” (p.228).

Another explanation for the increases in violence over time that was perceived by the participated nurses was as a result that nurses not being trained for mental health nursing. All of these mentioned reasons may contribute to a greater or lesser extent in the overall increasing frequency and severity of violence reported by the nurses in this study. However, increasing workloads are also affecting nurses as they become more exhausted, impatient and burned-out—because they are under pressure from having less time to care for patients and not enough time to complete their work. Both factors contribute to the increase in violence directed towards them. In addition, nurses were not confident in the way workload issues were addressed by hospital management.

Nurses said that they were seeing more mental health patients in their departments. This could be an additional factor that contributes to increasing rates of violence, because general nurses may not be trained in caring for mental health patients, who, for example, may have overdosed on antidepressants, or who are involuntary patients. The Kynoch et al. (2011) findings are similar. Their study concluded that “unlike specially trained psychiatric nurses, registered nurses in acute care settings are often expected to care for these patients with little knowledge and skill regarding appropriate and effective techniques for dealing with aggressive behaviours.”

Nurse acceptance that high frequency and severity of violence is “part of the job” mitigates both nurses’ and hospital management’s ability to adequately address the problem. Luck et al. (2006b) argued that the majority of nurses in Australia are female, and that this gender is one variable that increases the risk of violence towards nurses, influencing the perception that violence is “part of the job”. Violence against nurses could only be addressed if the attitude of acceptance of violence was changed (Chapman & Styles, 2006). However, the underreporting of violence means hospital managers are not aware of the severity or extent of the problem, and may not be making it a priority to find a solution. The underreporting of violence is presented in the next section.
6.2.4. Underreporting of violence

Nurses in this study were found to only report the most extreme instances of verbal and physical violence, despite being instructed by management to report all instances. Several other studies including Lyneham (2000), Pinar (2011) and Chen (2013) have all found underreporting of violent incidents. Underreporting is becoming more common. Lyneham (2000) found 70% of nurses in an ED chose not to report violence. Pinar and Ucma (2011) discovered that approximately 80% of nurses did not report the incidences of violence they experienced. One of the most recent studies, by Chen et al. (2013) found 90% of participants who encountered workplace violence said they would not report it.

There are several reasons for not reporting violence incidences which include firstly, the perception of nurses that 'nothing will be done' if a report is made. Secondly, nurses mentioned that they do not have the ability to report on an incident due to lack of time, heavy workloads, a long reporting process and unfriendly reporting procedures that require justification. Thirdly, some nurses did not know how to complete an incident report. In addition, nurses who decided to report were concerned they would be accused of causing the situation and be further victimised.

Previous studies have found a similar range of reasons for nurses to underreport incidents of violence. Chen et al. (2013) highlighted some reasons for not reporting violent incidents including: “no benefits were gained from reporting incidents;” “they didn’t want to avoid their job responsibilities” and “there was insufficient time to complete a report”. Hodge and Marshall (2007) also found similar reasons were given for underreporting, such as the reporting process took time and effort, the nurses’ views that violence is to be expected, the perception of performance failure and increased tolerance for minor incidents. Pinar and Ucma (2011) mentioned additional factors, such as that there was “no noticeable follow-up in place for reports, as well as nurses had a fear of losing their jobs, fear of being blamed by administrators and fear of legal procedures that would follow.” Other studies have also found a lack of reports being
made to hospital managers (Ferns, 2002; Shoghi et al., 2008; Talas et al., 2011). Violence towards nurses from colleagues (horizontal violence) is also increasing, and is also underreported. The next section addresses horizontal violence against nurses.

6.2.5. Horizontal violence

Horizontal violence was out of the scope of this study as the aim was to explore vertical violence towards nurses. Nevertheless, participants repeatedly raised this issue in the focus groups.

Therefore, I decided to ask further questions about horizontal violence in the survey, based on the interview findings. The horizontal violence survey findings indicated relatively high levels of verbal abuse of nurses by doctors (45%), other nurses (55%) and other hospital staff (34%) in the previous 12 months. Reports of physical violence were very low with only 4% of nurses reporting physical violence from another nurse and 1% of nurses experiencing physical violence from other hospital staff members. None of the nurses reported experiencing physical violence from a doctor. It is unclear at this stage whether there is any relationship between horizontal violence and vertical violence. However, the addition of horizontal violence into a workplace with an already high frequency and severity of violence from patients and visitors is a concerning development.

Other studies have found lower levels of horizontal violence compared with the present study. Farrell’s findings of horizontal violence, for example, were lower but still substantial. The Farrell et al. (2006) study indicated that verbal violence perpetrated by nursing colleagues was reported by 28.7% of nurses and verbal violence by doctors was reported by 27.1% of nurses. Rates of physical violence were very low, with physical violence committed by nurses reported by 3.6% of nurses and physical violence by medical doctors reported by 3.1% of nurses. The Granstra (2015) study found that violence between hospital staff is a growing problem with more than 50% of nurses experiencing horizontal violence.

The negative effects of horizontal violence in the healthcare system could be wide ranging. For example, violence between staff may have the following effects: reduced ability of staff to work as a team; compromised communication between
nurses and compromised patient care. A recent study by Purpora and Blegen (2015) found that horizontal violence was higher among nurses with lower job satisfaction and less supportive peer relationships.

**6.2.6. Nurse-initiated violence**

An unintended finding of this study was the incidence of verbal and physical violence by nurses towards patients. More than one-quarter (26%) of nurses who participated in the survey indicated that nurses verbally abused patients or visitors. Physical violence was relatively rare, with 5% of nurses reporting that they had observed physical violence by nurses towards patients or visitors. Violence by nurses towards patients violates the nurse professional standards and the therapeutic relationship between nurses and patients. It is not possible to determine whether the verbal and physical violence towards patients and visitors occurs as a result of the high level of violence towards nurses from patients and visitors. It is reasonable for hospital management to eliminate or at least to minimise verbal and physical violence towards their staff from patients and visitors. In addition, it is reasonable to expect that hospital management would require nurses and other hospital workers to respect each other, avert horizontal violence and inhibit vertical violence, as mentioned in the Australian Nursing and Midwifery Council (NAMC) as in the Code of Ethics for Nurses (2008) that “nurses value respect and kindness for self and others” and “nurses value a culture of safety in nursing and health care.” Section 6.3 discusses the effects of vertical and horizontal violence on nurses, including the personal and professional impacts.
Chapter 6: Discussion

6.3. **Effects of workplace violence**

The findings of this study reveal that workplace violence impacts on nurses, affects witnesses of violence and affects nurses’ abilities to interact with patients and visitors. This section discusses the findings regarding the first research question: “*How do nurses who work at a regional public hospital perceive that violence in the workplace impacts on nurses including their ability to interact with patients and visitors?*”

The impacts are categorised into two main aspects: firstly, personal, including mental, impacts and secondly, professional impacts. The professional impacts include two features: decision to resign and interaction with patients and visitors as was presented in the following sections.

6.3.1. **Personal impacts**

Personal impacts are those which impinge on the nurses’ private lives, including their mental wellbeing. Mental wellbeing extends to their relationships with partners, feelings of fear or threat, stress, exhaustion and hypervigilance, even when nurses have left the work environment. All of these impacts were reported by nurses who participated in the study. They have also been reported in the literature (Henderson, 2003; Hutchinson et al., 2013; Pich et al., 2011). The workplace violence data in the current study are not detailed enough to determine the cost to nurses or the healthcare system, for example in sick days, stress leave, injury or resignations. However, the data are strong enough to indicate that further research is needed to determine the emotional cost to nurses, and the overall financial cost to nurses, hospitals and the healthcare systems in which they work. Quantifying the direct and indirect cost of workplace violence may provide added leverage to draw attention to the problem, and to provide a business case for hospital management and governments to take action to reduce violence against nurses in the workplace.

Some nurses in my study reported psychological changes as a result of the impact of workplace violence, such as becoming cynical, intolerant, desensitised and tough-skinned. Findings of the study revealed that both verbal and physical violence had high impacts on nurses’ personal lives. Physical violence had slightly more impact...
than verbal violence (Table 19 and Table 20). Significantly, most nurses reported experiencing emotional symptoms that can be associated with post-traumatic stress disorder (PTSD), such as repetition of disturbing memories or fears of attack, as well as repeated thinking or speaking about an attack. These findings are supported by a study conducted by Luce, Firth-Cozens, Midgley, and Burges (2002) who found PTSD in health service staff, and Grenyer et al. (2004) that found a correlation between cumulative emotional effects and frequent exposure to violence. Indeed, participants in the focus groups experienced verbal and physical violence on a daily basis. The evidence indicates that workplace violence has profound impacts on the personal lives of nurses. Inevitably these in turn affect nurses’ professional abilities and their decisions to remain in their nursing careers, as discussed in the next section. Direct and indirect costs of workplace violence need to be quantified so that a business case can be made for hospital management to address the issue effectively.

6.3.2. Professional impacts

Nurses who are subjected to unacceptable levels of workplace violence inevitably are less able to provide optimal and effective care to patients. The findings of this study demonstrate that workplace violence increased the participated nurses’ risk of medical errors, led to the participated nurses taking extra sick leave and worsened their relationships with other staff. In addition, nurses’ productivity levels were reduced and their job motivation and satisfaction fell. These findings are in agreement with previous studies (Farrell et al., 2006; Gacki-Smith et al., 2009; Henderson, 2003; Hodge & Marshall, 2007; Hutchinson et al., 2013; Jackson et al., 2002; Jones & Lyneham, 2001). Given the research findings of repeated studies indicating the increased medical risk associated with workplace violence, timely action is required by hospital management to address the issue. If the issue is not addressed, continuing high levels of workplace violence will have negative impacts on the overall healthcare system.

Impacts on the personal and professional lives of nurses are occurring despite reasonable levels of support for nurses after violent incidents from their colleagues and supervisors (see Table 23). Friends and family are also a source of support following
incidents of verbal or physical violence, (see Table 25 and Table 25). However, participants from the focus groups reported that they tried not to involve their family and friends in talking about the violence they experience at work because of a desire to “protect them”.

Although nurses say they are supported by their line managers and colleagues during and following incidents of verbal and physical violence, nurses say they lack support from upper hospital management (see Table 25 and Table 25). The survey results validated the focus group findings in that they did not feel they were supported by their hospital. The focus group and survey findings in this study are similar to the findings in O’Connell et al. (2000) who reported that 77% of respondents stated that their colleagues were the most supportive, followed by family members and friends.

Given the findings, further research is needed to quantify the association between levels of workplace violence and rates of medical error. Findings relating to medical errors would provide a strong argument for hospital management to take action to reduce workplace violence if a causative link is shown between workplace violence and rates of medical errors.

6.3.2.1. Decision to resign from a job

In some cases, workplace violence leads nurses to consider resigning from or leaving the profession completely. This situation has significant personal implications for nurses, and also significant implications for the healthcare system. The cost to the healthcare system of young nurses leaving the profession is significant because of the training costs invested in them. The cost of experienced nurses leaving the profession is significant because of the loss of qualifications and expertise from the nursing profession, and the from hospital where they work. These findings are consistent with previous research (Chapman & Styles, 2006; Farrell et al., 2006; Jackson et al., 2002; O’Connell et al., 2000) which found that violence towards nurses can influence nurses’ desires to resign, the loss of experienced nurses from the workforce and the inability to attract nurses back to their jobs.

Given the effect on qualified nurses, workplace violence is likely to also affect nursing students during clinical placements in hospitals or other healthcare sectors.
Ferns and Meerabeau (2009) found that nursing students and less-experienced nurses were more vulnerable to patient violence and violence may influence their final career decisions. McKenna et al. (2004) found that 16 graduate nurses in New Zealand indicated that they had considered leaving nursing in their first year as a consequence of their experience of workplace violence. Magnavita and Heponiemi (2011) reported that violence towards nurses undermined the nurses’ self-esteem and morale. This may have implications for individual nurses, and also for the profession now and in the future.

The findings of the focus group interviews revealed that younger and less-experienced nurses had more difficulties with workplace violence compared with more experienced nurses. There were several reasons for this, including a feeling of failure, taking the violent event personally and having fewer strategies and less resilience compared with more experienced nurses. These findings confirm the findings of Pich et al. (2011) which found that older, more experienced nurses were more likely to be resilient to violence than their younger counterparts. Hegney et al. (2003) also confirmed that nurses who had less than five years’ experience were more likely to encounter workplace violence from other nurses or from medical practitioners.

Based on the focus groups findings, it appears young nurses or less-experienced nurses may be more vulnerable to workplace violence and more at risk of quitting their jobs. Experienced nurses in the focus groups said they were trying to support, compensate for and protect their less-experienced colleagues, for example, by not allocating them to care for aggressive patients.

The impacts of violence towards less-experienced nurses or to nursing students need further investigation. Specific training is needed in university courses for those entering or re-entering the profession to report workplace violence, to learn coping mechanisms and to seek support from colleagues, family and hospital management. Increased awareness of the frequency and severity of violence and strategies for dealing with violence are urgently needed.

Nursing students who are given coping strategies to deal with violence and support services, before they undertake their first clinical placement, would be more likely to be emotionally and practically equipped to cope. In addition, student nurses
who understand the necessity and importance of reporting incidents of violence would be more likely to report, providing hospital management with improved data on workplace violence and a need to address it. Hegney et al. (2003) found that inexperienced nurses are more likely to report workplace violence than experienced nurses.

Despite experiencing violence on a daily basis, nurses chose to stay in their jobs. Several reasons were given for this (see section 4.6.5.1.), including the job satisfaction and interacting with patients and their families.

