Australian Nursing And Midwifery Federation

SUBMISSION TO THE NATIONAL INQUIRY INTO SEXUAL HARASSMENT IN AUSTRALIAN WORKPLACES

March 2019

Australian Nursing & Midwifery Federation

Annie Butler
Federal Secretary

Lori-Anne Sharp
Assistant Federal Secretary

Australian Nursing and Midwifery Federation
Level 1, 365 Queen Street, Melbourne VIC 3000
T: 03 9602 8500
F: 03 9602 8567
E: anmffederal@anmf.org.au
W: www.anmf.org.au

About the ANMF

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 275,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a trade union and professional organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The ANMF believes all nurses, midwives and carers have the right to work in a safe and healthy workplace environment and to perform their work without risks to their physical and psychological health and safety.

The ANMF considers in all aspects of working life a zero tolerance approach to any form of sexual harassment in the workplace must be adopted. To achieve the elimination of sexual harassment in the workplace there must be systemic change to workplace structures that perpetuate gender inequality and cultural attitudes that condone unacceptable behaviour. These changes must be encouraged and supported by legislative, regulatory and policy reform.

National Inquiry into Sexual Harassment at Work

The ANMF welcomes the opportunity to make a submission to the Australian Human Rights Commission on this important inquiry and commends the AHRC for taking leadership in identifying and addressing the effects of sexual harassment in the workplace.

The ANMF has read the submission of the ACTU and wishes to express its strong support for all of the recommendations made by the ACTU to address both the causes and effects of sexual harassment in the workplace. This submission provides some industry specific information on the prevalence, nature and reporting of sexual harassment and the impact this has on workers and their participation in the workforce.

The ANMF has also considered the Boland report, which recommends the development of a new Regulation on psychosocial hazards be developed as a matter of priority. This recommendation is strongly supported and will be discussed further in this submission.

Prevalence, nature and reporting of sexual harrassment

Prevalence and nature

The AHRC 2018 survey: '*Everyone's business*: *Fourth national survey on sexual harassment in Australian workplaces'* shows the prevalence of workplace sexual harassment in the past five years by industry group. Health Care and Social Assistance sat at the national average across industries at 33%.

In 2018 The NSW Nurses & Midwives Association collaborated with Dr Jacqui Pich of University of Technology Sydney to conduct an extensive survey of nurses and midwives in NSW looking at their exposure to patient related violence and aggression. The survey asked about all forms of violence, including sexual harassment as experienced by nurses and midwives from patients, relatives and visitors to health services. It did not look at violence between colleagues at work.

Dr Pich presented her preliminary findings on the work, *'Violence against nurses and midwives from patients and or relatives and friends'*, at the 6th International Conference on Violence in the Health Sector in Toronto in October 2018. The report *'Violence in Nursing and Midwifery in NSW:Study Report'* (the Pich report) has recently been published and is annexed to this submission.

The survey attracted responses from 3,416 participants, working in nursing and midwifery including areas of medical, surgical, mental health and aged care across the public sector (78%), private sector (16%) and not for profits (7%). Reflective of gender representation in the industry, 87% of respondents were women.

Of the total number of participants surveyed, 47% reported experiencing an episode of violence in the previous week and 80% in the 6 months prior to completing the survey.

The report looked at the type of violence experienced in the previous 6 months. Verbal or non-physical violence was the most common type of violence reported, with 76% of participants experiencing an episode. Of those participants who had experienced verbal or non-physical violence, 25% had experienced sexually inappropriate behaviour.

Nearly 25% of participants reported physical abuse/violence in the previous 6 months. Of those participants 13% experienced inappropriate sexual conduct and 2% - or 35 individuals - had experienced sexual assault.

When invited to describe the nature of the inappropriate sexual conduct experienced, participants added the following:

- *A 23 year old ice user threatened to knife rape me*
- *I have had semen thrown on me*
- *Grabbed by the waist and pinned to the bed rail*
- *My right breast was grabbed by a dementia patient and squeezed so hard it hurt for 24 hours afterwards.*

Impact of violence

The Pich report examines the consequences of episodes of violence. While the report does not attribute consequences to the effects of sexual violence specifically, the findings on the consequences more broadly are relevant.

28% of participants reported they had suffered a physical or psychological injury as a result of an episode of violence. Nearly a third of those sought medical attention and over a third took time off work ranging from the remainder of a shift to over a year.

Some participants elaborated by saying they ended up resigning, were forced into retirement or took random days off when too distressed to work. The impact of violence can be highly detrimental to the working lives of nurses and midwives in terms of time away from work. Absence from work also impacts on colleagues, management of services and care of patients and health care recipients.

The Pich report also identifies the emotional consequences of experiencing violence at work. These can range from long term psychological harm to feelings of unhappiness, powerlessness, fear, anxiety, shame and guilt.

This extract from the Pich report shows the range of detrimental effects that can be experienced:

> **4.4.1 Emotional response**
>
> *Participants reported a range of ongoing emotional responses following an episode of violence, some of which indicated negative coping strategies, for example "increase in use of alcohol or other substances/medications". A number of the responses were long-term in nature, including those linked to Post Traumatic Stress Disorder (PTSD), for example "weight loss/gain", "nightmares and flashbacks" and "altered sleep patterns". PTSD itself was selected as a response by 8% of participants. In addition some responses impacted the nursing practice of participants, for example "withdrawal from people/situations" and "fear/anxiety re future episodes"* (Table 18).[1]

The report identifies that in addition to the impact on the individual there is a clinically adverse outcome for health care recipients as well. Participants reported a withdrawal not only from an offending individual but were more likely to experience a lack of empathy for patients generally. A loss of ability to empathise and interact with patients is detrimental to the overall ability to provide care.

With reference to other studies, Dr Pich concludes that nurse 'burn out' leads to a lack of joy in providing care and spending less time with patients whom they perceive as abusive. *'Thus the negative effects of patient related violence extend to the workplace and can lead to difficulties with the recruitment and retention of nurses, decreased productivity and efficiency, increased absenteeism and fewer resources for nurses'*.[2] There is a cost flow on to the recruitment and retention of nurses and workers compensation claims.

Again, while the impacts above are speaking about the response to experiencing violence in the workplace more generally, the study included those who experienced sexually inappropriate conduct. It is not difficult to infer that a nurse, midwife (or carer) who has been subjected to sexually inappropriate behaviour would experience the impacts described above.

---

[1] Jacqui Pich, Christopher Oldmeadow and Matthew Clapham 'Violence in Nursing and Midwifery in NSW: Study Report' p. 49-50

[2] Ibid 71

Reporting

The ACTU *'Sexual Harassment in Australian Workplaces: Survey results (Report 2018)'* indicates that 58.8% of people who experienced sexual harassment told someone about it. Of those only 26.7% made a formal complaint. The Pich report also looked at the level and nature of reporting.[3] It found 33% reported all episodes of violence, 45% reported selectively and 22% did not report at all.

The Pich report showed reasons for not reporting included the belief that nothing would change in the long-term, that it was an accepted/expected part of the job and there was a lack of follow up.

The survey conducted for the Pich report identified a problem specific to those working in health - some 390 participants did not report because they perceived the perpetrator as not responsible for their actions due to their clinical or personal circumstances. This perception poses a significant barrier to both reporting and managing risk. The ACTU survey also recorded that 56.1% of people who made a formal complaint were not at all satisfied with the outcome of the complaint process. The Pich study found almost half of participants were not satisfied with their employer's immediate response.

Participants in the Pich study felt they did not receive adequate information, support or outcomes as a result of making a complaint. Some considered they were blamed for the incident.

The ANMF is concerned that there is significant under reporting of instances of sexual harassment in the workplace, both using internal mechanisms or seeking the assistance of the union. In order to tackle sexual harassment in the workplace, there needs to be significant cultural change. It must become acceptable to make a complaint and the complaint process should be effective and prompt and not expose the complainant to the risk of negative repercussions.

Where violence and harassment cannot be prevented, it must be dealt with promptly and positively by management. Staff should be supported and encouraged to report incidents and seek help. Management must be responsive and proactive in addressing concerns and taking steps to minimise future risk. In all respects, this is a cultural issue that requires consistent behavioural modelling- management must lead by example and enable all staff to call out unacceptable behaviour without fear of repercussion.

Work Health and Safety

It is the ANMF's view that sexual harassment in the workplace needs to be treated as an OHS issue.

As discussed above, a significant cultural challenge in health is to change the perception that experiencing violence at work 'is part of the job'. This perception highlights the importance of addressing the problem from an OHS perspective. Risk management to minimise exposure to inappropriate behaviour and placing the onus of designing safe work practices on employers will be more effective than remedy after the fact.

It is acknowledged, however, that prevention will not always be possible, particularly in environments such as emergency departments, mental health and drug and alcohol treatment facilities. In these settings it is particularly important to focus on the environment and supporting clinical best practice rather than vilifying individual perpetrators of violence.

Employers have an obligation to provide a safe workplace under the Model Laws or state equivalents in Victoria and Western Australia. The employer's obligation as it currently stands can be met by showing it has policies and procedures in place and has provided training to staff.

The ANMF supports the contention that the obligation to provide a safe workplace should be required to include taking pro- active steps beyond simply having policies and procedures in place.

In line with this, the ANMF supports recommendation 2 of the Model WHS Laws 2018 Review Report calling for a new Regulation on psychosocial hazards. The regulation and any supporting Code should provide clear what steps should be taken to eliminate or minimise risk. These should extend beyond a 'tick a box' compliance regime of having a policy and providing cursory online training.

The ANMF (Victoria Branch) developed the *'10 Point Plan to End Violence and Aggression: A Guide for Health Services'* that sets out a method for assessing and eliminating or minimising risk. The 10 Point Plan identifies areas of work for example from security, admission practices, reporting, investigating and responding to events. It then describes progressively what high risk, reduced risk and low risk practice looks like in these areas. It is a practical tool to aid continuous improvement and as a positive example of work that can be done to minimise all forms of violence in the workplace. A copy of the 10 Point Plan is attached.

The drivers of workplace sexual harassment

The ANMF refers to the ACTU submission at pages 10-14 identifying gender inequality as a major cause of sexual harassment. It is also a major barrier to being empowered to report and act on sexual harassment.

The Workplace Gender Equality Agency report of August 2018 'Australia's Gender Pay Gap Statistics' shows that Australia's full-time gender pay gap is 14.6%. That means women earn on average $244.80 per week less than men. The national gender pay gap narrowed from 15.3% in May 2017 to 14.6 in May 2018. Disturbingly, when broken down by industry, the gap in Health Care and Social Assistance increased from 21.9% to 25% over the same period.

In September 2008 the (then) ANF submitted to the House of Representatives '*Inquiry into pay equity and associated issues related to increasing female participation in the workforce'*. The submission set out in general terms, some of the issues that contribute to the gender pay gap:

'Many factors contribute to the gender pay gap including the historical and continuing undervaluing of women's work, levels of workplace participation, workplace conditions and the way work is organised, tribunal processes and methods of setting wages and conditions, education and training and other workplace factors such as access to overtime and higher levels of casualization and part-time work for females.'[4]

These factors are as relevant in 2019 as they were in 2008. The lack of progress in reduction of the gender pay gap supports the argument that change needs to be more sustained and substantial.

For young people, LGBTIQ people, people with a disability, Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds, the effects of structural inequality and insecure work are compounded.

Proposed reform

The ACTU submission to this Inquiry puts forward a range of detailed recommendations for legislative and regulatory reform. These include:

- Amendment to the Fair Work Act to empower the Fair Work Commission to resolve, by conciliation or arbitration if necessary, sexual harassment and discrimination disputes;

[4] Australian Nursing Federation submission to the 'Inquiry into pay equity and associated issues related to the increasing female participation in the workforce' September 2008, p.6

- Unions and other interested parties to have the capacity to bring representative complaints on behalf of workers;
- Strengthening the powers of FWC to address gender equality, including the establishment of a Gender Equality Panel;
- A new Workplace Health and Safety (WHS) Regulation and Code of Practice should be developed in consultation with social partners and experts on all psychosocial hazards, including sexual harassment;
- Unions should have the right to prosecute breaches of WHS regulations;
- The *Sex Discrimination Act 1984* should be strengthened, including by empowering and resourcing the Sex Discrimination Commissioner to conduct own motion inquiries, authorising courts to award exemplary and punitive damages for breaches of the Act and extending time limits for sexual harassment complaints. A new 'positive duty' on employers should be considered;
- The Australian Government should actively support the development of, ratify and fully implent a new ILO Convention supplemented by a Recommendation preventing violence and harassment in the world of work;

The ACTU recommendations are fully supported by the ANMF.

Conclusion

Elimination of sexual harassment in the workplace will not be achieved, without practical reform and sustained cultural change to the way in which we view, report and respond to sexual harassment.

The ANMF is committed to continuing to raise awareness of the problem, campaigning for appropriate legislative reform and supporting the many structural changes proposed by the ACTU. The work is essential to ensuring the health and wellbeing of our members, supporting their optimal participation in the workforce and in turn the best outcomes for health care recipients.

10 POINT PLAN TO END VIOLENCE AND AGGRESSION

A GUIDE FOR HEALTH SERVICES

RESPECT AND PROTECT OUR VICTORIAN HEALTHCARE WORKERS

Australian Nursing & Midwifery Federation
VICTORIAN BRANCH

anmfvic.asn.au/ovaguide

CONTENTS

Message from Victorian Health Minister Jill Hennessey .... **page 1**

Message from ANMF (Vic Branch) Secretary Lisa Fitzpatrick .... **page 1**

Introduction .... **page 2**

- Pre-conditions
- Scope
- Terminology
- Instructions for use

1. **Improve security** .... **page 4**
2. **Identify risk to staff and others** .... **page 6**
3. **Include family in the development of patient care plans*** .... **page 9**
4. **Report, investigate and act** .... **page 10**
5. **Prevent violence through workplace design** .... **page 11**
6. **Provide education and training to healthcare staff** .... **page 12**
7. **Integrate legislation, policies and procedures** .... **page 14**
8. **Provide post-incident support** .... **page 16**
9. **Apply anti-violence approach across all health disciplines** .... **page 17**
10. **Empower staff to expect a safe workplace** .... **page 18**

* ANMF Note: Referral to Patient Care Plan includes all associated documents e.g. Behavioural Management Plan.

First edition published in 2017. This edition was revised and printed in October 2018.

MESSAGE FROM THE HON JILL HENNESSY MP

Minister for Health, Minister for Ambulance Services

Nurses and midwives have the right to be safe – and feel safe – at work. You care for us at our most vulnerable and deserve the utmost respect for the work you do.

You – and everybody who works in the healthcare system – deserves to go home safely to their family after each shift. Violence and aggression just shouldn't be part of the job.

Yet it often is.

It's something our Government is determined to address.

We won't tolerate occupational violence and aggression against nurses, midwives and other healthcare workers and we will continue to work with you to make your workplaces safer.

I want to thank the ANMF for its leadership in developing this *10 Point Plan to End Violence and Aggression: A Guide for Health Services*. This is an important tool – which alongside a range of resources – outlines the actions healthcare organisations can take to end violence and aggression in our workplaces.

Safer workplaces are vital so that nurses and midwives can concentrate on what you do best – taking care of the community.

Jill Hennessy

MESSAGE FROM LISA FITZPATRICK

Branch Secretary, ANMF (Vic Branch)

Nurses and midwives, and other health workers, are experiencing frequent and frightening serious physical and psychological injuries at work. Many are rightly saying enough is enough.

But we need more than words to ensure the people who work in our healthcare system go home safely to their families and friends after each shift.

To stop the unacceptable number of assaults, the Australian Nursing and Midwifery Federation (Victorian Branch) developed and released the 10 point plan to end violence and aggression in 2014. We've been working since to treat violence as an occupational health and safety risk.

The knowledge, information and actions necessary to end preventable violence at work are in this guide. This is what a successful organisational response to the prevention of violence and aggression should look like.

This guide will only work if chief executive officers and hospital boards drive these changes so that a safer way of doing things is absorbed into the DNA of every level of management.

No more fragmentation. To be running a hospital operating in the green safe zone of this guide, the work of clinical managers must intersect with the occupational health and safety and the human resources managers.

The data is mounting. The specifics of violent incidents and the human cost are confronting. We know there is a problem. Here are the solutions.

This will take leadership and whole of community approach – government, hospital management and the public.

This guide outlines the actions hospitals can control. Let's work together to operate in the green zone so we can stop the unacceptable levels of violence in our healthcare facilities.

Lisa Fitzpatrick

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

INTRODUCTION

Ending violence and aggression requires changes to all levels of systems, as demonstrated in the adjacent diagram. This Guide is a tool to enable healthcare organisations to review their management and occupational health and safety systems, and ensure that occupational violence and aggression is appropriately recognised, represented and included as a risk, and actions taken to prevent incidents.