Nurse desire to be involved with patients and to put up with workplace violence is not a sound basis for hospital management to ignore the problem. The increase in frequency and severity of workplace violence and the personal and professional impact upon nurses mean hospital management needs to address the problem firmly and thoroughly.

6.3.2.2. Interaction with patients and visitors

Verbal and physical violence negatively impacts on nurses’ abilities to interact with patients and visitors. The focus group findings showed that nurses avoid aggressive patients and found it difficult to work, as they are continuously hyperalert, restricted in care options around high-risk patients and hypervigilant while interacting with patients and visitors. Exposure to repeated workplace violence and the risk of workplace violence negatively affects nurses by causing burnout, reducing their level of patient interaction and reducing their willingness to offer care and compassion towards aggressive patients. These findings are consistent with several other studies that found different impacts on the ability of nurses to work effectively. Firstly, violence towards nurses reduced nurses’ enjoyment of working with patients (Arnetz & Arnetz, 2001). Secondly, violence reduces nurses’ abilities to offer effective care to patients and increases their potential to make errors (Farrell et al., 2006; Gacki-Smith et al., 2009; Henderson, 2003; Hodge & Marshall, 2007; Hutchinson et al., 2013; Jackson et al., 2002; Jones & Lyneham, 2001). Thirdly, violence reduces the quality of care delivered to patients (Hegney et al., 2010; Hodge & Marshall, 2007; Lyneham, 2000).

Some participants in this study said they thought regional nurses reacted differently to patients and visitors compared with nurses working in larger cities, where
they are not likely to meet patients after they are discharged from hospital. In regional areas, however, there is more chance of meeting former patients or their relatives. The possible influence of anonymity in larger centres compared with regional centres is beyond the scope of this study. This factor would require further investigation.

To summarise, and answer research question one, nurses who work at a regional public hospital in Queensland experience verbal and physical violence that is so frequent and so severe that it has negative impacts on them personally, professionally and on their mental wellbeing. Secondly, workplace violence can be so serious that nurses resign from their jobs, especially the less-experienced nurses. Finally, workplace violence has negative impacts on interactions between nurses, patients and hospital visitors. The next section discusses nurse suggestions to reduce workplace violence.

6.4. Nurses’ suggestions

This section discusses the evidence relating to the second research question: “What do nurses who work at a regional public hospital suggest in order to reduce or avoid violence towards nurses?” and the third research question: “What are the nurses’ perceptions regarding strategies and support provided by a regional public hospital to address violence towards nurses?”

Nurses’ suggestions were canvassed because of their awareness and knowledge of the problem, and the likelihood that their suggestions were likely to be acceptable to their nursing colleagues.

Potential solutions were canvassed from focus group discussions and from survey questions. The nurses’ suggestions revealed several potential solutions that could be implemented at three levels of the organisation: first, general management strategies; second, management during violent incidents and thirdly, management after violent incidents. The following section focuses on management strategies and the nurses’ suggestions, while the next section emphasises the support provided to address violence towards nurses.
6.4.1. **General management strategies**

Even though nurses mentioned that it is hard to predict aggressive behaviour from patients before it actually occurs, it is still possible to adopt strategies for decreasing violence towards nurses (see section 4.7, Table 13). Given the large number of suggestions offered by the research participants, not all will be discussed here. This discussion will focus on the suggestions which appear most effective and capable of implementation.

6.4.1.1. **Improved social awareness**

Nurses who participated in the focus groups and survey agreed that social awareness of the issue and better support for mental health patients are very important parts of the solution. For example, community awareness campaigns on television to raise awareness of the problem and warnings about the consequences for offenders. There had not been any campaign during the data-gathering phase of the study but at the end of the write-up phase, in April 2016, Queensland Health initiated a public awareness campaign about violence towards nurses on television. Focus group nurses said a lack of awareness existed among the public and their family and friends about the level of violence they experienced.

Nurses provided several reasons for the lack of awareness, including that a nurse’s job is to care for people, therefore it is impossible that nurses who are caring for others can experience abuse (while providing care). Another reason is that nurses rarely talk about their experiences of violence with their family or friends because the nurses try to protect their family from worrying about them while they are at work. The participants also believed that people are exposed to, and accept, more violence now than they used to in the past.
6.4.1.2. More mental health patients in community

De-institutionalisation of mental health patients means that there are more mental health patients in the community. Nurses perceive that there are an increasing number of mental health patients in their wards with high-risk behaviours that escalate into violence.

These findings are similar to the findings in Crilly et al. (2004) that general social behaviour and mental illness play a role in violence. He found that the 27% of the perpetrators of violence were under the influence of alcohol, 25% were under the influence of drugs and 38% exhibited behaviours associated with mental illness. Providing improved support for mental health patients in the community might reduce violence in hospital wards.

Some of the nurses believe that the Mental Health System in Australia does not adequately support mental health patients, and that nurses are put at risk when they are asked to nurse mental health patients, but are not qualified to do so. This also leads to an increase overall workload, and causes less time with patients—adding to the existing problem of increasing workplace violence.

Participants also noted that hospitals have the authority to manage violence by introducing strategies, such as educating and training in effective communication, training in de-escalation techniques, optimising medication management and providing effective assessment and counselling for patients. Nurses also mentioned the necessity of frequent reviews of patients by medical officers, specific training for staff who care for mental health patients and provision of the required medications for these patients.
6.4.2. Management during violent incidents

Nurses from both focus groups and the survey suggested management of violence during the incident includes strategies such as de-escalation techniques, seclusion of a patient for a short period and use of mechanical or chemical restraints. Surveyed nurses believed the hospital should allow them to use chemical and mechanical restraints. Nurses asked for better support from doctors during violent incidents, including more understanding, listening to nurses’ opinions and assisting with medications.

Previous studies have found that the main interventions for managing aggressive behaviours in acute care settings include chemical restraints and mechanical restraints (Kynoch et al., 2011), and that they are required when necessary to protect nurses and patients (Hodge & Marshall, 2007).

This study found further nurse-suggested strategies for managing violence during an incident, including using sedatives, stopping work on a particular shift and withholding treatment if a patient is violent towards staff. The nurses in the focus groups added further strategies, such as asking for a break or even changing the staff during a shift.

Nurses who participated in the survey agreed that if a patient or visitor was being verbally abusive or physically violent, they would ask the person to stop, defend themselves and report to hospital security. These findings were in agreement with previous studies that showed the response of nurses to workplace violence (Chen et al., 2009).

6.4.3. Management after a violent incident

Study participants were critical of post-incident management and made several suggestions for improving interventions after violence incidents. The suggested interventions included reporting to police, providing care for the nurses via social workers and psychologists and supporting access to legal advice. Nurses believed counselling should also be provided and that incident reports should be made to a senior staff member after violent incidents. Given the importance of accurate reporting of the frequency
and severity of violent incidents to a clear understanding of the size and complexity of the problem, nurses suggested that their hospital should give them sufficient time to report the violent incident and that reporting mechanisms be user-friendly. These findings are supported by studies by (Anderson 2002, Rowe & Sherlock 2005, Chapman et al. 2010). Pich et al. (2011) also found that nurses were frustrated by lengthy reporting processes about violent incidents. Nurses in this study wanted feedback following their report, so that they felt they were being supported in their decision to report incidents to both their hospital management and police.

In addition, nurses said hospitals should be required to assist them to participate in professional debriefing forums following an incident, and should improve access to counselling services. This study confirmed findings of earlier research by Anderson (2011) that nurses desire better access to debriefing forums and counselling services following an episode of violence. However, this study revealed that some nurses are not aware of the counselling services within their hospital. O'Connell et al. (2000) made a similar finding. An additional problem is that counselling services are located outside of the hospital and are available only during the morning and weekdays shifts. However, nurses on night shifts may need to access the counselling services during the evening, at night or on weekends.

The lack of common procedures for reporting verbal and physical violence in hospitals means reporting by nurses is seen as onerous. This mitigates accurate recording of the frequency and severity of workplace violence, and mitigates hospital management addressing the issues, since they have no quantification or qualification of the problem, or how it should be addressed. Lack of routine and timely reporting procedures means nurses are not receiving adequate counselling and support from hospital management, and are left to cope alone with victimisation by violent patients and hospital visitors. Over time, the compounding effect of being exposed to violence, but not able to report it and receive care and help, reduces nurses’ job satisfaction and their willingness to remain in the job.

The following section addresses the failure to date of hospital management to implement strategies to reduce workplace violence.
6.4.4. Implementation of management strategies

This study has found that although the hospital has a workplace violence policy, it does not make staff sufficiently aware of it nor does the hospital implement it effectively. Despite the policy existing, nurses reported a lack of implementation of management strategies, including inappropriate implementation of policy, lack of reporting following incidents of violence, lack of support for nurses following an incident, lack of debriefing and lack of access to counselling services. There is a possibility that a head nurse or clinical nurse would be more aware of the policies. Nevertheless, fewer than half of the survey participants said that the workplace violence policy was always implemented. These findings are consistent with the Lyneham (2000) findings that the workplace violence policy was inappropriately implemented, and the Hegney et al. (2006) findings that nurses in the public sector believed policies were inadequate.

Nurses who participated in the survey agreed that they should report violence in each instance. However, only 26.1% (n=91) of nurses said they always reported incidents. The participants in the focus groups estimated that less than 5% of violent incidents are reported and that workplace policies were not well understood by staff. These findings are in agreement with studies undertaken from 2001 to 2011 that found a lack of reporting of the incidence of violence (Clements et al., 2005; Ferns, 2002; Hegney et al., 2010; Jones & Lyneham, 2001; Lyneham, 2001; Shoghi et al., 2008; Talas et al., 2011).

An indication of the lack of awareness of the hospital’s policy was that some of the nurses who participated in the focus groups did not know the policy existed, nor the procedures on their ward for using it to report incidents. Nurses in the focus groups and in the survey cohort believed the workplace violence policy was not effective because there were no clear policies and guidelines. In addition, the policies were not being enacted and consequences for offenders were not enforced.

Wilkes et al. (2010) found that violence towards nurses persists in healthcare settings even when there is a policy in place. Several studies conducted in Queensland by Hegney et al. (2006); Hegney et al. (2010) found that the existence of a workplace
policy did not decrease levels of workplace violence, therefore the policy was not as effective as it should be.

Nurses who participated in both phases of this study provided other possible reasons that might explain the ineffectiveness and lack of implementation of the workplace policy. Firstly, the policy is too general and does not provide specific information that can be applied in a variety of situations, and that “blanket rules” are worse because every situation and patient is different. These findings are consistent with Hegney et al. (2006) who found a “one size fits all” policy was not effective in managing workplace violence. Secondly, the people who write the policy do not have experience of working in the ward. Thirdly, it is difficult to write a policy to cover every possible situation. Lastly, the policy lacks support for nurses from the hospital management.

Given the lack of awareness of workplace policies and the ineffectiveness of existing policies, it is necessary to conduct further research to find policy models that have been created in Australia or overseas, and shown to encourage reporting of workplace violence and effectively reduce violence in the workplace. These might then be adapted or adopted for use in this and other hospitals.

6.5. **Support during and after incidences of violence**

Nurses who were experiencing workplace violence were not always receiving adequate support from colleagues, managers, family and friends or from hospital management during and after incidents. The evidence discussed in this section relates to the third research question: *What are the nurses’ perceptions regarding strategies and support provided by a regional public hospital to address violence towards nurses?*

6.5.1. **Support from colleagues**

There was general consensus that nurses were generally supportive of each other during and after a violent incident. However, some nurses have felt unsupported by medical doctors during and after a violent incident. Some of the participants said medical doctors needed to listen to nurses’ opinions and provide adequate medical management of patients, such as medicating aggressive patients and using chemical
and mechanical restraints if and when required. Fewer than half the nurses in the survey, 40.9%, said that support from colleagues always occurred after an incident.

### 6.5.2. Support from managers

Generally, nurses who participated in the focus groups felt supported by their line managers and nurse unit managers. However, of those who participated in the survey, only 36.8% of nurses said support was always provided by supervisors (see Table 24). Nurses suggested improved recognition by their managers.

### 6.5.3. Support from family or friends

Nurses stated that they withheld some or all of the information about violence from their family and friends so as not to worry them. Family and friends are therefore not aware of the extent or severity of violence and are not able to be supportive.

Nurses who participated in the survey agreed that during a specific verbal and physical violent incident, their manager, colleagues or family and friends supported them. Colleagues were found to be most supportive, followed by family or friends in both verbal and physical incidents. The nursing manager was the least supportive. These findings are similar to those in a study by Arnetz and Arnetz (2001) where staff who did receive support after a violent incident most commonly received support from co-workers (49%), someone outside the workplace (18%) or from their workplace supervisor (14%).

### 6.5.4. Support from the hospital

Nurses who participated in both phases felt that they were not sufficiently supported by their organisation. Five participants made similar comments that they thought their hospital supported the offenders more than its own staff, and requested better support from their hospital management.

These findings reinforced the nurses’ perceptions that their hospital was not capable of protecting them sufficiently from incidents of verbal and physical violence.
Support for nurses who have experienced workplace violence was mixed. Colleagues and managers appeared to provide the most support, but some avenues of support, such as from family, friends and hospital management were not always forthcoming when necessary, partly because of a lack of disclosure by nurses of the violence they experienced in the workplace. Improved awareness by family, friends and hospital management and increased willingness by nurses to report and to seek support are required.

6.5.5. **Required to provide support**

When nurses were asked, “Who should provide nurses with support?” the intensive care nurses believed that the support from their colleagues was the most important and should come first. Emergency nurses thought that during violent incidents, the team leader should be the first person to provide support. Other suggested support providers within the hospital included counselling and debriefing services, such as social workers, legal advisers and psychologists, as well as security, in cases of physical violence. Support from other services outside of the hospital that were suggested included private counsellors, the nurses’ union, the QPS, relevant government departments, the media, the patients’ family and members of the community.