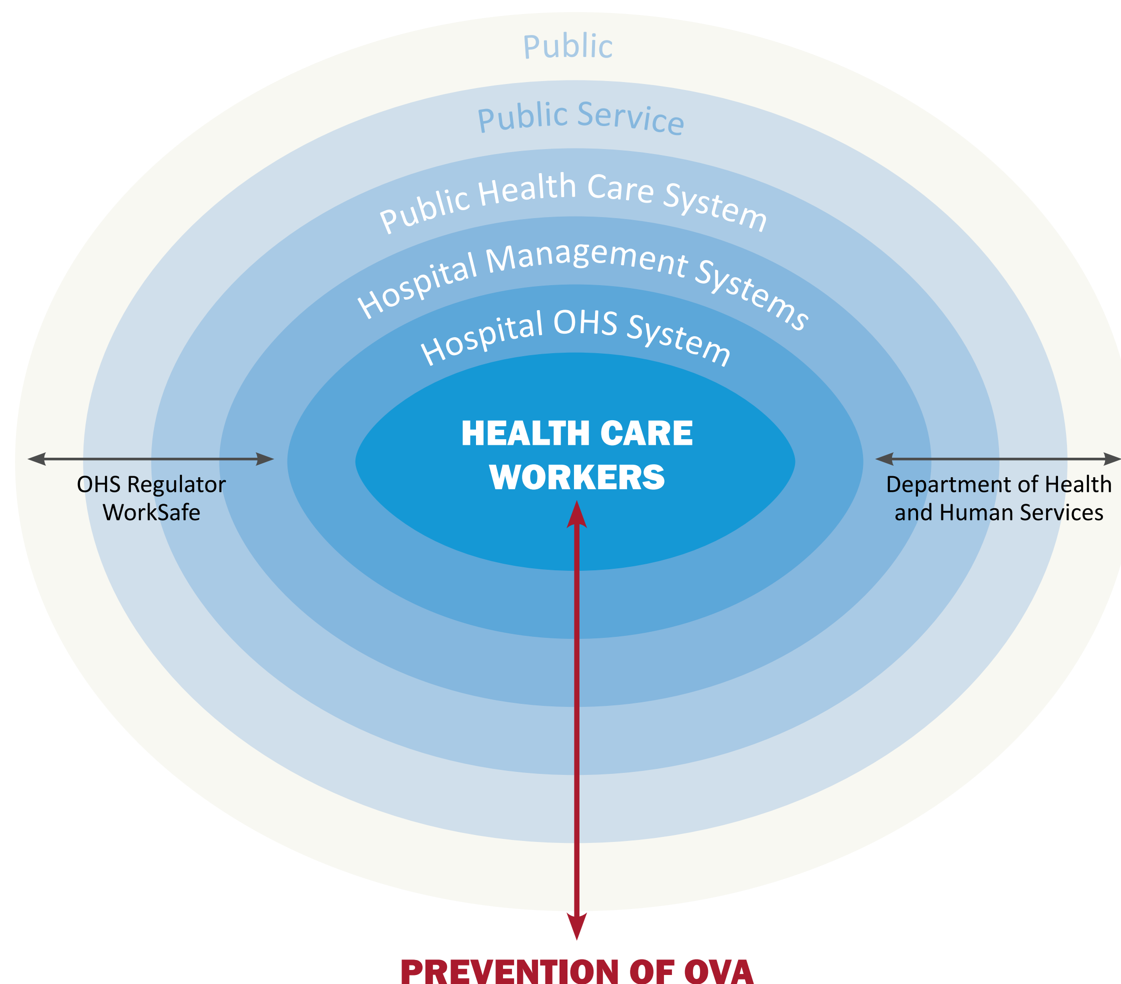


Diagram: Ending violence and aggression requires changes to all levels of systems

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

Pre-conditions

Commitment: the Guide will only be successful if implemented in an organisation (and system) which has a commitment to the prevention of occupational violence which is real and irrefutable. This commitment needs to come from not just the middle management of a facility, but is required from those with the ultimate power in the health system.

This commitment has been demonstrated by those in charge and in control, from the Victorian Premier and Health Minister, through to the Department of Health and Human Services. This Guide is intended to assist those at the health services individually. Validation of the commitment comes in many forms, not the least of which is the recognition of the problem to begin with, and the dedication of resources to implement strategies to prevent and address the systemic issues.

This commitment must manifest at the chief executive officer and board of director level, with again, the acknowledgment of the failings of the system in its current form, and a pledge to address the shortcomings. Such a demonstration should also include a reporting structure which means that each board of directors is provided with an in-depth report at each meeting of the number of assaults that have occurred within their hospital network, the details of each assault, the injuries suffered by the staff, and the corrective actions which have been put in place to reduce the risk of recurrence.

Communication, consultation and collaboration: another pre-condition to the framework is a commitment by those running the health service to undertake the 'Three Cs' – communication, consultation and collaboration, in relation to occupational violence and aggression, but more broadly as a management imperative.

Whilst the *Occupational Health and Safety Act 2004* mandates health services to undertake consultation in relation to matters which affect (or may affect) the health and safety of staff, experience shows that this is rarely undertaken in the manner in which it is described. Again, this must be demonstrated from decision makers, in order to affect change at a local level. Such communication, consultation and collaboration must involve representatives of all stakeholders, including health services, unions, workers, health and safety representatives and consumers.

Moreover, the presence and input at both a strategic and local level into such strategies will allow more robust systems to be developed and implemented, which will lead to wider acceptance, and increased ownership.

Scope

The principles and content of the ANMF (Vic Branch) 10 point plan is applicable to all health service and hospital facilities, including mental health, acute, emergency departments, aged care, community care and locations external to a purpose built workplace e.g. visiting health services.

Terminology

Clinical staff – includes nurses, midwives, doctors, allied health and other clinical staff

HSRs – health and safety representatives

OVA – occupational violence and aggression, which is defined by WorkSafe Victoria ('Prevention and management of violence and aggression in health services', June 2017) as an incident 'in which a person is abused, threatened or assaulted in circumstances related to their work… OVA includes a broad range of actions and behaviours that can create risk to health and safety of employees. It includes behaviour often described as acting out, challenging behaviour and behaviours of concern.

OVA can result in an employee sustaining physical and/or psychological injuries, and can sometimes be fatal. Employees can be exposed to OVA from a range of sources including clients, consumers, patients, residents, visitors and members of the public. Examples of OVA include, but are not limited to:

- biting, spitting, scratching, hitting, kicking
- pushing, shoving, tripping, grabbing
- throwing objects, damaging property
- verbal abuse and threats
- using or threatening to use a weapon
- sexual harassment or assault.'

Patient Care Plan - documents e.g. Behavioural Management Plan, admission documentation, risk assessments etc.

Patients – where patients are referred to, this may also be read to include clients, residents and consumers as appropriate.

NB: at all steps of the process, it is critical that frontline staff and HSRs are involved in consultation.

Instructions for use

The traffic light approach supports health services in their movement from a situation with high risk factors to the lower risk solutions, stepping along the way. The Guide can also be used as an 'audit-type' tool, whereby health services are able to self-assess against the criteria in the guide, and identify their areas for improvement.

The Guide provides a starting point for health services to work towards in relation to implementation of an organisational approach to the prevention of occupational violence and aggression. It has identified key factors that comprise each of the 10 Points, and that demonstrate or indicate compliance with the factors, and provides examples of high, medium and low risk solutions to each of the factors.

It is expected that facilities would be working towards the lowest risk solutions in order to ensure that their staff are provided an environment that is as safe as possible. Given the ongoing developments occurring within prevention of occupational violence and aggression, this guide provides a starting point, however a commitment to continuous improvement, and ongoing review and revision of controls in this area is required.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

1 IMPROVE SECURITY

CRITERIA	HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
1.1 **The Department of Health and Human Services must develop adequate baseline standards for security and fund public health services to comply, whilst private organisations must dedicate funding.**	The health service does not apply for funding opportunities, nor is there funding for security.	The health service applies for all funding opportunities, and responds to security funding needs.	The health service applies for all funding opportunities and submissions are based on priority areas evidenced from risk assessment findings. Further, dedicated ongoing security funding is identified in budgets.
1.2 **Specifically trained security personnel** **(see also 6 – Provide education and training to healthcare staff).**	No areas or partial areas and sites have on-site security personnel available.	Some on-site security personnel are available for some areas and sites whenever operational.	On-site security personnel are available in adequate safe numbers for all areas and sites during all operational hours.
	The training and experience of security personnel is not checked to identify whether they have healthcare specific training and experience.	The training and experience of security personnel is inconsistently reviewed, against an undocumented set of requirements.	All security personnel have had healthcare and organisation-specific training in their role, which is checked prior to engagement against a documented set of criteria, and is regularly reviewed and updated.
1.3 **Access to secure areas and safe zones.**	The facility has no staff secure areas, safe zones and lock-down area or procedures.	There are some established staff secure areas, safe zones, lock down areas and procedures but there are no systems in place.	A security audit of all established staff secure areas, safe zones and lock down areas and procedures has been conducted and improvement recommendations have been implemented.
	A security risk assessment of all areas in the facility has not been conducted.	A security risk assessment of all areas in the facility has been conducted to identify high risk areas, secure areas, safe zones and lock down areas including procedures.	A security risk assessment of all areas in the facility has been conducted to identify high risk areas, secure areas, safe zones and lock down areas including procedures and recommendations have been fully implemented and reviewed.
1.4 **Security cameras.**	CCTV is not installed on-site.	CCTV is installed in spots across areas and sites including car parks with inconsistent monitoring of footage / feed.	A security risk assessment has been conducted to ensure: • CCTV is installed in key areas across all areas and sites including car parks with accompanying CCTV warning signage also displayed in key areas for patients and visitors • CCTV is used for evidence in hospital and / or police investigations where appropriate • identification of ways in which CCTV could be used in a preventative manner occur regularly e.g. training reviews • procedures are in place to ensure footage is monitored according to identified high risk areas.
		The health service does not have procedures for accessing CCTV footage.	The health service has procedures for accessing CCTV footage.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

CRITERIA		HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
1.5	**Personal duress alarms.**	A risk assessment of all areas in the health service has not been conducted to identify any need for personal duress alarms.	A risk assessment of all areas in the health service has been conducted to identify high risk areas for staff needing wall mounted and personal duress alarms, including location identification.	A risk assessment of all areas in the health service has been conducted in consultation with HSRs and staff to identify high risk areas for staff needing wall mounted and personal duress alarms including location identification, and recommendations have been implemented.
		Personal and wall mounted duress system is not tested.	Personal and wall mounted duress system is regularly tested.	The facility has a duress alarm system procedure and testing schedule. Personal and wall mounted duress system is regularly tested and results documented.
		There is no training of staff in the use of duress alarms.	Inconsistent and unregulated training of staff in the use of duress alarms.	Regular, consistent training of staff in the use of duress alarms, governed by procedure, including trialing the alarms.
1.6	**Searching or personal belongings.** **See also 2 – Identify risk to staff and others and 6 – Provide education and training to healthcare staff.**	No procedures in place regarding searching patient and visitors upon admission and during a patient's stay.	Limited procedures are in place regarding searching patient and visitors upon admission and during a patient's stay.	The facility has clear procedures around performing patient and visitor searches to ensure a consistent approach.
1.7	**Regular security audits of health services, including maintaining security equipment.**	The facility does not have a documented security audit and risk assessment process.	The facility has a documented security audit and risk assessment process.	The facility has a documented security audit and risk assessment process with regular scheduling and implementation and review of identified risks.
		The facility has not reviewed the security audit and risk assessment tool.	The facility has reviewed the security audit and risk assessment tool.	The facility has reviewed the security audit and risk assessment tool and has a documented ongoing review schedule with results reported to the OHS / OVA governance committee for oversight.
1.8	**Monitoring systems for community clinics.**	A security risk assessment of the community clinics including monitoring systems has not been conducted.	A security risk assessment of the community clinics including monitoring systems has been conducted.	A security risk assessment of the community clinics including monitoring systems have been conducted and recommendations have been implemented.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

2 IDENTIFY RISK TO STAFF AND OTHERS

CRITERIA	HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
2.1 **Identifying the risk of a patient or others (e.g. visitors or family) being aggressive or violent towards staff must be part of clinical pre-admission (prior to decision to admit).**	The facility does not perform clinical pre-admission OVA risk assessments of patients.	The facility performs clinical pre-admission risk assessments but the criteria to assess and identify the risk of the patient / others being aggressive or violent is limited.	The facility performs clinical pre-admission risk assessments including appropriate criteria to assess and identify the risk of the patient / others being aggressive or violent. This also considers the patient medical record from previous admissions and is part of the handover for ambulance and police.
	If the clinical pre-admission risk assessment identifies risk of the patient / others being aggressive or violent, there is no system to ensure implementation of preventative controls.	If the clinical pre-admission risk assessment identifies risk of the patient / others being aggressive or violent, there is an ad hoc system of implementation of preventative controls.	When the clinical pre-admission risk assessment identifies risk of the patient / others being aggressive or violent, there is a system to ensure appropriate preventative measures are implemented and monitored throughout the patient stay.
	The facility has not developed a guidance list of preventive measures available for use at clinical pre-admission.	The facility has developed a limited guidance list of preventative measures available for use at the clinical pre-admission stage.	The facility has developed a robust guidance list of preventative measures available for use at the clinical pre-admission stage e.g. specialling patients, nursing in pairs, placing the patient in a highly visible area, sourcing more appropriate facility for admission, ensuring appropriately qualified and experienced staff are allocated for care, notification of security personnel.
	Clinical pre-admission does not include review of the appropriate setting (environment and model of care) for the individual patient.	Clinical pre-admission includes review of the appropriate setting (environment and model of care) for the individual patient.	Clinical pre-admission includes review of the appropriate setting (environment and model of care) for the individual patient and recommended preventative measures are implemented prior to admission.
	The facility / unit has no patient admission / exclusion criteria.	The facility or unit has patient admission criteria but the inclusion and exclusion criteria relating to staff and patient safety are not consistently complied with or supported, or are limited.	The facility or unit has patient admission criteria with clear inclusion and exclusion criteria relating to staff and patient safety and it is used during the clinical pre-admission assessment. Compliance is consistent and decisions made using the criteria are supported by management.
2.2 **Identifying the risk of a patient or other being aggressive or violent towards staff must be part of admission procedures (at admission).**	The facility does not perform clinical admission OVA risk assessments of patients.	The facility performs clinical admission risk assessments but the criteria to assess and identify the risk of the patient / others being aggressive or violent is limited.	The facility performs clinical admission risk assessments including appropriate criteria to assess and identify the risk of the patient / others being aggressive or violent. This also considers the patient medical record from previous admissions and is part of the handover for ambulance and police.
	If the clinical admission risk assessment identifies risk of the patient / others being aggressive or violent, there is no system to ensure implementation of preventative controls.	If the clinical pre-admission risk assessment identifies risk of the patient / others being aggressive or violent, there is an ad hoc system of implementation of preventative controls.	When the clinical admission risk assessment identifies risk of the patient / others being aggressive or violent, there is a system to ensure preventative measures are implemented and monitored throughout the patient stay.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

2 IDENTIFY RISK TO STAFF AND OTHERS CONTINUED

CRITERIA	HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
2.2 Continued.	The facility has not developed a guidance list of preventive measures available for use at clinical admission.	The facility has developed a limited guidance list of preventative measures available for use at the clinical admission stage.	The facility has developed a robust guidance list of preventative measures available for use at the clinical admission stage e.g. specialling patients, nursing in pairs, placing the patient in a highly visible area, sourcing more appropriate facility for admission, ensuring appropriately qualified and experienced staff are allocated for care etc.
	The facility / unit has no patient admission / exclusion criteria.	The facility or unit has patient admission criteria but inclusion and exclusion criteria relating to staff and patient safety are not consistently complied with or supported, or are limited.	The facility or unit has patient admission criteria with clear inclusion and exclusion criteria relating to staff and patient safety and it is used during the clinical admission assessment. Compliance is consistent and decisions made using the criteria are supported by management.
	Clinical admission does not include review of the appropriate setting (environment and model of care) for the individual patient.	Clinical admission includes review of the appropriate setting (environment and model of care) for the individual patient.	Clinical admission includes review of the appropriate setting (environment and model of care) for the individual patient and recommended preventative measures are implemented.
	Transfer of patient OVA risk information does not occur from discharging unit / health service to the admitting unit / health service.	Transfer of information is requested by admitting organisation / ward / unit or provided by discharging organisation / ward / unit but the information is limited or missing and the process is adhoc.	Transfer of information is actively requested by admitting organisation / ward / unit and provided by discharging organisation / ward / units including and / or police. Follow up systems are in place to ensure this information is available and acted upon.
2.3 **Identifying the risk of a patient or other being aggressive or violent throughout the patient's stay.**	Clinical documentation does not include provision to identify and assess a patient / others being aggressive or violent.	Clinical documentation (including clinical handover and clinical assessment) across all wards, areas and sites have provision for identifying the risk of a patient / others being aggressive or violent.	All clinical documentation (including clinical handover and clinical assessment) across all wards, areas and sites have provision to identify, review and update the risk of a patient / others being aggressive or violent and there are clear procedures to implement controls where risk is identified. This also considers the patient medical record from previous admissions and is part of the handover for ambulance and police.
2.4 **When a patient is admitted without notice to a healthcare facility – for example to an emergency department – a violence risk assessment must be initiated as soon as practicable.**	OVA risk assessments are not completed as soon as practicable or at all when a patient is admitted without notice.	OVA risk assessments are sometimes completed as soon as practicable when a patient is admitted without notice.	OVA risk assessments are completed as soon as practicable when a patient is admitted without notice and appropriate preventative actions are implemented.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

2 IDENTIFY RISK TO STAFF AND OTHERS CONTINUED

CRITERIA	HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
2.5 **Staff are alerted as soon as practicable to the risk of a patient or other being violent or aggressive.**	Current behavioural contracts are not disseminated within and across sites.	Behavioural contracts are developed but are not distributed. Staff caring for patients are not aware of them.	Current behavioural contracts are disseminated within and across sites, and flagged on computer systems.
	There are no communication processes to advise staff of the risk of a patient or other being violent or aggressive.	Communication processes to advise staff of the risk of a patient or other being violent or aggressive are not immediate.	Communication processes to advise staff of the risk of a patient or other being violent or aggressive are immediate including dissemination of behavioural management plans and associated information within and across sites.
	Clinical documentation has no provision to review and update OVA risk and requirements within and across sites.	Clinical documentation including assessment and handover have limited provision to review and update OVA requirements within and across sites.	All clinical documentation including assessment, care plans and handover documentation have provision to review and update OVA requirements within and across sites.
2.6 **Staff are alerted as soon as possible to the risk of a relative / visitor being violent or aggressive.**	Current behavioural contracts regarding relatives / visitors are not disseminated within and across sites.	Current behavioural contracts regarding relatives / visitors are disseminated amongst the health service's executive management only, or otherwise limited in their distribution.	Current behavioural contracts regarding relatives / visitors are disseminated within and across sites, and flagged on computer systems.
	There are no communication processes to advise staff of the risk of a relative / visitor being violent or aggressive.	Communication processes to advise staff of the risk of a relative / visitor being violent or aggressive are not immediate within and across sites.	Communication processes to advise staff of or the risk of a relative / visitor being violent or aggressive are immediate including dissemination of behavioural management plans and associated information within and across sites.
	No violent and aggressive visitor / relative alert system is available.	Some areas and sites have a violent and aggressive relative / visitor alert system.	All areas and sites have a violent and aggressive relative / visitor alert system with clear processes to flag and manage identified relatives / visitors.
2.7 **Health services must ensure patient alert systems, including violent or aggressive behaviour, are part of admission and patient stay procedures.**	No violent and aggressive patient alert system is available.	Some areas and sites have a violent and aggressive patient alert system.	All areas and sites have a violent and aggressive patient alert system with clear processes to flag and manage identified patients.
	The violent and aggressive patient alerts system is not integrated into the admission and patient stay process.	The violent and aggressive patient alerts system is somewhat integrated into the admission and patient stay process.	The violent and aggressive patient alerts system is fully integrated into the admission and patient stay process to ensure high risk patients are identified and appropriately managed.
	The violent and aggressive patient alert system is not compatible across the network systems.	The violent and aggressive patient alert system has limited uniformity across the network.	The violent and aggressive patient alert system is uniform across the network and is compatible with all patient information systems.
	The patient alert system does not provide information in relation to previous OVA risk factors and incidents specific to the patient.	The patient alert system provides limited information in relation to previous OVA risk factors and incidents specific to the patient, but is used inconsistently and on an adhoc basis, with the information unreliable.	The patient alert system provides information in relation to OVA risk factors and incidents specific to the patient, is used consistently and the information is reliable.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