6.6. **Differences in perceptions of workplace violence**

All ANOVA and t-test analyses revealed no significant differences between any category means (p>0.05) within any of the demographic variables of the study participants. This means that high levels of violence experienced by nurses in their workplace are not dependent on their demographic profile. The lack of variation according to age, gender, ethnic background, level of education, working status and department may indicate that violence towards nurses is dependent upon the intention of perpetrators to be aggressive towards nurses. This section discusses the possible explanations, and contributes to answering the last research question: “What differences are there in a regional public hospital nurses’ perceptions of workplace violence based on their selected demographic characteristics (age, gender, ethnic background, level of education, work experience, working status and department)?”
The lack of variation in workplace violence due to demographics may be explained by statistical or practical features.

It is possible that the statistical results are not surprising because most nurses consistently indicated that they Agreed or Strongly Agreed with the questionnaire statements. Their answers were overwhelmingly in the range between three and five in nearly all of the survey items on the five-point Likert scale. As a result of the ceiling effect, the means all groups’ comparisons were very similar with the questionnaire items, and the distribution of responses showed a negative skew which has resulted in very little variation of the data and no significant differences in the test results. It was impossible to know this before running the survey, therefore it wasn’t a mistake. Because responses are clustered at the top end of the scale scores of three, four and five, they are not really discriminating between respondents. Yet, there is a response bias, inherent in a nonrandomized sample, where those who participate have specifically interest in the topic.

Future research should consider an alternative scale that could identify finer scale differences between nurses’ opinions and perceptions to overcome the ceiling effect. Ceiling effect is the fact that nearly all respondents scored three, four or five, resulting in a negative skew for most five-point Likert items. An alternative scale such as a ten-point scale or a 100-point scale would provide a more detailed indication of subtler scale differences. Then, even if the plot might still be negatively skewed, in the cluster of responses at the high end of the Likert scale it would be easier to identify finer scale differences.

The practical reason for a lack of difference between demographic explanations for workplace violence is that violence towards nurses does not depend on the nurses’ demographic profile, but happens regardless of demographics to all nurses in hospital ‘high risk’ units. As the findings of this study show, no significant differences were found between any category means ($p>0.05$) within any of the demographic variables. This finding is similar to that in Chen et al. (2013), which found no significant correlations between workplace violence with the demographics categories of age, working years or nursing experience. Another study conducted in Queensland by Crilly et al. (2004) also did not find any statistical difference in nurse characteristics such as age,
gender, years of experience and working conditions, using t-test statistics. No significant differences were found in reported workplace violence with nurses’ genders and ages (Hegney et al., 2010).

Given the lack of statistical difference between demographic groups, addressing workplace violence will require policies which encompass all age groups, both male and female nurses, experienced and inexperienced staff and lesser and more highly qualified nurses.

Some studies, however, have found differences in reported workplace violence based on the nurses’ demographic variables. Gender and a history of violence were found to be significantly associated with workplace violence (Anderson & Parish, 2003), and age was found to be a factor in the Hegney et al. (2006) study. However, there were no significant differences in levels of violence towards nurses in public compared with private hospitals, or between nurses’ in different age groups, of different genders, seniority or years of nursing experience (Hegney et al., 2003).

This study found no significant difference in reported workplace violence according to demographic categories. Therefore causation is more likely to rest with the perpetrators’ intention rather than the nurses’ age, gender, level of education, years of experiences or other demographic profiles. Hahn et al. (2012) found that the more time staff spent in direct contact with patients, the more they were exposed to violence. For example, nurses with the most patient contact and those who worked more than 50% of a full-time work load were exposed to workplace violence more often than those who had less patient contact or who worked fewer hours.

According to the survey findings, for all ANOVA and t-test analyses no significant differences were found between any category means (p>0.05) within any of the demographic variables. Therefore, there were no differences in the perceptions of nurses towards verbal and physical violence based on their demographic variables. The findings of this study show that all nurses experience verbal and physical violence in their workplace regardless of their age, gender, ethnic background, level of education, work experience, working status and department. It therefore appears that perpetrators
of workplace violence do not restrict violence to any demographic of nurses, for example, by targeting young or old nurses, male or female nurses, full-time or part-time nurses, Australian or foreign nurses, senior or junior nurses.

6.6.1. Intentions to hurt

The types of violence that nurses experienced varied from verbal to physical violence, some of which was unintentional violence. However, sometimes it was intentional violence, which was more difficult for the nurses to cope with.

In addition, nurses are tolerant and do not perceive patients who are confused due to delirium or dementia, as a threat. However, they are negatively affected by patients who deliberately try to hurt them.

6.6.2. Impact of nurses’ gender

The findings of the survey found no significant differences in nurses’ perceptions of workplace violence based on their gender, but the focus group interviews found male and female nurses experienced violence in different ways.

6.6.2.1. Violence towards male nurses

Focus group participants indicated that male patients are more aggressive and physically violent towards male nurses in comparison to female nurses, see section 4.5.3. The survey findings confirmed that physical violence was experienced by all male nurses (100%) and almost all the female nurses (91.2%) throughout their nursing careers. These findings are similar to previous studies, such as Hegney et al. (2003), who found that male nurses employed in the public sector believed they were exposed to workplace violence more often than female nurses.

Earlier studies have found varying rates of violence against male and female nurses. Gender was not a significant factor in workplace violence according to studies by Levin et al. (1998) Crilly (2004) or Hegney et al. (2010). In a Pich et al. (2011) qualitative study in Australia, there was not much difference between male and female patients in terms of violent behaviour. However, other studies conducted in Australia found that male nurses do experience more workplace violence than female nurses.
Chapter 6: Discussion

(Farrell et al., 2006; Hegney et al., 2006; McKinnon & Cross, 2008). Hegney et al. (2006) found that the proportion of male nurses who reported workplace violence was substantially higher than the proportion of female nurses who reported violence in the 2001 and 2004 studies. Farrell et al. (2006) reported a significantly greater proportion of male nurses who were likely to be targets of both verbal and physical abuse compared with female nurses. McKinnon and Cross (2008) indicated that 100% of male respondents had been assaulted compared with 83.7% of female respondents.

It is not clear why male nurses appear to experience more violence, but it may be because they are more exposed to violent patients and violent situations. Female focus group participants said that male patients intimidated female staff, but the presence of male nurses in their department could prevent this intimidation. The added exposure of male nurses to violent situations was explained by the tendency to allocate male nurses to potentially violent patients. However, by allocating a male nurse to potentially violent situations, male nurses might be increasingly seen by their patients as bodyguards rather than as professional nurses. That might cause therapeutic relationship problems between a male nurse and a patient.

Therefore, the team leader needs to be aware of the concerns of the male nurses and perhaps needs to take the nurses’ genders into consideration. Instead of allocating a male nurse into a violent situation to prevent violence, there is the ability to increase the security of the wards by using professional bodyguards. In addition, nursing is a dual-gender profession, not just a female profession. It would be interesting to conduct further research to explore the implications of perceptions of male and female nurses on workplace violence.

6.6.2.2. Gender role stereotypes

Female nurses believed that patients behave differently towards nurses depending upon the gender of the carer. For example, patients may assume that female staff (nurses or doctors) are nurses, and may consider male nurses to be doctors. This may affect the amount of patient aggression towards nurses of different genders. In addition, female nurses believed that patients verbally abuse more female staff (nurses or
doctors) and that male patients intimidate female staff (nurses or doctors), more frequently than male staff.

However, the findings of this survey show that patients were verbally violent towards both female and male nurses in the past 12 months. In the same way, visitors were equally verbally violent towards both genders. Nurses who participated in the focus group interviews also believed that patients were more aggressive towards nurses compared with doctors. Similar findings were reported by Wand and Coulson (2006) who found that “patients and relatives in the ED, who seem prepared to be rude and offensive to nurses, are usually much less aggressive when approached by a doctor.”

**Summary**

Verbal and physical violence towards nurses is increasing in frequency and severity in Australia, as it is overseas. The severity of workplace violence seriously affects the personal life of nurses, causing them stress, distress, burnout and bodily injury. It also affects them professionally by leading nurses to leave their profession, and it affects their interaction with patients. The main causes of workplace violence appear to be unfavourable changes in the community, increasing numbers of mental health patients and increasing workloads for nurses. Nurses in this study have suggested possible solutions to reduce workplace violence, such as management strategies, policy implementation, increased support and improved processes for reporting violence. Male and female nurses each perceive the other gender as being less vulnerable to violence than their own gender; however, both genders experience similar frequency and severity of violence. Chapter 7 presents the conclusions of this study, limitations of the research and makes recommendations for further research.
CHAPTER 7: CONCLUSION

This study aimed to examine nurses’ perceptions of violence in their workplace—a regional public hospital in Queensland. A further aim was to investigate whether they believed that hospital policies, strategies and support were successful in preventing violence against nurses and managing aggressive patients and visitors. The study documented participant nurses’ views on the impacts of violence on nurses overall, including the effect on their ability to interact with patients and visitors. The findings provide contemporary insights into the incidence of verbal and physical violence by patients and visitors, at the ward level, in a regional public hospital in Queensland, Australia. The findings reflect the nurses’ perceptions of the factors that contribute to workplace violence and its effects on nurses’ personal and professional lives.

This study contributes to filling five major gaps in the literature. Firstly, it adds to the small amount of recent qualitative research on workplace violence towards nurses in Australia. Secondly, it contributes a qualitative study in a regional public hospital that explores the experience of nurses who have been the victim of workplace violence. Thirdly, it contributes to the small amount of research to date on workplace violence in the acute hospital setting of ICUs. Fourthly, it provides data and analysis at the ward level in a Queensland hospital. Finally, it suggests possible solutions from nurses to the continuing controversy over how to successfully address workplace violence towards nurses.

The research questions were derived from the research aims and the gaps in the research literature. The questions were:

1) How do nurses who work at a regional public hospital perceive that violence in the workplace impacts on nurses, including their ability to interact with patients and visitors?

2) What do nurses who work at a regional public hospital suggest in order to reduce or avoid violence towards nurses?

3) What are the nurses’ perceptions regarding strategies and support provided by a regional public hospital to address violence towards nurses?

4) What differences are there in regional public hospital nurses’ perceptions of workplace violence based on their selected demographic characteristics (age,
gender, ethnic background, level of education, work experience, working status and department)?

Detailed evidence about the factors that contribute to verbal and physical violence experienced by nurses, and its effects on nurses, was elicited from 23 nurses who participated in focus group interviews, and a survey questionnaire administered to 98 nurse participants in the study. The choice of a mixed method research paradigm allowed me to explore the complexity of the issue in qualitative interviews, and link the data from the interviews with data derived from answers to survey questions to extend the study. The research therefore contributes both qualitative and quantitative data to the body of knowledge about workplace violence towards nurses. Nurses who participated in the qualitative study shared their lived experience of violence and how it impacts on the nurses in their department. The data, findings and conclusions drawn provide a more thorough understanding of the impacts of violence on male and female nurses, and on how this affects their ability to care for patients.

Data collected indicate that nurses in the emergency, intensive care and mental health wards of a regional public hospital were subjected to unacceptable and dangerous levels of workplace violence. Increasing frequency and severity of physical and verbal (vertical) violence is mainly committed by patients, while fewer violent incidents are committed by visitors. Visitors were found to be more verbally violent, whereas patients were found to be more physically violent. In addition to the vertical violence, nurses also experienced horizontal violence from doctors, nurses and other staff. Nurses believed that hospital managers need to facilitate comprehensive timely reporting of all verbal and physical violence against staff, so that the scale of the problem can be better understood and effectively addressed.

Violence in the workplace affects nurses, patients and witnesses of the violence. The effect of verbal and physical violence on nurses affects their personal lives and has emotional and physical impacts. It also has impacts on the profession, by decreasing job satisfaction, reducing productivity at work and the nurses’ abilities to interact with patients and visitors. Violence also impacts on the nurses’ decisions to leave the nursing profession, in particular the younger and less-experienced nurses, who
were found to be at higher risk of leaving the profession because they had fewer coping strategies, lower resilience and feelings of failure.

Perceptions of workplace violence varied between nurse gender. Female nurses believed that the presence of male nurses in their department prevented violent incidents. However, by allocating male nurses to care for potentially aggressive patients, male nurses were concerned to be seen by their patients as bodyguards.

Factors which influence the rate and severity of assault of nurses are social, hospital, personal and patient factors. Social factors are significant because of increased community acceptance of violence and the increased number of mental health patients in all hospital departments. Hospital management and environmental factors also add to workplace violence. Management decisions have led to increased workloads, reduced numbers of experienced staff on wards and longer waiting lists. Environmental factors include patient stress, frustration and confinement in the hospital environment, as well as nurses’ attitudes towards patients, including poor communication skills. In addition, violence may be increasing because of the growing number of patients who are involuntary patients, drug-affected, have mental illnesses or unable to understand the health system.

The study’s findings provide the basis for offering recommendations that, if implemented, may mitigate the frequency and seriousness of violence against nurses, and lead to improvements in public hospitals. Nurses’ suggestions include three phases. Firstly, managing violence by adopting general and specific management strategies during and after violent incidents. Secondly, nurses recommend the implementing a workplace violence policy and monitoring its effectiveness. Thirdly, increasing the support services to staff during and after violent incidents, as well as increasing support from managers and hospital administration.

Collected data of violence experienced by nurses on a daily or weekly basis is lacking, and given the very high response rate of violence experienced in the ‘high risk’ units, it reflects that the data collection should be changed from yearly or monthly, to weekly or diary notes. This enables nurses to keep records regarding the type of violence experienced, and the perpetrator. This would assist in the decision-making and understanding of the seriousness of the problem and how to address it.
7.1. Implications of the findings

The implications of this research are at a practical level and a policy and strategic level.

7.1.1. Practical implications

There are five practical findings of the research:

1) Violence towards nurses is not dependent upon the demographic profiles of nurses. If effective strategies are not put in place to reduce verbal and physical abuse of nurses in public hospitals, it is foreseeable that staff numbers in specialised departments such as emergency, mental health and intensive care will diminish, leading to a shortage of staff and a reduction in the quality of patient care.

2) Hospital management could consider a faster, friendlier and easier form for nurses to report violence incidents. Nurses suggested a simple form could be filled in and forwarded to an administration officer. The administration officer could contact the nurse if further data were required. This would encourage nurses to report violence in the workplace, uncover the extent of the problem and enable alternative solutions to be explored. Hospital management should ensure nurses are told the outcomes of their violent incident reports.

3) Hospital management could consider informing the public that violence towards staff could lead to conditional providing of treatment and criminal prosecution. In addition, it could inform patients about the National Code of Conduct for Health Care Workers. There does not seem to be a Code of Conduct for patients, and perhaps it is required.

4) Hospital management could consider allocating permanent security staff in the ‘high risk’ units to help reduce the number of violent incidents in these departments. Addition of security staff would reduce the current use of male nurses as de facto security guards, and allow them to carry out their professional role as nurses.
5) The findings of this study suggest that less-experienced nurses might be affected more by workplace violence than experienced nurses. Therefore, more support and education should be considered by the education institutions that train nursing students. Students should be taught about workplace violence, the strategies to address it and available support services. Improved awareness may help nursing students to be better prepared and therefore equipped to deal with violence during clinical placements, or in their new workplace.

7.1.2. Policy and implementation of strategies

There are five practical implications of the research findings:

1) The high levels of violence that nurses experience on a daily basis require multi-systemic policies and practices to ensure that nurses are not assaulted in their workplace. In order to reduce the implications for nursing profession, the Australian nursing organizations such as Nursing Colleagues and NMBA, Nursing and Midwifery Board of Australia, should advocate for nurses and act as a regulatory agency.

2) Nurses should be part of a multidisciplinary team in hospitals that evaluates workplace policies, management strategies and considers education, training and debriefing sessions. In this study, nurses suggested that hospital management should comply with workplace policies, implement existing policies, take responsibility for control of violent situations and act in accordance with the policy in cases where verbal or physical violence has occurred.

3) Hospital management should provide increased support services, improve staff awareness of support services and increase the availability of consultant services. According to the nurses’ suggestions, the consultant services should be located at the hospital and not outside of the hospital, and should be operating 24/7, not limited to the mornings and week days only, as nurses work and experience violence in all shifts and during all seven days.

4) Hospital management might consider surveying nurses routinely every three months to establish if the nurses feel depressed or at breaking point. Support could then be given in a timely manner.
5) Hospital management could provide support for nurses who want to have charges laid against an offender.

6) Hospital management should implement strategies to reduce violence in the workplace. The implementation of strategies includes: ensuring appropriate ratios of nurses and medical doctors to patients, reducing waiting times for appointments with doctors and provision of television screens with patients’ numbers in waiting areas to facilitate patient flow.

7.2. Limitations of the research

This study was limited in scope because it was conducted only by one person and on a limited budget and in a limited time frame. This imposed some limits on the study, but did not detract from the value of the data and evidence, or from the value of the findings.

1) The scope of the study was limited to nurses working in one regional public hospital in Queensland. This may limit the generalising of some of the findings compared with broader studies that include regional and metropolitan hospitals, or interstate or overseas hospitals. However, the focus on one hospital provides an in-depth case study which has yielded valuable and specific data.

2) This study focused only on three ‘high risk’ units in a regional public hospital: emergency, intensive care and mental health. While this yields results specific to the most at-risk staff, it does not provide a control group for comparison with other hospital departments. The lack of a control group such as a medical ward was overcome as much as possible by benchmarking the findings against previous research findings. This study focused on areas of the highest risk of violence, rather than those with low risk.

3) A limitation of mixed methodology studies is the large amount of data that is generated during the investigation. This was largely overcome by the use of computerised coding and analysis.

4) The major disadvantage of focus groups is group-think in which stronger participants in a group influence what other members are willing to say (or not say) (Streubert and Carpenter (2011). Awareness of group-think was able to mitigate
the effect by inviting each of the focus group participants to contribute to each question. Therefore, the strength of the focus groups in gathering rich data and new ideas was maximised, while the disadvantages were minimised.

7.3. Recommendation for future research

This study was necessarily narrow in scope due to restrictions of time and resources. Extension and repetition of similar qualitative studies in future and in other countries will provide further validation, rebuttal or refinement of the findings here. The following recommendations are suggested for future research.

A larger study could be conducted to include all the hospital departments in a regional public hospital, to provide clearer comparison between departments. Then, comparisons could also be made between frequency and severity of violence in general wards compared with high-stress wards such as emergency, intensive care and mental health. In addition, a daily diary, or at least better recording of the details of violent incidents, is required.

The research could be expanded to include other public and private hospitals in regional, rural and metropolitan areas to get a better understanding of the extent of violence in different locations. Further research with larger samples could identify specific safety problems and trial some of the suggestions proposed in this study to see which solutions are most effective and cost-efficient.

Research could be carried out with nursing students and inexperienced nurses to see if greater awareness of workplace violence and coping strategies are protective of inexperienced nurses.

Further research into perceived differences by male and female nurses of violence against other nurses of the same or opposite gender could provide useful strategies for placement of male and female staff on wards. Studies into gender stereotyping of males as doctors and females as nurses would also be useful to create effective community awareness programs to combat gender stereotyping and encourage patients to be more accepting of male nurses in their role as professional health carers, rather than having their role relegated to that of de facto security guards in hospital wards.
Further research into the implications of workplace violence for the nursing profession is required. Supplementary research is required in checking for policy implications for advocate of nurses and/or accrediting and/or regulatory agencies of the Australian nursing organizations such as Nursing Colleagues and NMBA, Nursing and Midwifery Board of Australia.

The suggestions given by nurses in this study for mitigating violence could be used as the basis for trialling strategies to reduce the frequency and seriousness of violence against nurses, and thus lead to improved workplace safety for nursing staff.
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APPENDIXES

Appendix A: USQ Ethics Approval

The researcher obtained ethical clearance for this project from the Human Research Ethics Committee (HREC) of USQ. The USQ Ethics Approval no.is H13REA249

OFFICE OF RESEARCH
Human Research Ethics Committee
PHONE +61 7 4631 2600 FAX +61 7 4631 5555
EMAIL ethics@usq.edu.au

25 November 2013

Mrs Hila Dafny
21 Lavenia Drive
Daiing heights QLD 4350

Dear Hila

The USQ Human Research Ethics Committee has recently reviewed your responses to the conditions placed upon the ethical approval for the project outlined below. Your proposal is now deemed to meet the requirements of the National Statement on Ethical Conduct in Human Research (2007) and full ethical approval has been granted.

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<td>Verbal and physical violence toward nurses in Queensland</td>
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<tr>
<td>Approval date</td>
<td>25 November 2013</td>
</tr>
<tr>
<td>Expiry date</td>
<td>25 November 2016</td>
</tr>
<tr>
<td>HREC Decision</td>
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The standard conditions of this approval are:

(a) conduct the project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments made to the proposal required by the HREC
(b) advise (email: ethics@usq.edu.au) immediately of any complaints or other issues in relation to the project which may warrant review of the ethical approval of the project
(c) make submission for approval of amendments to the approved project before implementing such changes
(d) provide a “progress report” for every year of approval
(e) provide a “final report” when the project is complete
(f) advise in writing if the project has been discontinued.

For (c) to (e) forms are available on the USQ ethics website:
http://www.usq.edu.au/research/ethicsq/human

Please note that failure to comply with the conditions of approval and the National...
Statement (2007) may result in withdrawal of approval for the project.

You may now commence your project. I wish you all the best for the conduct of the project.

Annamaree Jackson
Ethics Committee Support Officer
Copies to: dafnys2012@gmail.com
Appendix B: The Darling Downs Hospital and Health Services
Ethics Approval

Dear Mrs Dafny

HREC Reference number: HREC/14/QTDD/6
Project title: The perceptions of nurses regarding possibilities of violence, strategies and support.

Thank you for submitting the above project for ethical and scientific review. This project was considered by the Darling Downs Hospital and Health Services Human Research Ethics Committee (HREC).

This HREC is constituted and operates in accordance with the National Health and Medical Research Council’s (NHMRC) National Statement on Ethical Conduct in Human Research (2007), NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2007) and the CPMP/ICH Note for Guidance on Good Clinical Practice. Attached is the HREC Composition with specialty and affiliation with the Hospital (Attachment I).

Following consultation with one or more expert reviewers with qualifications or knowledge in disciplines relevant to your research proposal, I am pleased to advise that the Human Research Ethics Committee has granted approval of this research project at the following site:

• [redacted]

The documents reviewed and approved include:

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<td>31 March 2014</td>
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<tr>
<td>Letter of invitation to participant - interview</td>
<td>1</td>
<td>17 January 2014</td>
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<td>17 January 2014</td>
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<td>Other HREC approvals : USQ HREC approval</td>
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Appendixes

| Response to Request for Further Information | 31 March 2014 |
| Focus Group Questions | 3 | 31 March 2014 |
| Survey Questionnaire | 3 | 31 March 2014 |
| Focus Group Invitation | 3 | 31 March 2014 |
| Consent Form: Focus Group | 3 | 31 March 2014 |
| Patient Information Sheet - Anonymous Survey | 3 | 31 March 2014 |
| Patient Information Sheet – Focus Group | 3 | 31 March 2014 |
| Cover Page Online Survey | 3 | 31 March 2014 |

Please note the following conditions of approval:

1. The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
   unforeseen events that might affect continued ethical acceptability of the project.
   Serious Adverse Events must be notified to the Committee as soon as possible. In addition the Investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected causality and whether changes are required to the Patient Information and Consent Form. In the case of Serious Adverse Events occurring at the local site, a full report is required from the Principal Investigator, including duration of treatment and outcome of event.

2. Amendments to the research project which may affect the ongoing ethical acceptability of a project must be submitted to the HREC for review. Major amendments should be reflected in a revised online NEAF (accompanied by all relevant updated documentation and a cover letter from the principal investigator, providing a brief description of the changes, the rationale for the changes, and their implications for the ongoing conduct of the study). Hard copies of the revised NEAF, the cover letter and all relevant updated documents with tracked changes must also be submitted to the HREC Coordinator as per standard HREC SOP. Further advice on submitting amendments is available from http://www.health.qld.gov.au/ohmr/html/regu/regu_home.asp

3. Amendments to the research project which only affect the ongoing site acceptability of the project are not required to be submitted to the HREC for review. These amendment requests should be submitted directly to the Research Governance Officer (by-passing the HREC).

4. Proposed amendments to the research project which may affect both the ethical acceptability and site suitability of the project must be submitted firstly to the HREC for review and, once HREC approval has been granted, then submitted to the RGO.

5. Amendments which do not affect either the ethical acceptability or site acceptability of the project (e.g. typographical errors) should be submitted in hard copy to the HREC Coordinator. These should include a cover letter from the principal investigator providing a brief description of the changes and the rationale for the changes, and accompanied by all relevant updated documents with tracked changes.
6. The HREC will be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.

7. The Principal Investigator will provide an annual report to the HREC and at completion of the study in the specified format.

8. The Health Service administration and the Human Research Ethics Committee may inquire into the conduct of any research or purported research, whether approved or not and regardless of the source of funding, being conducted on hospital premises or claiming any association with the Hospital; or which the Committee has approved if conducted outside the Darling Downs Hospital and Health Service.

HREC approval is valid for 3 years from the date of this letter.

Should you have any queries about the HRECs consideration of your project please contact Dr Hwee Sin Chong, Chair of the Darling Downs Hospital and Health Service Human Research Ethics Committee. The HREC terms of Reference, Standard Operating Procedures, membership and standard forms are available from http://www.health.qld.gov.au/ohmr/html/requ/requ_home.asp

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorisation from the Chief Executive of that site has been obtained.

A copy of this approval must be submitted to the Health Service Research Governance Officer with a completed Site Specific Assessment (SSA) Form for authorisation from the Chief Executive to conduct this research at the Darling Downs Hospital and Health Service.

Once authorisation to conduct the research has been granted, please complete the Commencement Form (Attachment II) and return to the office of the Human Research Ethics Committee.

The HREC wishes you every success in your research.

Yours sincerely

Dr Hwee Sin Chong MBChB MHM FRACMA
Chair
Darling Downs Hospital & Health Service
Human Research Ethics Committee

[Signature]

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Appendix C: Site Specific Assessment (SSA) Approval

The researcher obtained specific Site Specific Assessment (SSA) approval from the Darling Downs Hospital and Health Service.

Enquiries to: Wendy Friend
Telephone: (01) 4615 0066
Facsimile: (01) 4616 5009

Mrs Hila Dafny
Centre for Rural and Remote Area Health
University of Southern Queensland
West Street
TOOWOOMBA QLD 4350

Dear Mrs Dafny

HREC reference number: HREC/14/QD/D/6
SSA reference number: SSA/14/QD/34
Project title: The perceptions of nurses regarding possibilities of violence, strategies and support.

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to take place at the following site(s):

- [Redacted]

The following conditions apply to this research proposal. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval.

1. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project are to be submitted to the HREC for review. A copy of the HREC approval/rejection letter must be submitted to the RGO;
2. Proposed amendments to the research protocol or conduct of the research which only affects the ongoing site acceptability of the project, are to be submitted to the research governance officer;
3. Proposed amendments to the research protocol or conduct of the research which may affect both the ongoing ethical acceptability of the project and the site acceptability of the project are to be submitted firstly to the HREC for review and then to the research governance officer after a HREC decision is made.

Yours sincerely

Dr Peter Bridgwater FRACP FCIM FRACMA GCM GAICD
Chief Executive
Darling Downs Hospital & Health Service
The researcher obtained specific Site Specific Assessment (SSA) approval from the Nurses Unit Managers to conduct the study in their departments.

Site Specific Assessment Approval from the Intensive Care Unit Nurse Manager
Appendixes

Site Specific Assessment Approval from the Acute Mental Health Unit 1 Nurse Manager

(b) Declaration by delegated Department Heads at the site where the Principal Investigator/Site Coordinator will conduct the research for the purpose of resourcing the research project.

- I certify that I have read the project details in this SSA for the research project application named above.
- I certify that I have discussed this research project and the resource implications for this Department, with the Principal Investigator/Site Coordinator.
- I certify that there are suitable and adequate facilities and resources for the research project to be conducted at this site. This is for 'Actual costs' and 'in kind' contribution.
- My signature indicates that I support this research project being carried out using such resources.

Name of Department: Acute Mental Health Unit

Name of Head of Department: [Redacted]

Signature: [Signature]

Date: 9/3/14

* Where an investigator is also Head of Department, certification must be sought from the person to whom the Head of Department is responsible. Investigators must not approve their own research on behalf of their Department.
Site Specific Assessment Approval from the Acute Mental Health Unit 2 Nurse Manager
Site Specific Assessment Approval from the Acute Mental Health Unit 3 Nurse Manager

(b) Declaration by delegated Department Head(s) at the site where the Principal Investigator/Site Coordinator will conduct the research for the purpose of resourcing the research project.

- I certify that I have read the project details in this SSA for the research project application named above.
- I certify that I have discussed this research project and the resource implications for this Department, with the Principal Investigator/Site Coordinator.
- I certify that there are suitable and adequate facilities and resources for the research project to be conducted at this site. This is for 'Actual costs' and 'In kind' contribution.
- My signature indicates that I support this research project being carried out using such resources.

Name of Department: Acute Mental Health Unit

Name of Head of Department: [redacted]

Signature: [signature]

Date: 9/6/14

* Where an Investigator is also Head of Department, certification must be sought from the person to whom the Head of Department is responsible. Investigators must not approve their own research on behalf of their Department.
Site Specific Assessment Approval from the Emergency Department Nurse Manager
Appendix D: Letter of Support from the Executive Director

The researcher obtained permission from the hospital manager, and a letter of support to recruit staff.

To whom it may concern

Hila Ariola Dafny, MPH BSN, PhD Student

I, Judy March, Executive Director, Nursing and Midwifery Services support Researcher, Hila Dafny to conduct a study on "Verbal and Physical Violence towards Nurses in Queensland" as part of her PhD studies. The study will take place on the Emergency Department (ED), Intensive Care Unit (ICU) and Mental Health Department (MHD).

Yours faithfully

Judy March
Executive Director
Nursing and Midwifery Services
Appendix E: Focus Group Invitation

These two invitations were posted on the bulletin board of the tea room in each department including the direction to participate in the Focus Group at USQ.

---

Focus Group Invitation

It is reported in the literature that violence against nurses is a significant problem in the nursing workplace worldwide. Nurses are at extremely high risk of incurring workplace violence during their working life. The healthcare industry has been found to be the most violent industry in Australia.

Hello,
I would like to invite you to attend a focus group session about "The perceptions of nurses regarding possibilities of violence, strategies and support". The focus group interview will be conducted outside of work hours at the University of Southern Queensland, Toowoomba.

The participants should be nurses who work in The Emergency Department, The Acute Mental Health Unit or The Intensive Care Unit.

The aim of the focus group is to explore the perceptions of nurses on how the possibility of physical and verbal violence from patients and visitors in the workplace might impact on nurses including their ability to interact with patients and visitors. This study will further aim to investigate the nurses’ perceptions of the possible support and strategies of their Hospital to prevent and manage aggressive patients and visitors.

The focus group in each department will have about 5-8 nurses. The focus group sessions will take approximately an hour and will be digitally recorded. You are free to withdraw anytime from the session. The data will be de-identified to ensure participants’ confidentiality.

Benefits to participants and the nursing community from this session would be:
- Discovering the experiences, thoughts and feelings of nurses about the possibilities of verbal and physical violence in the workplace and a better understanding of how it might impact on them including their ability to interact with patients and visitors.
- Contribution to healthcare management in developing policy against violence, prevention and guidelines to support nurses who experience violence at their workplace.
- Improvement and/or development of education programs that could be implemented in Australian health institutions and in nursing education systems.

Please note that there will be refreshments and the participants will receive A $25 gift voucher to reimburse them for their time and effort.
Please contact the researcher for more information and the time for the event.

Kind Regards,
Mrs Hila Dafny (R.N, B.S.N, M.P.H, PhD candidate)
Faculty of Health, Engineering and Sciences
The Centre for Rural and Remote Area Health (CRRAH), USQ.
Email: HilaAriela.Dafny@usq.edu.au Phone: 07-46315459 or 04-81598630 after hour mobile
“The perceptions of nurses regarding possibilities of violence, strategies and support”

Seeking a total of 8 Nurses for about an hour
Focused Group Discussion

**Light Refreshments Available and**

$25 gift voucher

Please contact:

Hila Dafny
RN, B.S.N, M.P.H, PhD candidate

07-46315459
04-81598630
HilaAriela.Dafny@usq.edu.au
Appendix F: USQ Direction for the Focus Group Participants

Focus Group Meeting
Location: Q303
Q Block, 3rd Floor, Room 3303
Please park your car:
Parking 2 or Parking 1A
Please contact Mike Daffy:
04 8159 8630 or 07 4631 5459
Appendix G: Focus Group Direction Participants at USQ Entrances

“The perceptions of nurses regarding possibilities of violence, strategies and support”

Focus Group Session

3rd Floor

Room: Q303

Hila Dafny
Appendix H: Online Invitation to Participate in The Focus Group

This online focus group invitation was sent by the NUMs of each department to the participants (the nurses who work in each department) with the attached of the Focus Group Invitation (Appendix E) and the Focus group Participant Information Sheet (Appendix J).

Hello (the name of the NUM),

I hope this finds you well.

Now the time has come to recruit nurses to participate in my study, entitled, “The perceptions of nurses regarding possibilities of violence, strategies and support”. I got the ethics approval and Site Specific Assessment form signed by the Chief Executive of the Darling Downs Hospital and Health Service (please see attached).

It would be much appreciated if you please circulate attached invitation to the nurses working in your department.

Thanks for your support!

Regards,
Hila

For Nurses….

Hello,

You are invited to take part in a study entitled: “The perceptions of nurses regarding possibilities of violence, strategies and support”. The aim of the study is to explore the perceptions of nurses on how the possibility of physical and verbal violence from patients and visitors in the workplace might impact on nurses including their ability to interact with patients and visitors. Please see that attached invitation form.

Note: There is refreshments and a $25 gift voucher to reimburse your time and effort.

Please contact the researcher for more information and the time for the event.

Kind Regards,

Hila Dafiry
M.P.H, B.S.N, PhD Student
University of Southern Queensland
Toowoomba | Queensland | 4350 | Australia
Ph: 07 4631 5459 | Fax: 07 4631 5452 | M:04 8159 8630
Email Hilda.Dafiry@usq.edu.au
Appendix I: Focus Group Consent Form

The University of Southern Queensland
Focus Group Consent Form

HREC Approval Number: HREC/14/QTDD/6
Dear Participant,

Full Project Title: The perceptions of nurses regarding possibilities of violence, strategies and support.

Principal Researcher: Hila Ariela Dafy

I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. I understand and agree to take part.

I know that the research is funded by the FFI Fellowship (Fellowships Fund Inc, Graduate Women QLD)

I understand the purpose of the research project and my involvement in it.

I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future.

I confirm that I am over 18 years of age.

I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential. Names will not be used throughout the study whether in data analysis, recorded audio interviews or transcription of audio recordings.

I understand that I will be audio taped during the study.

I understand that the Hardcopy data will be stored in a locked filing cabinet separate to any data requiring storage at USQ CRRAH (Centre for Rural and Remote Area Health). Data, audio recording and transcripts will be stored on a password protected external hard drive in a locked filing cabinet separate to consent forms to ensure that participants cannot be identified. Computer data bases will be stored on a password encrypted hard drive on the USQ secure server.

I understand that the transcripts from recordings cannot be reviewed and that withdrawal from the study is an option but withdrawal of data already obtained is not an option.

Name of participant: .................................................................

Signed: .................................................................................. Date: .................................................................

If you have any ethical concerns or complaints with how the research is being conducted, please contact the DDHHS HREC Coordinator on the following details.

HREC Coordinator
Darling Downs Hospital and Health Services
Human Research Ethics Committee
Pechey Street Toowoomba
Queensland 4350
Telephone: +61 7 4616 6686
Facsimile: +61 7 4616 5089

Focus group Consent Form, Version 3, 31/01/2014
Appendix J: Focus group Participant Information Sheet

HREC Approval Number: HREC/14/QTDD/6

Full Project Title: The perceptions of nurses regarding possibilities of violence, strategies and support

Principal Researcher: Mrs Hilia Dafny

Dear Participant,

I would like to invite you to take part in this research project.

1. Procedures
The nature and the purpose of the study:
It is reported in the literature that violence against nurses is a significant problem in the nursing workplace worldwide. Nurses are at extremely high risk of incurring workplace violence during their working life. The healthcare industry has been found to be the most violent industry in Australia. The purpose of the study is to explore the perceptions of nurses on how the possibility of physical and verbal violence from patients and visitors in the workplace might impact on nurses including their ability to interact with patients and visitors. This study will further aim to investigate the nurses’ perceptions of the possible support and strategies of their Hospital to prevent and manage aggressive patients and visitors.

Participation in this project will involve three focus group sessions with nurses, one in each of three departments: Emergency Department, Intensive Care Unit and Acute Mental Health Unit of a regional public Hospital in Queensland. The focus group sessions will be conducted outside of work hours at the University of Southern Queensland, Toowoomba. Each focus group will consist of 5-8 nurses. The focus group sessions will take approximately an hour and will be digitally recorded. Data will be de-identified to ensure the participants’ confidentiality. This research is funded by the FFI Fellowship ( Fellowships Fund Inc, Graduate Women QLD).

Benefits to participants and the nursing community would be:
- Discovering the experiences, thoughts and feelings of nurses about the possibilities of verbal and physical violence in the workplace and a better understanding of how it might impact on them including their ability to interact with patients and visitors.
- Contribution to healthcare management in developing policy against violence, prevention programs and guidelines to support nurses who experienced violence at their workplace.
- Improvement and/or development of policies and education programs that could be implemented in Australian health institutions and in nursing education systems.

The risks associated with the study:
The participating nurses will volunteer to share their views and perceptions. Some of the nurses might have experienced violence toward them by patients and their visitors and this could cause some of the participants’ distress or feelings of discomfort. However, some nurses may feel empowered by sharing their views and gain a deeper understanding through sharing and articulating successful practices.
Potential risks will be minimised and/or managed:
In order to minimize discomfort or distress, the discussion during the focus groups will be about general issues and not individual experiences. In addition, the facilitator will provide individual support and will discuss options to link the potential distressed participants with appropriate support services. The list of the appropriate support services will be given to each of the participants in the focus group at the beginning of the discussion. Furthermore, if an individual becomes distressed, the facilitator will provide the relevant information on how to access additional support services. In addition, he or she will be encouraged by the facilitator to refer to those support services.

The support services are:
1) The participants can be referred to a consultation provided by the hospital: Employee Assistance Services (EAS) is an in-house service which has been provided for the past 20 years to support QH employees in the South East corner of Queensland. Employee Assistance Services (EAS) is the in-house provider within the District or Division. Employee Assistance is voluntary at all times, is self-referral and is free-of-charge for up to six (6) counselling sessions per calendar year. The counselling services can be for personal and/or work issues. Ph: 1300 361 008.
2) Lifeline Ph: 131114.
3) Access your GP and discussed appropriate referrals that can be made for you.

2. Voluntary Participation

Participation is entirely voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

You can choose not to respond/answer any specific questions. All the information will remain confidential and care will be exercised to not identifying any information with individuals. Your participation in focus group discussion will not be able to be withdrawn because during the transcript of the audio tape the data will be de-identified to ensure the participants’ confidentiality.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with the University of Southern Queensland or your hospital.

Please notify the researcher if you decide to withdraw from this project.

Should you have any queries regarding the progress or conduct of this research, you can contact the principal researcher:

Mrs Hila Dafny (R.N, B.S.N, M.P.H, PhD candidate)
Faculty of Health, Engineering and Sciences
The Centre for Rural and Remote Area Health (CRRAH), USQ,
USQ, CRRAH West Street.
Email: HilaAriela.Dafny@usq.edu.au
Phone: 07-46315459 or 04-81598630 (after hour phone)

If you have any ethical concerns or complains with how the research is being conducted, please contact the DDHHS HREC Coordinator on the following details:

HREC Coordinator
Darling Downs Hospital and Health Services
Human Research Ethics Committee
Pechey Street Toowoomba
Queensland 4350
Telephone: +61 7 4616 6896
Facsimile: +61 7 4616 5099

Focus Group Participant Information Sheet, Version 3, 31/03/2014
Appendix K: Focus Group Participants Demographic Profile

The Demographic Profile of the Focus Group’s participants

Demographic profile

The perceptions of nurses regarding possibilities of violence, strategies and support

Please complete the questionnaire by either ticking (✓) or writing in the space provided. If you do not know how to answer a question, just go on to the next one.