3 INCLUDE FAMILY IN THE DEVELOPMENT OF PATIENT CARE PLANS*

CRITERIA	HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
3.1 **Patient Care Plans do not only take into account the clinical component of caring for a patient but also how caring for the patient may impact on the health and or safety of staff or others.**	The process of developing the Patient Care Plan only considers the clinical component of caring for a patient.	The documented process of developing the Patient Care Plan considers some factors which may impact on the health and/or safety of staff and others, but does not identify preventative measures.	The documented process of developing the Patient Care Plan not only considers the clinical component of caring for a patient but also considers how caring for the patient may impact on the health and/or safety of staff or others and requires identification and implementation of preventative actions.
	The identified potential impacts to the health and/or safety of staff or others are not formally documented within the Patient Care Plan when developing a Patient Care Plan.	The identified potential impacts to the health and/or safety of staff or others are formally documented within the Patient Care Plan when developing a Patient Care Plan.	The identified potential impacts to the health and/or safety of staff or others and preventative measures are formally documented within the Patient Care Plan when developing a Patient Care Plan.
	Clinical staff (doctors, nurses, midwives, allied health and others) involved in the development of a Patient Care Plan do not consider how a Patient Care Plan may impact on the health and/or safety of staff or others.	Some clinical staff (doctors, nurses, midwives, allied health and others) involved in the development of a Patient Care Plan consider how a Patient Care Plan may impact on the health and/or safety of staff or others.	All clinical staff (doctors, nurses, midwives, allied health and others) involved in the development of a Patient Care Plan consider how a Patient Care Plan may impact on the health and/or safety of staff or others.
3.2 **The patient's history, presentation and risk factors, and those of their visitors and relatives, are taken into account in the development of Patient Care Plans.**	The patient's history, presentation and risk factors, and those of their visitors and relatives, are not taken into account in the development of Patient Care Plans.	The patient's presentation only is taken into account when developing Patient Care Plans and considering how the care may affect the health and safety of staff or others.	The patient's history, presentation and risk factors, and those of their visitors and relatives, are taken into account when developing Patient Care Plans and considering how the care may affect the health and safety of staff or others.
3.3 **Where possible, Patient Care Plans should involve family members to ensure clear standards of behavior are set and healthcare professionals can provide a consistent approach.**	Patient Care Plans are not developed in conjunction with the patient and family / carer.	Patient Care Plans are developed in conjunction with the patient and family / carer.	Patient Care Plans are developed in conjunction with the patient and family / carer, and clear standards of behavior towards staff are set and documented.
	Patient Care Plans are not developed in conjunction with the patient and family / carer.	Patient Care Plans developed in conjunction with patient and family / carers do not seek observations, insights, information and advice on strategies that may increase and/or reduce the risk of aggressive or violent patient behaviour and proactive early intervention strategies that may reduce the risk that the violent or aggressive behavior will escalate further.	Patient Care Plans developed in conjunction with the patient and family / carer seek observations, insights, information and advice on strategies that may increase and/or reduce the risk of aggressive or violent patient behaviour and proactive early intervention strategies that may reduce the risk that the violent or aggressive behavior will escalate further. This information is then used in the development of the Care Plan.
	The facility has no behavioral contract policy and procedure.	The facility has a behavioral contract policy but it is inconsistently applied.	The facility has a behavioural contract policy and procedure with supporting tools that are consistently applied, and support is provided by management for this.

*** ANMF Note: Referral to Patient Care Plan includes all associated documents e.g. Behavioural Management Plan.**

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

4 REPORT, INVESTIGATE AND ACT

CRITERIA	HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
4.1 Health services must build trust by investigating incidents in a consultative and collaborative manner.	Health and safety incident investigations do not commence or are not completed in a timely manner.	Health and safety incident investigations are commenced and completed in a timely manner.	Health and safety root cause incident investigations are commenced and completed in a collaborative, timely manner (including with ANMF involvement as requested), and this is documented in the incident investigation procedure.
	Staff / HSRs are not consulted during OVA incident investigations.	Limited consultation with staff / HSRs occurs during OVA incident investigations.	Staff / HSRs are consulted during OVA incident investigations.
	Following an OVA incident, the commencement of an OVA incident investigation is not communicated to staff.	Following an OVA incident, the commencement of an OVA incident investigation is communicated to injured staff or management only.	Following an OVA incident, the commencement of an OVA incident investigation is communicated to all staff located within the work area e.g. on a ward, all shifts would be advised.
	Following an OVA incident Investigation, system learnings are not disseminated back to staff.	Following an OVA incident investigation, system learnings are disseminated to affected staff only.	Following an OVA incident investigation, system learnings are disseminated to all staff located within the work area and organisationally where appropriate.
	OVA incident investigations are not undertaken.	OVA incident investigations take into account only clinical or OHS contributing factors, and/or focus on identifying individual contributions, rather than system factors.	OVA incident investigations take into account all relevant contributing factors, with a 'no blame' focus.
4.2 Health services must build trust by taking clear and relevant action over incidents.	Preventative actions are not identified nor implemented after any OVA incidents or near misses.	Preventative actions are identified and implemented after only multiple or high risk OVA incidents but are not identified for less critical OVA incidents.	Preventative actions are identified and implemented after all OVA incidents and near misses, and trends analysed to identify any patterns.
	No monitoring and review system is in place to collate and review trends, incident reports and investigations to establish if clear and relevant actions are taken and processes followed.	A formal monitoring and review system is in place to collate and review trends, incident reports and investigations to establish if clear and relevant actions are taken and processes followed, but is implemented on an ad hoc basis.	Formal collating, monitoring and review of incident investigations and reports are undertaken to establish trends as per the monitoring and review process. This is subject to formal reporting measures in the health service.
	OVA incidents are not investigated.	OVA incidents are investigated as a silo (i.e. the current incident only).	OVA incident investigations are systematic and include a review of the patient OVA history across admissions / time and review of any previous implemented preventative measures, as well as the current incident. Investigations will also consider the history of incidents in the unit / ward to identify systemic factors and/or environmental contributing factors.
	-	Investigation of the current OVA incident does not review the lead up across time to the OVA incident (e.g. pre-admission procedure, admission procedure, pre incident strategies, proactive early intervention strategies etc.)	Investigation of the current OVA incident reviews the lead up across time to the OVA incident (e.g. pre-admission procedure, admission procedure, pre incident strategies, proactive early intervention strategies etc.)

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

4 REPORT, INVESTIGATE AND ACT CONTINUED

CRITERIA	HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
4.3 **Health services must build trust by communicating actions taken as a result of incident reports.**	Actions taken as a result of incident reports are not communicated to the persons reporting.	Actions taken as a result of incident reports are communicated to the persons reporting via a written entry into the incident reporting system only.	Actions taken as a result of an incident report are verbally communicated to the persons reporting, as well as via written entry into the incident reporting system.
	-	-	Actions taken as a result of an incident report are communicated to all staff located within the work area.
4.4 **Health services must meet their governance and funding requirements by ensuring boards are provided with details of violent incidents, not just statistics, so they understand the effects of violence on healthcare workers.**	The facility's board and CEO do not receive OVA report data.	The facility's board and CEO receive OVA statistical information only.	The facility's board and CEO receive details about violent and aggressive incidents and effects on healthcare workers, as well as OVA statistical data, and information around preventative actions taken.
4.5 **Health services must build trust by working with police to enable prosecution of offenders.**	Health services do not have a collaborative relationship with local police.	The health service has a sporadic, ad hoc relationship with local police.	The health service has a collaborative relationship with local police that assists staff to pursue their right to prosecution of offenders of OVA in a supportive manner.

5 PREVENT VIOLENCE THROUGH WORKPLACE DESIGN

CRITERIA	HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
5.1 **The principles of crime prevention through environmental design should be mandatory in designing, refurbishing, renovating and retrofitting workplaces to prevent and minimise violence.**	The principles of crime prevention through environmental design (CPTED) are not considered during the design process (design, brief preparation, feasibility, contract documentation, construction, pre-occupancy and post-occupancy evaluation).	The health service has a design policy that provides mandatory commitment to consider the principles of crime prevention through environmental design (CPTED) during all stages of the design process.	The health service has a design policy that provides a mandatory commitment to consider and implement the principles of crime prevention through environmental design (CPTED) during all stages of the design process.
	The health service has not undertaken an environmental and workplace design risk assessment.	The health service has undertaken an environmental and workplace design risk assessment across some areas and sites reviewing and identifying infrastructure and process improvements in accordance with CPTED principles.	The health service has undertaken environmental and workplace design risk assessments across all areas and sites, reviewing and identifying infrastructure and process improvements in accordance with CPTED principles, and recommendations have been implemented, or where not yet implemented, budgeted for and prioritised such improvements according to level of risk.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