1. What year were you born? 19______
2. What is your gender? __Female ___Male
3. Please indicate if your background is: (please select only one)
   __Aboriginal __Torres Strait Islander __Other Australian __Other, please specify________
4. What is your highest level of education? (please select only one)
   __Nursing Diploma __Associated Degree __Bachelor’s Degree
   __Master’s Degree __Doctoral Degree __Other, please specify________
5. Do you have any training in? (Please select all that applies)
   __Emergency __Intensive Care __Mental Health __Other, please specify________
6. Years of work experience as a nurse: ______ years
7. Do you work currently? __Full time __Part time __Casual __Agency
Appendix L: Focus Group General Questions

Focus group questions:

1. Does physical or verbal violence occur by patients or their visitors?

2. What do you think about workplace violence?

3. If violence did occur in the workplace, who do you think it might impact on:
   a) Nurses that experience it?
   b) Witnesses to it?
   c) Nurses’ ability to interact with patients or visitors?

4. What kind of strategies, from your point of view, are there in your hospital to address violence toward nurses?
   Are they implemented? Are they effective?

5. Do you know about the policy in your workplace regarding violence from patients and visitors?
   Do you think it is accessible? Is it implemented? Is it effective?
   Do you think that this policy needs to be changed? If yes, why and what changes?

6. Do you think that support is provided after violent incidents to the nurses?
   What kind of support? By whom?

7. In your opinion, what kind of support and by whom would help the most to reduce violence toward nurses in the workplace?

8. What do you suggest in order to reduce or avoid violence toward nurses?

9. What are your workloads like, do you feel you have sufficient time to complete your work?

10. How much Autonomy do you feel you have to make decisions in your workplace?
    What causes you to feel that you have the autonomy?
Appendix M: Survey Invitation

This Survey Invitation was posted in each participated department and under it there was a box with the Anonymous Survey Participant Information Sheet (Appendix P) that was attached to the Anonymous Survey Questionnaire (Appendix Q) and beside it there was a secure box (Appendix R) that allowed to the participants to return their surveys.

“The perceptions of nurses regarding possibilities of violence, strategies and support”

Please fill out one of the below survey or if you prefer, you can do it on-line at http://usqsurvey.usq.edu.au/~HREC14QTDD6_master

Thank you for your contribution to the study!

Survey closes 29 November

Kind regards,
Hila Dafny
RM, B. ScN, M.P.H, PhD candidate
Appendix N: Online Invitation to participate in the Survey

This online invitation was sent by the NUMs of each department to the participants (the nurses who work in each department) with attached Cover Page for Online Anonymous Survey (Appendix O) and the Anonymous Survey Participant Information Sheet (Appendix P).

Hello (the name of the NUM),

I hope this finds you well.

Now the time has come to recruit nurses to participate in the online survey study, entitled, “The perceptions of nurses regarding possibilities of violence, strategies and support”.

It would be much appreciated if you could please forward it to the nurses working in your department.

Thanks for your support!

Regards,

Hila

For Nurses....

Hello,

You are invited to take part in a study entitled: “The perceptions of nurses regarding possibilities of violence, strategies and support”.

The aim of the study is to explore the perceptions of nurses on how the possibility of physical and verbal violence from patients and visitors in the workplace might impact on nurses including their ability to interact with patients and visitors.

If you are interested in participating in the study please follow the link below to the short (10 minute) survey and further information on the study.

http://usqsurvey.usq.edu.au/~HREC14QTDD6_master

If you have problem with the link, please cut and paste the link to the browser.

I’d also appreciate it if you could forward it to anyone you know who is an RN in your department.

Thanks very much!

Kind Regards,

Hila Dafry

M.P.H, B.S.N, PhD Student
University of Southern Queensland
Toowoomba | Queensland | 4350 | Australia
Ph: 07 4631 5459 | Fax: 07 4631 5452 | M:04 8159 8630
Email HilaDafry@usq.edu.au
Appendix O: Cover Page for Online Anonymous Survey

Cover page online survey

Hello,

It is reported in the literature that nurses routinely encounter verbal abuse and physical violence in their work place. Nurses, who work in emergency and mental health departments, are particularly at risk. This can have a significant impact on nurses’ health and safety and their abilities to offer effective care. However, the implications are much broader for the professions’ ability to attract and retain nurses within the healthcare system.

This study will attempt to explore the perceptions of nurses on how the possibility of physical and verbal violence from patients and visitors in their workplace might impact on nurses including their ability to interact with patients and visitors. This study will further aim to investigate the nurses’ perceptions of the possible support and strategies of their Hospital to prevent and manage aggressive patients and visitors.

Your participation is entirely voluntary and you are free to withdraw from the survey at any time. The collected data will be treated confidentially. **It will take you approximately 10 minutes to complete the survey.**

Please find attached a direct URL link for you to complete the survey. Any questions regarding this survey can be directed to the principal researcher:

Mrs Hila Dafny
Email: HilaAriela.Dafny@usq.edu.au
Phone: 07 4631 5459 or 04 8159 8630 (mobile)

If you have any ethical concerns or complain with how the research is being conducted, please contact the DDHHS HREC Coordinator
Telephone: +61 7 4616 6696 or Facsimile: +61 7 4616 5099

...........................................

Thank you for your assistance with this study.

The survey contains three sections:
I. About to your demographic information.
II. About possibilities of physical and verbal violence
III. About possible strategies and support to manage violence.

Kind regards,

Mrs Hila Dafny (R.N, B.S.N, M.P.H, PhD candidate)
Faculty of Health, Engineering and Sciences
The Centre for Rural and Remote Area Health (CRRAH), USQ

Cover page online survey, Version 3, 31/03/2014
Appendix P: Anonymous Survey Participant Information Sheet

This Anonymous Survey Participant Information Sheet was attached to the online invitation (Appendix N) and also was attached to the Printed Anonymous Survey Questionnaire (Appendix Q) and was located under the Survey Invitation (Appendix M) in each participated department.
Potential risks will be minimised and/or managed:

1) The participants can seek a consultation provided by the hospital: Employee Assistance Services (EAS) is an in-house service which has been provided for the past 20 years to support QH employees in the South East corner of Queensland. Employee Assistance Services (EAS) is your in-house provider within your District or Division. Employee Assistance is voluntary at all times, is self-referral and is free-of-charge for up to six (6) counselling sessions per calendar year. The counselling services can be for personal and / or work issues. Ph: 1300 361 008.
2) Lifeline Ph: 131114.
3) Access your GP and discussed appropriate referrals that can be made for you.

2. Voluntary Participation

Participation is entirely voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

You can choose not to respond/answer any specific questions. All the information will remain confidential and care will be exercised to not identifying any information with individuals. It will not be possible to withdraw your data afterwards because of anonymity.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with the University of Southern Queensland or your hospital.

Please notify the researcher if you decide to withdraw from this project.

Should you have any queries regarding the progress or conduct of this research, you can contact the principal researcher:

Mrs Hila Dafny (R.N, B.S.N, M.P.H, PhD candidate)
Faculty of Health, Engineering and Sciences
The Centre for Rural and Remote Area Health (CRRAH), USQ.
USQ, CRRAH West Street.
Email: HilaAriela.Dafny@usq.edu.au
Phone: 07-46315459 (after hour phone): 04-81598630

If you have any ethical concerns or complains with how the research is being conducted, please contact the DDHHS HREC Coordinator on the following details.

HREC Coordinator
Darling Downs Hospital and Health Services
Human Research Ethics Committee
Pechey Street Toowoomba
Queensland 4350
Telephone: +61 7 4616 6696
Facsimile: +61 7 4616 5099

Anonymous Survey Participant Information Sheet, Version 3, 31/03/2014
Appendix Q: Printed Final Anonymous Survey

SURVEY QUESTIONNAIRE

The perceptions of nurses regarding possibilities of violence, strategies and support

Please complete the questionnaire by either ticking (✓) or writing in the space provided. If you do not know how to answer a question, just go on to the next one.

A. PERSONAL AND WORKPLACE DATA

1. What year were you born? 19____
2. What is your gender? ___Female ___Male
3. Please indicate if your ethnic background is: (Please select all that apply)
   ___ Aboriginal    ___ Torres Strait Islander    ___ Australian born    ___ Other, immigrated to Australia
4. What is your highest level of education? (please select only one)
   ___ Nursing Diploma    ___ Associated Degree    ___ Bachelor’s Degree
   ___ Master’s Degree    ___ Doctorate Degree    ___ Other, please specify________
5. Do you have any training in? (Please select all that apply)
   ___ Emergency        ___ Intensive Care        ___ Mental Health        ___ Other, please specify________
6. Years of work experience as a nurse: _______ years
7. Do you work currently? ___ Full time ___ Part time ___ Casual
8. Which department are you working in? (Please select all that apply)
   ___ Emergency Department   ___ Intensive Care Unit   ___ Mental Health Department

WORKPLACE VIOLENCE

Workplace violence are incidents where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health.

Please answer by ticking (✓):

9. Do you believe that violence toward nurses occurs in the workplace? ___ Yes ___ No
9.1 In your opinion, during which shifts might nurses mainly experience workplace violence? (Select only one)
   ___ Morning ___ Evening ___ Night ___ Unsure
   In your opinion:
   

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplac</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e violence has increased over the last five years</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Workplac</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e violence is worrying for me</td>
<td></td>
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</tr>
</tbody>
</table>

B. VERBAL AND PHYSICAL VIOLENCE

Physical violence is defined as the use of physical force against another person or group that results in physical, sexual or psychological harm. It includes among others, beating, kicking, slapping, stabbing, shooting, pushing, biting and punching.

Verbal violence is defined as being yelled at or shouted at, cursed at or sworn at, spoken to in an inappropriate, offensive, rude, or hostile manner, having malicious rumours spread about, or being belittled or humiliated.

10. Throughout your nursing career, have you ever personally experienced:
   
   Verbal violence? ___ Yes ___ No
   Physical violence? ___ Yes ___ No. If NO, please go to Question 11 on the next page.

Please answer the following statements by: (1) ticking (✓) for Yes/No (2) ticking (✓) for Verbal and/or Physical

<table>
<thead>
<tr>
<th>In the last 12 months have you:</th>
<th>Verbal violence</th>
<th>Physical violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>11</td>
<td>Experienced a violent event</td>
<td></td>
</tr>
<tr>
<td>112</td>
<td>Witnessed an event</td>
<td></td>
</tr>
<tr>
<td>113</td>
<td>This workplace violence was from:</td>
<td></td>
</tr>
<tr>
<td>114</td>
<td>Toward patients</td>
<td></td>
</tr>
<tr>
<td>115</td>
<td>Toward nurses</td>
<td></td>
</tr>
<tr>
<td>116</td>
<td>Toward patients or visitors</td>
<td></td>
</tr>
<tr>
<td>117</td>
<td>Toward doctors</td>
<td></td>
</tr>
<tr>
<td>118</td>
<td>Toward hospital staff</td>
<td></td>
</tr>
</tbody>
</table>

Final Survey Questionnaire designed and created by Hila Ariela Dafny, 2014, Copyright, All rights reserved.
12. How do you think Verbal and Physical Violence might impact on nurses? Please indicate the level of agreement with the following statements by ticking (✓) for Verbal and Physical categories.

<table>
<thead>
<tr>
<th>Might impact on nurses:</th>
<th>Verbal violence</th>
<th>Physical violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>Personal: have a:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative psychosocial effect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative emotional effect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduces ability to offer effective care to patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduces motivation to work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increases potential to make errors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negatively impacts relationships with staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentally</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeated disturbing memories or thoughts of attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeatedly thinking or talking about the attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being “super alert” or watchful and on guard</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. In your opinion, how might nurses manage workplace violence? Please indicate your level of agreement by ticking (✓) for Verbal and Physical categories.

<table>
<thead>
<tr>
<th>Possible management of violence</th>
<th>Verbal violence</th>
<th>Physical violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>12.1 Take no action</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.2 Ask the person to stop</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.3 Talk to friends/family for support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.4 Talk to colleague for advice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.5 Seek counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.6 Try to defend themselves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.7 Complete an incident form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.8 Complete a compensation claim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.9 Report to a senior staff member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.10 Report to Hospital security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.11 Transfer to another position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.12 Pursue prosecution</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13A. What are the reasons for workplace violence?

C. STRATEGIES, SUPPORT, WORKLOAD AND AUTONOMY

14. Below is a list of statements about support during violence incidence. Please indicate your level of agreement by ticking (✓) for Verbal and Physical categories.

<table>
<thead>
<tr>
<th>Support during violence incident</th>
<th>Verbal violence</th>
<th>Physical violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>14.1 The incident was well managed by the hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.2 My manager supported me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.3 My colleagues supported me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.4 My family/friends supported me</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14A. Others who should provide nurses support, please describe:

Final Survey Questionnaire designed and created by Hila Ariela Dafny, 2014, Copyright, All rights reserved.
15. Below is a list of statements about strategies, support, workload and autonomy at your workplace.

   By ticking (✓), Please indicate: (1) the level of your agreement to the following statements
   (2) Do you think it is implemented in your department?