6 PROVIDE EDUCATION AND TRAINING TO HEALTHCARE STAFF

CRITERIA	HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
6.1 Education about how to prevent and respond to aggression and violence should begin at the undergraduate level.	The health service does not monitor or review the education provided to newly qualified nurses and midwives about how to prevent and respond to aggression and violence.	The health service monitors education provided on an adhoc basis, but has no organisational policies to ensure consistent minimum education on how to respond and prevent OVA is provided.	The health service monitors and reviews education provided to newly qualified nurses and midwives, and has a process in place to ensure consistent minimum education is provided on how to systematically prevent and respond to OVA.
	Student nurses do not receive employer specific training on how to prevent and respond to OVA.	The health service provides employer-specific training to all student nurses on how to prevent and respond to OVA from an individual perspective as part of their clinical placements.	The health service provides employer-specific training to all student nurses on their role in how the organisation will systematically prevent and respond to OVA as part of their clinical placements, at the start of their placement.
	Graduate nurses do not receive employer specific training on how to prevent and respond to OVA.	The health service provides employer-specific training to all graduate nurses on how to prevent and respond to OVA from an individual perspective as part of their graduate year.	The health service provides employer-specific training to all graduate nurses on their role in how the organisation will systematically prevent and respond to OVA as part of their graduate year as an induction item i.e. at the beginning of the year.
6.2 Education about how to conduct incident investigations, prevent and respond to aggression and violence should continue throughout a health worker's career.	The health service's new staff induction / orientation program does not include employer specific training about how to prevent and respond to OVA.	All new staff receive employer-specific training on how to prevent and respond to OVA from an individual perspective as part of the health service's induction / orientation program.	All new clinical (doctors, nurses, midwives, allied health and others) and non-clinical staff receive employer-specific, multi-disciplinary training on how the organisation will systematically prevent and respond to OVA as part of the health service's induction / orientation program. This includes visiting (VMOs), consultants and GPs.
	Health workers do not receive education about how to prevent and respond to aggression and violence throughout their career which is relevant to their knowledge, role and experience.	Health workers have generic refresher training about how to prevent and respond to aggression and violence available on an elective basis.	Health workers receive mandatory, regular refresher training and education about how to prevent and respond to aggression and violence throughout their career which is relevant to their knowledge, role and experience, which includes a face to face component. This would include recognition of early warning signs for agitation and pre-code responses, development of skills to reduce conflict, implementation of employer processes that consistently identify and record risks of or actual violence and safety management plans.
	Staff receive no education and training about the functions and powers of security staff and Victoria Police.	Staff receive limited generic education about the functions and powers of security staff and Victoria Police including how and why to lodge a police report.	All clinical (doctors, nurses, midwives, allied health and others) and non-clinical staff receive mandatory, multidisciplinary training and education about the functions and powers of security staff and Victoria Police including their role in OVA prevention and management, and how and why to lodge a police report. This includes visiting (VMOs), consultants and GPs.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

6 PROVIDE EDUCATION AND TRAINING TO HEALTHCARE STAFF CONTINUED

CRITERIA	HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
6.2 Continued.	OHS incident investigation and post-incident support training for middle management (i.e. NUMs, ANUMs, MUMs, AMUMs etc.) is not provided.	OHS incident investigation and post-incident support training is available on an elective basis.	All middle management receive mandatory OHS incident investigation and post-incident support training.
6.3 Employer-specific training and education for both health workers and security staff should be provided.	Emergency procedure training drills (including Code Grey and Black) are not undertaken.	Emergency procedure training drills are infrequently undertaken.	Emergency procedure training drills (including Code Grey and Black) are scheduled regularly, are mandatory and attended by all members of the emergency teams, such as Code Grey and Black. Debriefs are conducted after each to identify learnings and improvements.
	Employees are not trained in procedures for searching patient and visitors.	Employees receive limited training in procedures for searching patient and visitors.	Employees receive regular, mandatory training in procedures for searching patient and visitors that are compliant with legislative provisions and related policies. This includes visiting (VMOs), consultants and GPs.
	No training is provided in relation to behavioural contracts, nor duty of care obligations / withdrawal of service following aggressive incidents.	Training is available to staff in relation to behavioural contracts on an elective basis.	Employees including corporate representatives receive education to assist all staff to understand and enact behavioral contracts. Clear guidelines are provided in relation to withdrawal of service.
	OVA-related training has not been developed in consultation with staff.	OVA-related training has been developed in consultation with some clinical staff.	All OVA-related training has been developed in consultation with staff from all clinical and non-clinical areas, and is regularly reviewed for appropriateness.
6.4 Standardised training for both health workers and security staff should occur.	The health service has not benchmarked OVA training programs against similar health services nor Department of Health and Human Services standards for consistency and quality.	The health service has started to benchmark OVA training programs against similar health services and Department of Health and Human Services standards for consistency and quality, but has not implemented changes to address gaps.	The health service has benchmarked all OVA training programs against similar health services and Department of Health and Human Services standards for consistency and quality, and has addressed identified gaps.
6.5 Regular, multidisciplinary refresher training for health workers and security staff.	The facility does not offer OVA refresher training to all clinical (doctors, nurses, midwives, allied health and others) and non-clinical staff.	All clinical (doctors, nurses, midwives, allied health and others) and non-clinical staff can access OVA refresher training.	All clinical (doctors, nurses, midwives, allied health and other) and non-clinical staff receive regular, mandatory OVA refresher training, including a face to face component at least annually. Training is collective and multi-disciplinary, involving workers from clinical and non-clinical departments. This includes visiting (VMOs), consultants and GPs.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

7 INTEGRATE LEGISLATION, POLICIES AND PROCEDURES

CRITERIA	HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
7.1 Health services' responses to aggression and violence such as Code Grey and Code Black must be consistent with state-wide guidance, and apply to all situations of occupational violence and aggression.	The facility does not have a Code Grey procedure.	The facility has a Code Grey procedure but it is not in line with Department of Health and Human Services guidelines or is not fully implemented.	The facility has an effective Code Grey procedure in line with Department of Health and Human Services guidelines that is implemented, regularly trialed and used by staff.
	No clear process exists for when multiple concurrent Code Greys / Blacks are called.	-	A clear process and response plan exists for when multiple concurrent Code Greys / Blacks are activated, which is implemented and trialled.
	-	For health services who do not have a capacity to perform 5 person Code Grey response, other means of addressing this issue must be developed and implemented.	-
	The facility does not have a Code Black procedure.	The facility has a Code Black procedure in line with Australian Standards (AS 4083).	The facility has a Code Black procedure in line with Australian Standards (AS 4083), which is implemented, regularly trialled and is used by staff.
	-	The OVA prevention and response system, policy and procedures do not cover all identified situations at risk of occupational violence and aggression.	The OVA prevention and response system, policy and procedures have been implemented and reviewed, and cover all identified situations at risk of occupational violence and aggression, and staff have been provided with education about any updates.
7.2 Workplaces should integrate their violence prevention policies with other policies such as clinical assessment, de-escalation, escalation, post incident support, training and education and security policies.	OVA prevention and response system, policy and procedures are not integrated.	OVA prevention and response system, policy and procedures have been reviewed and have limited integration.	OVA prevention and response system, policy and procedures (inclusive of education and training for all staff) are implemented and regularly reviewed for consistency, and are integrated into the health service's broader systems, such as: • security policies • equipment e.g. personal duress and fixed alarms, CCTV, patient searches and storage of belongings (including weapons), storage of dangerous goods, mandatory training.
	OVA prevention and response system, policy and procedures have not been reviewed and integrated with security policies.	OVA prevention and response system, policy and procedures have been reviewed with security policies and inconsistencies have been identified.	OVA prevention and response system, policy and procedures are implemented and regularly reviewed with security policies for consistency, and are integrated.
	OVA prevention and response system, policy and procedures have not been reviewed and integrated with clinical and non-clinical OVA-related training and education policies.	OVA prevention and response system, policy and procedures have been reviewed with clinical and non-clinical OVA-related training and education policies and inconsistencies have been identified.	OVA prevention and response system, policy and procedures are regularly reviewed with clinical and non-clinical OVA-related training and education policies for consistency and are integrated.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

7 INTEGRATE LEGISLATION, POLICIES AND PROCEDURES CONTINUED

CRITERIA		HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
7.2	**Continued.**	Clinical and non-clinical OVA-related training has not been updated to ensure best practice and current information.	Clinical and non-clinical OVA-related training has been partially updated to ensure best practice and current information.	All clinical and non-clinical OVA-related training is regularly reviewed to ensure it covers all aspects of OVA, has currency with OVA industry knowledge, changes in the health service's system due to the OVA action plan, key OHS cultural approaches and consistency of OVA / OHS messaging.
		Local area processes for preventing and responding to violence have not been reviewed and are not consistent with organisational policies.	Local area processes for preventing and responding to violence have been reviewed in line with organisational policies but are not fully consistent with organisational policies.	Local area processes for preventing and responding to violence have been reviewed at regular intervals and are consistent with organisational policies.
		No consultation with employees is undertaken regarding development and review of OVA-related policies and procedures.	Limited consultation is undertaken with employees regarding development and review of OVA-related policies and procedures.	Staff are regularly consulted in the development and review of all OVA-related policies and procedures.
7.3	**Systemic policy changes and decisions about a patient's care should take into consideration any potential for the change to increase the incidence of aggression and violence.**	Systemic policy changes do not consider the potential to increase the prevalence of OVA incidents.	Systemic policy changes consider the potential to increase the prevalence of OVA incidents but this process is not integrated within the health service's system to prevent and minimise impacts.	Systemic policy changes consider the potential to increase the prevalence of OVA incidents and this process is formally integrated within the health service's system to prevent and minimise the impacts.
		Decisions about a patient's care do not consider the potential to increase the prevalence of OVA incidents.	Decisions about a patient's care consider the potential to increase the prevalence of OVA incidents but this process is not formally integrated within the health service's system, nor is there a process to prevent and minimise the impacts.	Decisions about a patient's care consider the potential to increase the prevalence of OVA incidents and this process is formally integrated within the health service's system, with actions implemented to prevent and minimise the impacts.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