<table>
<thead>
<tr>
<th>Strategies, Support, workload and Autonomy</th>
<th>Level of agreement</th>
<th>Is it implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management Strategies:</td>
<td>Strongly Disagree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>15.1 Hospital has workplace violence policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.2 Hospital should involve nurses in developing workplace violence policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.3 Nurses should report violence in each instance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.4 Hospital should report violence to police in each instance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available services to nurses:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.5 Hospital should provide training on violence management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.6 Hospital should provide consultation after an incident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.7 Hospital should allow using of medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.8 Hospital should allow using mechanical restraint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.9 Hospital should encourage nurses to attend aggression management training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.10 Hospital should allow access to policies addressing workplace violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal support services for nurses in hospital:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.11 Should provide opportunities for education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.12 Should ensure nurses work under safe conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.13 Should provide training to address violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.14 Should allow nurses to manage patient care adequately and effectively</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.15 Should encourage new ideas to deal with violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.16 Should allow sharing information and feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.17 Should provide resources for resolving problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.18 Should show clear guidance about violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.19 Should assess the needs of the department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.20 Should facilitate support from colleagues after an incident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.21 Should provide support from supervisors after an incident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.22 Should empower nurses to accomplish work in an effective manner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workload in my department:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.23 Should allow nurses to feel safe in their work environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.24 Negatively affects my ability to manage patient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.25 Contributes to violence toward nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.26 Nurses do have sufficient time to complete their work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.27 There is a process in place that deals with workload issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autonomy at work:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.28 Nurses have the ability to make necessary decisions related to patient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.29 Nurses’ autonomy contributes to reducing workplace violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.30 Nurses are satisfied with their authority to manage violence at work</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. Suggestions: What are the most important measures that would prevent and manage violence in your workplace?

   Prevention of violence: ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   Management of violence: ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   Thank you for your time and contribution in filling out this survey.
   You participation is greatly appreciated!

   Final Survey Questionnaire designed and created by Hila Ariela Dafry, 2014, Copyright, All rights reserved.
Appendix R: Anonymous Survey Questionnaire Secure Boxes

These secure boxes were located in the tea room of each department.
Appendix S: Note Posted on Each Secure Box

“The perceptions of nurses regarding possibilities of violence, strategies and support”

Please return your completed survey to this box

Thank you for your contribution to the study!

Kind regards,
Hila Dafny
RN, B.S.N., M.P.H., PhD candidate
07-46315459  04-81598630
HilaAriela.Dafny@usq.edu.au
Appendix T: Notification of Commencement of Research Protocol

Darling Downs Hospital and Health Service
Human Research Ethics Committee (EC00182)

NOTIFICATION OF COMMENCEMENT OF RESEARCH PROTOCOL

PROTOCOL NO: HREC/14/QTDD/6. SSA/14/QTDD/34

PROTOCOL TITLE: The perceptions of nurses regarding possibilities of violence, strategies and support.

PRINCIPAL INVESTIGATOR: Mrs Hila Dafny

This is to advise that the above research protocol commenced on:

28 / 05 / 2014

Signature: Hila Dafny Date: 28 / 05 / 2014

Please forward to HREC when protocol commences

Great state. Great opportunity.

Queensland Government
Appendix U: ANOVA Tests (F-test) and t-Test

ANOVA Test by variables: Age, Years of Work Experience, Departments and Level of Education

1) F-Test of Age:

Table 1: Age Groups by Verbal Violence

<table>
<thead>
<tr>
<th>Verbal Violence</th>
<th>Three Age Groups by years</th>
<th>F value</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22-35 years</td>
<td>36-50 years</td>
<td>50-68 years</td>
</tr>
<tr>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Impact</td>
<td>31</td>
<td>4.12</td>
<td>39</td>
</tr>
<tr>
<td>Management</td>
<td>28</td>
<td>3.41</td>
<td>40</td>
</tr>
<tr>
<td>Support</td>
<td>30</td>
<td>3.60</td>
<td>40</td>
</tr>
</tbody>
</table>

Table 2: Age Groups by Physical Violence

<table>
<thead>
<tr>
<th>Physical Violence</th>
<th>Three Age Groups by years</th>
<th>F value</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22-35 years</td>
<td>36-50 years</td>
<td>50-68 years</td>
</tr>
<tr>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Impact</td>
<td>28</td>
<td>4.37</td>
<td>37</td>
</tr>
<tr>
<td>Management</td>
<td>29</td>
<td>3.78</td>
<td>40</td>
</tr>
<tr>
<td>Support</td>
<td>31</td>
<td>3.97</td>
<td>38</td>
</tr>
</tbody>
</table>

Table 3: Age Groups by Strategies Management and Support Services

<table>
<thead>
<tr>
<th>Strategies and Services</th>
<th>Three Age Groups by years</th>
<th>F value</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22-35 years</td>
<td>36-50 years</td>
<td>50-68 years</td>
</tr>
<tr>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Level of Agreement</td>
<td>27</td>
<td>4.22</td>
<td>36</td>
</tr>
</tbody>
</table>

2) F-Test of Years of Work Experience:

Table 4: Years of Work Experience by Verbal Violence

<table>
<thead>
<tr>
<th>Verbal Violence</th>
<th>Years of Work Experience</th>
<th>F value</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-5 years</td>
<td>6-15 years</td>
<td>16-43 years</td>
</tr>
<tr>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Impact</td>
<td>23</td>
<td>4.14</td>
<td>37</td>
</tr>
<tr>
<td>Management</td>
<td>23</td>
<td>3.45</td>
<td>33</td>
</tr>
<tr>
<td>Support</td>
<td>24</td>
<td>3.61</td>
<td>35</td>
</tr>
</tbody>
</table>
### Table 5: Years of Work Experience by Physical Violence

<table>
<thead>
<tr>
<th>Physical Violence</th>
<th>Years of Work Experience</th>
<th>F value</th>
<th>Sig. P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-5 years</td>
<td>6-15 years</td>
<td>16-43 years</td>
</tr>
<tr>
<td>Impact</td>
<td>N</td>
<td>Mean</td>
<td>N</td>
</tr>
<tr>
<td>Management</td>
<td>21</td>
<td>4.39</td>
<td>35</td>
</tr>
<tr>
<td>Support</td>
<td>24</td>
<td>3.84</td>
<td>33</td>
</tr>
</tbody>
</table>

### Table 6: Years of Work Experience by Strategies Management and Support Services

<table>
<thead>
<tr>
<th>Strategies and Services</th>
<th>Years of Work Experience</th>
<th>F value</th>
<th>Sig. P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-5 years</td>
<td>6-15 years</td>
<td>16-43 years</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>N</td>
</tr>
<tr>
<td>Impact</td>
<td>21</td>
<td>4.20</td>
<td>34</td>
</tr>
<tr>
<td>Management</td>
<td>52</td>
<td>3.91</td>
<td>24</td>
</tr>
<tr>
<td>Support</td>
<td>53</td>
<td>3.62</td>
<td>23</td>
</tr>
</tbody>
</table>

### 3) F-Test of Departments:

#### Table 7: Departments by Verbal Violence

<table>
<thead>
<tr>
<th>Verbal Violence</th>
<th>Departments</th>
<th>F value</th>
<th>Sig. P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MHU</td>
<td>ED</td>
<td>ICU</td>
</tr>
<tr>
<td>Impact</td>
<td>N</td>
<td>Mean</td>
<td>N</td>
</tr>
<tr>
<td>Management</td>
<td>55</td>
<td>4.04</td>
<td>24</td>
</tr>
</tbody>
</table>

#### Table 8: Departments by Physical Violence

<table>
<thead>
<tr>
<th>Physical Violence</th>
<th>Departments</th>
<th>F value</th>
<th>Sig. P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MHU</td>
<td>ED</td>
<td>ICU</td>
</tr>
<tr>
<td>Impact</td>
<td>N</td>
<td>Mean</td>
<td>N</td>
</tr>
<tr>
<td>Management</td>
<td>53</td>
<td>4.33</td>
<td>21</td>
</tr>
<tr>
<td>Support</td>
<td>54</td>
<td>3.93</td>
<td>23</td>
</tr>
</tbody>
</table>
Table 9: Departments by Strategies Management and Support Services

<table>
<thead>
<tr>
<th>Strategies and Services</th>
<th>Departments</th>
<th>F value</th>
<th>Sig. P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MHU</td>
<td>ED</td>
<td>ICU</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>N</td>
</tr>
<tr>
<td>Level of Agreement</td>
<td>52</td>
<td>4.21</td>
<td>19</td>
</tr>
</tbody>
</table>

4) F-Test of level of Education:

Table 10: Level of Education by Verbal Violence

<table>
<thead>
<tr>
<th>Verbal Violence</th>
<th>Level of Education</th>
<th>Bachelor’s degree</th>
<th>Master’s degree</th>
<th>Diploma in nursing and other certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Impact</td>
<td>57</td>
<td>4.09</td>
<td>26</td>
<td>4.17</td>
</tr>
<tr>
<td>Management</td>
<td>54</td>
<td>3.49</td>
<td>25</td>
<td>3.65</td>
</tr>
<tr>
<td>Support</td>
<td>57</td>
<td>3.64</td>
<td>25</td>
<td>3.46</td>
</tr>
</tbody>
</table>

Table 11: Level of Education by Physical Violence

<table>
<thead>
<tr>
<th>Physical Violence</th>
<th>Level of Education</th>
<th>Bachelor’s degree</th>
<th>Master’s degree</th>
<th>Diploma in nursing and other certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Impact</td>
<td>52</td>
<td>4.30</td>
<td>26</td>
<td>4.48</td>
</tr>
<tr>
<td>Management</td>
<td>55</td>
<td>3.83</td>
<td>25</td>
<td>4.02</td>
</tr>
<tr>
<td>Support</td>
<td>55</td>
<td>3.82</td>
<td>26</td>
<td>3.86</td>
</tr>
</tbody>
</table>

Table 12: Level of Education by Strategies Management and Support Services

<table>
<thead>
<tr>
<th>Strategies and Services</th>
<th>Level of Education</th>
<th>Bachelor’s degree</th>
<th>Master’s degree</th>
<th>Diploma in nursing and other certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Level of Agreement</td>
<td>49</td>
<td>4.28</td>
<td>26</td>
<td>4.17</td>
</tr>
</tbody>
</table>


\textit{t}-Test

\textit{t}-Test by variables: Gender, Background and Work Status

1) \textit{t}-Test of Gender:

Table 1: \textit{t}-test for the differences in perception between males and females nurses towards verbal violence

<table>
<thead>
<tr>
<th>Verbal Violence</th>
<th>Gender</th>
<th>T value</th>
<th>Sig. (2-tailed) P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Mean</td>
<td>Male</td>
</tr>
<tr>
<td>Impact</td>
<td>58</td>
<td>4.18</td>
<td>37</td>
</tr>
<tr>
<td>Management</td>
<td>56</td>
<td>3.54</td>
<td>34</td>
</tr>
<tr>
<td>Support</td>
<td>59</td>
<td>3.59</td>
<td>35</td>
</tr>
</tbody>
</table>

Table 2: \textit{t}-test for the differences in perceptions based on the gender of nurses towards physical violence

<table>
<thead>
<tr>
<th>Physical Violence</th>
<th>Gender</th>
<th>T value</th>
<th>Sig. (2-tailed) P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Mean</td>
<td>Male</td>
</tr>
<tr>
<td>Impact</td>
<td>56</td>
<td>4.44</td>
<td>33</td>
</tr>
<tr>
<td>Management</td>
<td>58</td>
<td>3.85</td>
<td>34</td>
</tr>
<tr>
<td>Support</td>
<td>58</td>
<td>3.84</td>
<td>35</td>
</tr>
</tbody>
</table>

Table 3: \textit{t}-test for the differences in perceptions based on the gender of nurses towards strategies and services

<table>
<thead>
<tr>
<th>Strategies and Services</th>
<th>Gender</th>
<th>T value</th>
<th>Sig. (2-tailed) P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Mean</td>
<td>Male</td>
</tr>
<tr>
<td>Level of Agreement</td>
<td>51</td>
<td>4.22</td>
<td>36</td>
</tr>
</tbody>
</table>

2) \textit{t}-Test of Background

Table 4: Background by Verbal Violence

<table>
<thead>
<tr>
<th>Verbal Violence</th>
<th>Background</th>
<th>T value</th>
<th>Sig. (2-tailed) P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Immigrated to Australia</td>
<td>Mean</td>
<td>Aboriginal and Australian Born</td>
</tr>
<tr>
<td>Impact</td>
<td>17</td>
<td>3.96</td>
<td>73</td>
</tr>
<tr>
<td>Management</td>
<td>14</td>
<td>3.51</td>
<td>71</td>
</tr>
<tr>
<td>Support</td>
<td>15</td>
<td>3.68</td>
<td>74</td>
</tr>
</tbody>
</table>
### Table 5: Background by Physical Violence

<table>
<thead>
<tr>
<th>Physical Violence</th>
<th>Background</th>
<th>T value</th>
<th>Sig. (2-tailed) P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Immigrated to Australia</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aboriginal and Born</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Mean</td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Impact</td>
<td>15</td>
<td>4.42</td>
<td>69</td>
</tr>
<tr>
<td>Management</td>
<td>14</td>
<td>3.89</td>
<td>73</td>
</tr>
<tr>
<td>Support</td>
<td>15</td>
<td>3.86</td>
<td>73</td>
</tr>
</tbody>
</table>

### Table 6: Background by Strategies Management and Support Services

<table>
<thead>
<tr>
<th>Strategies and Services</th>
<th>Background</th>
<th>T value</th>
<th>Sig. (2-tailed) P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Immigrated to Australia</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aboriginal and Born</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Mean</td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Level of Agreement</td>
<td>17</td>
<td>4.21</td>
<td>66</td>
</tr>
</tbody>
</table>