8 PROVIDE POST-INCIDENT SUPPORT

CRITERIA		HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
8.1	**In the event of aggressive or violent incidents, staff members should receive extensive and appropriate follow up, support and care, including information about, and access to, the workers' compensation system and the police reporting system process.**	No documented post incident reporting procedure exists.	A post incident reporting procedure exists that does not incorporate all minimum standards, or is implemented on an ad hoc basis.	The health service has a documented, implemented post incident reporting procedure which covers: • post incident follow up timelines and processes for contacting involved workers • protocols that ensure evidence is undisturbed (where applicable) • support and care options for all staff / patients involved • information, access to and processes for workers' compensation system • documented review of the patient care plan inclusive of implementing mechanisms to provide a safe workplace • responsibility for arranging repairs etc without delay • information, access to and processes for police reporting system without loss of pay.
		-	The health service's post incident reporting procedure, processes and tools are implemented and reviewed for improvement.	The health service's post incident reporting procedure, processes and tools are implemented and regularly reviewed for improvement and recommendations implemented.
		The health service does not provide information, support or accompany staff during the police reporting process.	The health service provides limited support to staff to pursue police reporting.	The health service provides workers with information and support and option for accompanying staff during the police reporting and prosecution process as requested.
		The health service does not have a police liaison.	The health service has an identified police liaison.	The health service has a police liaison and appropriate employer representative(s) conduct regular contact meetings. A regular report on these meetings is provided to the OHS committee, and information / updates are also distributed to staff.
		Critical incident, general and operational debriefs are not conducted following incidents.	Critical incident, general and / or operational debriefs are sometimes conducted following incidents.	Clear processes, requirements and appropriately trained staff are available to conduct critical incident, general and operational debriefs following incidents.
8.2	**Incident investigation and actions taken as a result must also be reported.**	Actions taken as a result of an incident are not communicated to the workers involved.	Actions taken as a result of an incident are recorded and are available to those involved.	Actions taken as a result of an incident are communicated directly to the involved workers, and others in the service who are potentially affected, without employee privacy being breached.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

9 APPLY ANTI-VIOLENCE APPROACH ACROSS ALL HEALTH DISCIPLINES

CRITERIA	HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
9.1 **All healthcare workers and other workers who come into contact with patients (and their families and visitors) have consistent knowledge around the prevention and responses to violence, and the health service's procedures and expectations.** See also 6 – Provide education and training to healthcare staff	No OVA training is available or there are only limited places for staff to attend.	Some categories of clinical staff receive and attend OVA training.	All clinical (doctors, nurses, midwives, allied health and others) and non-clinical staff receive and attend multidisciplinary, mandatory OVA training at orientation and then at regular intervals.
	There is no messaging for patients, family and visitors in relation to acceptable behavioural standards in the health service.	There is some messaging around behavioural expectations which is not proactively provided to all patients, family and visitors pre-admission / on arrival / admission to the health service.	Clear messaging is provided to all patients, family and visitors pre-admission / on arrival / admission to the health service setting out appropriate behaviour, and the possible consequences of failing to comply with these expectations.
	The OVA working party does not have representation of all work groups.	There is limited representation of clinical and non-clinical workers on the OVA working party, with little opportunity for consideration of their views and experiences.	All clinical and non-clinical workers and ANMF (as requested) are represented on the OVA working party and their views and experiences considered in the development and implementation of the OVA action plan.
9.2 **All workers in healthcare settings should have the expectation that they will not encounter violence or aggression at their workplace.** See 10 - Empower staff to expect a safe workplace	Workers do not receive messaging from management that they should not accept violence or aggression in their workplace.	All workers receive informal messaging from management that they should not accept violence or aggression in their workplace.	All workers in the health service receive consistent and supportive modelling from management that they should not accept violence or aggression in their workplace e.g. formal component of training, policies, messaging, policies, follow up etc and put into action.
	No review of clinical training, practices, policies and procedures around behaviors of concern has occurred to ensure alignment with OVA messaging, policies and procedures.	Limited review of clinical training, practices, policies and procedures around behaviors of concern has occurred to align with OVA messaging, policies and procedures.	All clinical training, practices, policies and procedures around behaviors of concern are regularly reviewed to align with OVA messaging, policies and procedures.
9.3 **All workers' reports about aggressive or violent behavior from a patient or their visitors should be taken into consideration when making decisions about the patient's care and management.**	OVA incident reports, including Code Grey and Code Black reports, and in clinical notes, about the patient or visitor are not reflected in the patient care plan or taken into consideration when making decisions about the patient's care and management.	OVA incident reports, including Code Grey and Code Black reports, and in clinical notes, about the patient or visitor are taken into consideration when making decisions about the patient's care and management but there is no clear standardised documented process.	A clear process exists and is implemented to ensure OVA incident reports, including Code Grey and Code Black incidents, in clinical notes, and any other known forms of violence or aggression in relation to the patient or visitor(s) are recorded in the medical records, and that the patient care plan reflects the identified hazard.
	No weight is given to reports by nurses and midwives of aggressive or violent patient behaviour by those making decisions about a patient's care plan.	Little weight is given to reports by nurses and midwives of aggressive or violent patient behaviour by those making decisions about a patient's care plan.	Consideration is given to the potential OVA risks as identified by all disciplines at all times, and actions implemented to reflect concerns and prevent / minimise impacts.
9.4 **In making decisions, it is important to communicate, consult and collaborate with all staff involved in the patient's management and care.**	Collaborative multi-disciplinary case conferences for patients with challenging behavior do not occur.	No clear model or process exists for regular collaborative multi-disciplinary case conferences for patients with challenging behavior.	A clear model and process exists and is implemented for regular collaborative multi-disciplinary case conferences for patients with challenging behavior, with OVA as a specific consideration. Where appropriate, this involves family members, carers and / or nominated persons.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

10 EMPOWER STAFF TO EXPECT A SAFE WORKPLACE

CRITERIA	HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
10.1 **Management must demonstrate commitment to changing the culture of healthcare workplaces to reflect no acceptance of aggression or violence in health services.** **In workplaces where there is no acceptance of aggression or violence, staff will become empowered to report incidents, and implement preventative actions, and believe in their right to a safe workplace.**	There is no OVA working party, nor OVA oversight committee with oversight of implementation of actions in relation to OVA.	There is an OVA working party doing work in relation to prevention of violence and aggression, but there is no overarching strategy, or it does not have reporting responsibility to a higher level OVA oversight committee.	A high-level OVA committee is designated to have oversight of all OVA work, and a further OVA working party has developed an OVA strategy and action plan to implement an organisational, risk management approach to prevention of violence and aggression. ANMF is represented on the OVA oversight committee and OVA working party upon request.
	No executive management representatives are active members of the OVA working party.	Some executive management representatives are active members of the OVA working party	The health service's CEO and executive management are active members of the OVA working party.
	Executive management do not receive any safety culture and OVA-specific training.	Executive management including the CEO receive limited safety culture and OVA-specific training.	All management roles (including the CEO, board and executive) receive safety culture and OVA-specific training.
	The health service does not have a prevention of OVA policy.	The health service has a prevention of OVA policy.	The health service has a collaboratively-developed prevention of OVA policy that is fully endorsed (signed) by the CEO and chair of the board.
	The health service's incident reporting and investigation policies do not promote a no blame culture.	The health service's policies refer to a no blame culture, but this is not actively supported in tools etc, or is not fully and actively implemented.	The health service's incident reporting and investigation policies promote a no blame culture with at least 90% of staff reporting that the no-blame culture is actively implemented. Further, managers are provided with education and training, and have access to incident reporting and investigation tools.
	OVA training does not exist or does not promote a non-acceptance of aggression or violence in the workplace.	OVA training does not actively promote a non-acceptance of aggression or violence in the workplace, or is not based on appropriate policy.	OVA training actively promotes non-acceptance of aggression or violence in the workplace and includes workers' rights for safe workplace and provisions if this is breached.
	Use of language by senior and middle management around non-acceptance of OVA does not demonstrate positive safety culture e.g. language is used which suggests that violence is an inevitable part of healthcare workplaces.	Use of language by senior and middle management around non-acceptance of OVA sporadically and/or inconsistently demonstrates positive safety culture e.g. language is sometimes / inconsistently used which suggests that violence is not okay, but sometimes is used suggesting violence is an inevitable part of healthcare workplaces.	Positive safety culture is demonstrated through consistent use of language which promotes non-acceptance of OVA by all staff, including senior and middle management e.g. language is always used which promotes the message that violence is never okay, and steps will be taken to investigate and reduce the risk into the future.
	There are no OVA strategic programs nor action plans in place.	There are either OVA strategic programs or action plans in place, which have not been developed with stakeholders, or are not monitored by an oversight committee. The board does not receive progress reports.	OVA strategic programs and action plans have been developed in consultation with stakeholders including ANMF, and are monitored by an OVA oversight committee, with regular reports on progress presented to the board.
	No extra resourcing is provided to achieving OVA action plan and OVA strategic outcomes.	Limited resourcing is allocated to achieving OVA action plan and OVA strategic outcomes.	Extra resourcing is allocated to achieving OVA action plan and OVA strategic outcomes.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