### 3) t-Test of Work Status

#### Table 7: Work Status by Verbal Violence

<table>
<thead>
<tr>
<th>Verbal Violence</th>
<th>Work Status</th>
<th>T value</th>
<th>Sig. (2-tailed) P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part-Time and Casual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Mean</td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Impact</td>
<td>71</td>
<td>4.05</td>
<td>23</td>
</tr>
<tr>
<td>Management</td>
<td>68</td>
<td>3.51</td>
<td>21</td>
</tr>
<tr>
<td>Support</td>
<td>69</td>
<td>3.62</td>
<td>24</td>
</tr>
</tbody>
</table>

#### Table 8: Work Status by Physical Violence

<table>
<thead>
<tr>
<th>Physical Violence</th>
<th>Work Status</th>
<th>T value</th>
<th>Sig. (2-tailed) P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part-Time and Casual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Mean</td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Impact</td>
<td>67</td>
<td>4.34</td>
<td>21</td>
</tr>
<tr>
<td>Management</td>
<td>67</td>
<td>3.85</td>
<td>24</td>
</tr>
<tr>
<td>Support</td>
<td>68</td>
<td>3.84</td>
<td>24</td>
</tr>
</tbody>
</table>
Table 9: Work Status by Strategies Management and Support Services

<table>
<thead>
<tr>
<th>Strategies and Services</th>
<th>Work Status</th>
<th>T value</th>
<th>Sig. (2-tailed) P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Part-Time and Casual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Mean</td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Level of Agreement</td>
<td>63</td>
<td>23</td>
<td>4.23</td>
</tr>
</tbody>
</table>

Appendix V: Pilot Anonymous Survey

PILOT - SURVEY QUESTIONNAIRE

VERBAL AND PHYSICAL VIOLENCE TOWARD NURSES FROM PATIENTS AND VISITORS IN QUEENSLAND

Please complete the questionnaire by either ticking (✓) or writing in space provided. If you do not know how to answer a question, just go on to the next one.

A. PERSONAL AND WORKPLACE DATA

1. What year were you born? 19

2. What is your gender? __Female ___Male

3. What is your highest level of education? (please select only one)
   ___Nursing Diploma ___Associated Degree ___Bachelor’s Degree
   ___Master’s Degree ___Doctoral Degree ___Other, please specify

4. Do you have any training in? (Please select all that applies)
   ___Emergency ___Intensive Care ___Mental Health ___Other, please specify

5. Years of work experience as a nurse: _______years

6. Do you work currently? ___Full time ___Part time ___Casual ___Agency

7. Which department are you working in? (Please select all that applies)
   ___Emergency Department ___Intensive Care Unit ___Mental Health Department

WORKPLACE VIOLENCE

Workplace violence are incidents where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health.

Please answer by ticking (✓):

8. In your opinion, during which shifts have you mainly experienced workplace violence? (Select only one)
   ___Morning ___Evening ___Night ___Combination ___N/A

9. In your opinion, during which shifts have you mainly observed workplace violence? (Select only one)
   ___Morning ___Evening ___Night ___Combination ___N/A

In your opinion:

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace violence has increased over the last five years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace violence is worrying me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. VERBAL AND PHYSICAL VIOLENCE

Physical violence defined as the use of physical force against another person or group that results in physical, sexual or psychological harm. It includes among others, beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching.

Verbal violence defined as being yelled at or shouted at, cursed at or sworn at, behaved towards in an inappropriate, offensive, rude, or hostile manner, having malicious rumours spread about, or being belittled or humiliated.

Did you experience verbal or physical violence? ___Yes ___No. If NO, please go to Question 1 on the next page.

Please answer the following statements by: (1) ticking (✓) for Yes/No (2) ticking (✓) for Verbal and/or Physical

<table>
<thead>
<tr>
<th>In the last 12 months have you:</th>
<th>Yes</th>
<th>No</th>
<th>Verbal</th>
<th>Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced a violence event</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Witnessed a violence event</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace violence that you have experienced was from.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients toward nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visitors toward nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses toward other nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses toward patients or visitors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others, please describe:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pilot Survey Questionnaire designed and created by Hila Ariela Dafny, 2014, Copyright, All rights reserved.
1. How do you think Verbal and Physical Violence impacts on you? 
Please indicate the level of impact on you in the following statements by ticking (✓) for Verbal and Physical:

<table>
<thead>
<tr>
<th>Impact on me:</th>
<th>Verbal violence</th>
<th>Physical violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly</td>
<td>Disagree</td>
</tr>
<tr>
<td>Personally:</td>
<td>Disagree</td>
<td></td>
</tr>
<tr>
<td>1.1 Negative effect on me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Negative psychosocial effect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Negative emotional effect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4 Not effect at all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionally:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5 Reduces ability to offer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>effective care to patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.6 Reduces motivation to work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.7 Increases potential to make</td>
<td></td>
<td></td>
</tr>
<tr>
<td>errors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.8 Negatively impacts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>relationships with staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.9 Not effect at all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentally:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.10 Repeated disturbing memories</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.11 Repeated thoughts or images</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.12 Avoiding thinking about or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>talking about the attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.13 Being ‘super alert’ or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>watchful and on guard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.14 Not effect at all</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. How would you manage workplace violence? 
A. During the event? Please describe: __________________________________________
B. After the event? Please indicate your level of agreement by ticking (✓) for Verbal and Physical:

<table>
<thead>
<tr>
<th>Management of violence</th>
<th>Verbal violence</th>
<th>Physical violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly</td>
<td>Disagree</td>
</tr>
<tr>
<td>2.1 Take no action</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2 Ask the person to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>stop</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3 Talk to friends/family/colleague</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4 Seek counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5 Try to defend myself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6 Pursue prosecution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.7 Complete an incident form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.8 Complete a compensation claim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.9 Transfer to another position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.10 Report to a senior staff member</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. C. STRATEGIES, SUPPORT AND SATISFACTION

3. Below is a list of statements about support during violence incidence. 
C. Please indicate your level of agreement by ticking (✓) for Verbal and Physical:

<table>
<thead>
<tr>
<th>Support during violence incidence</th>
<th>Verbal violence</th>
<th>Physical violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly</td>
<td>Disagree</td>
</tr>
<tr>
<td>3.1 The incidence was well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>managed by the hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 My manager encouraged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 My colleagues encouraged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4 My family/ friends encouraged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5 Others encouraged reporting,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please describe</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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4. Below is a list of statements about strategies, support and satisfaction at your workplace. By ticking (✓), please indicate: (1) the level of your agreement to the following statements (2) is it implemented in your department?

<table>
<thead>
<tr>
<th>Strategies, support and satisfaction about Workplace violence</th>
<th>Level of agreement</th>
<th>Is it implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important Management Strategies:</td>
<td>Strongly Agree</td>
<td>Agree</td>
</tr>
<tr>
<td>Nurses should have knowledge of workplace policies dealing with violent patients / visitors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses should know how to report violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses should participate in developing policy against violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses should report violence in such instances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals should take action by reporting violence to police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses should have access to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff training programs dealing with violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation after a violent incident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mechanical restraint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggression training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policies that address workplace violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support and satisfaction from my organisation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supports the opportunity for nurses' education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures nurses work under safe conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides training to address violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allows nurses to manage patient care adequately and effectively</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourages new ideas to deal with violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing information and feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not provide resources for resolving problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates clear guidance about violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assesses the needs of the team/department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support from co-workers after an incidence of violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support from supervisors after an incidence of violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support from family and friends after an incidence of violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses feel safe in their workplace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall violence at my workplace is effectively managed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workload at work: effects negatively on manage patient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workload at work: contribute to violence in my department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My work environment empowers me to accomplish my work in an effective manner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My organisation has a committee and/or processes in place that deal with workload issues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Suggestions:
In your opinion, what are the three most important measures that would reduce violence in your workplace?

a) ____________________________________________________________

b) ____________________________________________________________

c) ____________________________________________________________

Thank you for your time and contribution in filling out this survey.
You participation is greatly appreciated!
Appendix W: Original Draft Anonymous Survey

DRAFT - SURVEY QUESTIONNAIRE

VERBAL AND PHYSICAL VIOLENCE TOWARD NURSES FROM PATIENTS AND VISITORS IN QUEENSLAND

Please complete the questionnaire by either ticking (✓) or writing in space provided. If you do not know how to answer a question, just go on to the next one.

A. PERSONAL AND WORKPLACE DATA

1. What year were you born? 19_____
2. What is your gender? ___Female  ___Male
3. What is your highest level of education? (please select only one)
   ___Nursing Diploma  ___Associate Degree  ___Bachelor’s Degree
   ___Master’s Degree  ___Doctoral Degree  ___Other, please specify________
4. Do you have any training in? (Please select all that applies)
   ___Emergency  ___Intensive Care  ___Mental Health  ___Other, please specify________
5. Years of work experience as a nurse: _______ years
6. How do you work currently? ___Full time  ___Part time
7. Which department are you working in? (Please select all that applies)
   ___Emergency Department  ___Intensive Care Unit  ___Mental Health Department
8. In the last four weeks, what shifts have you mainly worked? (Please select only one)
   ___Morning  ___Evening  ___Night

WORKPLACE VIOLENCE

Workplace violence are incidents where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health.

Please answer by ticking (✓):

<table>
<thead>
<tr>
<th>In your opinion:</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace violence has increased over the last five years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace violence is worrying me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. VERBAL AND PHYSICAL VIOLENCE

Physical violence defined as the use of physical force against another person or group that results in physical, sexual or psychological harm. It includes among others, beating, kicking, slapping, stabbing, showing, pushing, biting and pinching.

Verbal violence defined as being yelled at or shouted at, cursed at or sworn at, behaved towards in an inappropriate, offensive, rude, or hostile manner, having malicious rumours spread about, or being belittled or humiliated.

<table>
<thead>
<tr>
<th>In the last 12 months have you:</th>
<th>Verbal attack</th>
<th>Physical attack</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced an attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Witnessed an attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both experienced and witnessed an attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neither experienced nor witnessed an attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace violence that you have experienced was from:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visitors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both patients and visitors</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. How do you think *Verbal and Physical Violence* impacts on you? 
Please indicate the level of impact on you in the following statements:

<table>
<thead>
<tr>
<th>Impact on me:</th>
<th>Verbal violence</th>
<th>Physical violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>Personally</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Negative physical effect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Negative psychosocial effect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Negative emotional effect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionally</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4 Reduce ability to offer effective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>care to patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5 Reduce motivation to work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.6 Increased potential to make</td>
<td></td>
<td></td>
</tr>
<tr>
<td>errors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.7 Negatively impact relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>with staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentally</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.8 Repeated disturbing memories of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.9 Repeated thoughts or images of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.10 Avoiding thinking about or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>talking about the attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.11 Being &quot;super alert&quot; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>watchful and on guard</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. How would you manage *workplace violence*? 
Please indicate your level of agreement on the following measures:

<table>
<thead>
<tr>
<th>Management of violence</th>
<th>Verbal violence</th>
<th>Physical violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 Take no action</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2 Ask the person to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>stop</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3 Talk to friends/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>family/colleague</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4 Seek counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5 Try to defend</td>
<td></td>
<td></td>
</tr>
<tr>
<td>myself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6 Pursue prosecution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.7 Complete an accident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.8 Complete a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>compensation claim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.9 Transfer to another</td>
<td></td>
<td></td>
</tr>
<tr>
<td>position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.10 Report to a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>senior staff member</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. STRATEGIES, SUPPORT AND SATISFACTION

3. Below is a list of statements about support during violence incidence. 
Please indicate your level of agreement with the following statements:

<table>
<thead>
<tr>
<th>Support during violence incidence</th>
<th>Verbal violence</th>
<th>Physical violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>3.1 The incidence was well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>managed by the hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 My manager encourage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 My colleagues encourage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4 My family/friends encourage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5 Other encourage reporting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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4. Below is a list of statements about strategies, support and satisfaction at your workplace. Please indicate the (1) level of your agreement to the following statements and (2) is it implemented:

<table>
<thead>
<tr>
<th>Strategies, support and satisfaction at workplace</th>
<th>Level of agreement</th>
<th>Is it implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management strategies</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>It is important to have knowledge of workplace policies dealing with aggressive patients/visitors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is important to have an access to the policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital should take action for reporting violence to police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is important that nurses know how to report violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses should participate in developing policy against violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses should report violence in each instance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses should have accessibility to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff training programs dealing with violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation after a violent incidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical restraint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mechanical restraint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggression management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of policies to address violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support and satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My organisation develops nurse’s knowledge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My organisation supports the opportunity for nurses’ promotion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My organisation ensures nurses working under safe conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My organisation provides training needs to address violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My organisation allows the nurses to manage patient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My organisation encourages new ideas to deal with violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective communication by sharing information and feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources for resolving problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support from co-workers after an incidence of violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support from supervisors after an incidence of violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support from family and friends after an incidence of violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses feel safe in their workplace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My organisation demonstrates clear guidance about violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My organisation assesses resources needs of the team department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My work environment empowers me to accomplish my work in an effective manner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My organisation has a committee and or processes in place that deal with workload at work</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Suggestions:
In your opinion, what are the three most important measures that would reduce violence in your workplace?

a) 

b) 

c) 

Thank you for your time and contribution in filling out this survey. You participation is greatly appreciated!