10 EMPOWER STAFF TO EXPECT A SAFE WORKPLACE CONTINUED

CRITERIA		HIGH RISK	REDUCED RISK SOLUTION	LOW RISK SOLUTION
10.1	**Continued.**	The health service does not invite nor recognise employee OVA achievements (e.g. OVA safety suggestions by employees, actions taken by employees to identify OVA hazards and improve safety).	Employee OVA achievements are invited and recognised in a limited capacity at an organisational wide and local level (within the units).	Employee OVA achievements and suggestions are actively invited and recognised both at an organisational wide and local level (within units). Improvements are made as a result with appropriate acknowledgement.
		No clarity around employee's control or decision making ability is provided to prevent or minimise OVA.	The facility has an escalation policy but it does not provide clear boundaries.	The facility has a clear escalation policy that creates clarity about employee, manager (NUM/ANUM) and executive management escalation points and decision making ability, and is implemented with decisions for extra resources supported.
		Organisational values place prime and sole focus on patient safety and experience, without regard for staff safety.	Organisational values recognize staff safety, but it is considered secondary to patient safety.	Safety culture for both patients and staff are included and represented as of equal importance in organisational values and represented in all branding.
10.2	**All action plans around prevention and management of violent and aggressive incidents should be developed in consultation with staff.**	There is no OVA working party, nor OVA oversight committee with oversight of implementation of actions in relation to OVA.	There is an OVA working party doing work in relation to prevention of violence and aggression, but there is no overarching strategy, or it does not have reporting responsibility to a higher-level OVA oversight committee.	A high level OVA committee is designated to have oversight of all OVA work, and a further OVA working party has developed an OVA strategy and action plan to implement an organisational, risk management approach to prevention of violence and aggression. ANMF is represented on the OVA oversight committee and OVA working party upon request.
		No representatives from clinical (doctors, nursing, midwives, allied health and others) and non-clinical areas on the OVA working party.	The facility demonstrates a limited commitment to an integrated approach to OVA prevention by representatives of some clinical (doctors, nursing, midwives, allied health and others) and non-clinical areas being active members of the OVA working party.	The facility has an integrated approach to OVA prevention and management by actively including representatives of all clinical (doctors, nursing, midwives, allied health and others) and non-clinical areas / departments and ANMF (as requested) as being active members of the OVA working party, with meetings scheduled at times that enable staff to attend.
		No HSRs are members of the OVA working party.	HSRs are invited (but not actively encouraged) to be members of the OVA working party and / or meetings are not scheduled to facilitate attendance.	Appropriate number of HSRs are active members of the OVA working party, and are encouraged and facilitated to attend in paid time.
		HSRs and employees are not consulted in the formulation of the health service's OVA strategy and action plan.	Limited consultation with HSRs and employees has occurred in regard to the development and project work of the health service's OVA strategy and action plan with less than 85% awareness of the OVA action plan amongst staff.	HSRs, employees and ANMF have been and are regularly consulted in the development and project work of the health service's OVA strategy and action plan, and there is greater than 85% awareness of the OVA action plan amongst staff.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

© This work is copyright. Apart from any use permitted under the Copyright Act 1968, no part may be reproduced by any process, nor may any other exclusive right be exercised, without the permission of The Secretary, Australian Nursing & Midwifery Federation (Victorian Branch), Melbourne, 2017.

Australian Nursing & Midwifery Federation

VICTORIAN BRANCH

anmfvic.asn.au

Violence in Nursing and Midwifery in NSW: Study Report

Author

Chief investigator: Dr Jacqui Pich PhD BNurs (Hons I) BSc

Project support

Christopher Oldmeadow: HMRI – statistical support

Matthew Clapham: HMRI – statistical support

UTS UNIVERSITY OF TECHNOLOGY SYDNEY

Executive summary

Workplace violence is one of the most significant and hazardous issues faced by nurses and midwives globally with patients the most common source of this violence. It is a potentially life-threatening and life-affecting workplace hazard often downplayed as just" part of the job". Within this context the specialities of emergency, mental health and aged care have been reported to be at highest risk for episodes of violence. Violence includes a continuum of behaviours from verbal abuse and threats, sexual harassment through to physical assaults. It involves both explicit and implicit challenges to the well-being, safety or health of nurses and midwives at work (Mayhew & Chappell, 2005).

This cross sectional study of NSW nurses and midwives utilised an online questionnaire to achieve the study objectives, and was designed to uncover the experiences of participants with episodes of violence. The sample size of 3612 makes this one of the largest studies of its kind in Australia and globally and underscores the significance placed on the topic by NSW nurses and midwives.

The data in this report demonstrate the achievement of the proposed aims and objectives of this study including:

1. Nurse/midwife reported incidence of episodes of violence from patients and/or family and friends and associated outcomes in the preceding six months;
2. Nurse/midwife reported incidence of the types of violent behaviours experienced;
3. Compared of the experiences of NSW nurses and midwives in the private and public sector with this violence;
4. Compared the experiences of NSW nurses and midwives in metropolitan, regional and remote areas with this violence;
5. Identified the experiences of NSW nurses and midwives with this violence in different clinical areas and patient-related services;

6. Identified the risk factors for violent episodes – including perpetrators, geographical location, clinical specialty;

7. Identified NSW nurses' and midwives' perceptions of risk prevention measures and risk management strategies adopted by their employers.

While some differences were identified, the overall experiences of NSW nurses and midwives with violence from patients and/or their relatives or friends was consistent across employment sector and geographical work area. The key results of this study include:

1. There were 1454 participants (1454/3101, 47%) who had experienced an episode of violence in the previous week and 2460 who had experienced violence in the six months prior to completing the survey (2460/3092, 80%).
2. The majority of nurses and midwives (81%) reported between one and 10 episodes, however 38 (2%) reported experiencing more than 10 episodes
3. Older and more experienced nurses and midwives reported less episodes of violence, with younger and less experienced participants at greater risk of violence.
4. Males were more likely to experience an episode of violence than females (88% to 78%).
5. More than half of participants working in all clinical areas had experienced an episode of violence during the preceding six months.
6. The rates of violence were highest for those working in the specialities of emergency, drug and alcohol and mental health.
7. The public health sector had a higher percentage of participants having been involved in violent episodes in the last six months compared to private (82% compared to 69%).
8. There was a reported injury rate of 28% as a result of an episode of violence.
9. Psychological injuries were the most common type of injury reported by participants, in a result that was consistent across geographical work areas and work sector.
10. Participants from metropolitan areas were more likely to report a physical or psychological injury than their regional and remote colleagues.
11. Verbally abusive behaviours were experienced at higher rates by those participants working in the public sector.

12. The majority of participants were selective in their reporting of episodes of violence, with 67% reporting only some or no episodes of violence.
13. Non-physical outcomes associated with being involved in an episode of violence, and impacting on nurses and midwives' professional role include: considering leaving the profession, powerlessness, burnout, depression, fear of future episodes, anxiety, altered sleep patterns and reduced empathy which may affect the quality of care provided to patients.
14. Nurses and midwives also reported a range of problems which affected their personal lives following involvement in an episode of violence, some of which were ongoing in nature, for example post traumatic stress disorder (PTSD).
15. There were some frequently identified nursing and midwifery behaviours associated with episodes of violence, many of which related to communication with patients.
16. Patients who presented with substance misuse, mental health issues, alcohol intoxication and/or cognitive impairment were perceived by participants to be of highest risk for potential violence.
17. Almost half of participants stated that they were not satisfied with their employer's immediate response.
18. Two-thirds of participants reported that they had not been provided with adequate information, support and follow-up following an episode of violence.
19. More than half of participants had not been given access to counselling following an episode of violence.
20. Mandatory training is often not made available to staff with many having to complete this at their own expense outside the workplace.
21. There is a reliance on online training for topics that require hands-on knowledge and practice to be effective, for example takedown training.

There is an obligation to act on the information that nurses and midwives have provided in this study and in the words of one participant: *"…please actually act on this information you collect and improve our working conditions, Too many good nurses are being harmed and no one seems to care…" (P198).*

Recommendations

1. Healthcare employers in all sectors need to review current strategies and update and amend them accordingly to ensure that nurses and midwives are afforded a safe work place.
2. Where policies and procedures exist to protect nurses and midwives, these should be enforced and penalties imposed on employers who do not comply.
3. Mandatory training should be made available for all nurses and midwives as applicable and provided at the place of employment at the employers' expense. Employers should be monitored regularly for compliance and appropriate actions taken where this does not occur.
4. Training should be offered in a face to face format where possible.
5. Reporting of episodes of violence should be encouraged and acted on in a timely manner by employers with feedback provided to affected nurses and midwives and consequences for perpetrators.
6. Nurses and midwives should be offered immediate and ongoing support by their employer following all episodes of violence.
7. Nurses and midwives should be included in all planning and policy development on the topic of violence as they represent the largest group in healthcare and are most vulnerable to violence from patients and their relatives and friends.

Contents

Violence in Nursing and Midwifery in NSW: Study Report 1

Executive summary 2

Recommendations 6

List of appendices 13

Chapter 1 Background 14

1.1 Definition of violence 14

1.2 Types of violence 15

1.2.1 Verbal abuse 15

1.2.2 Non-verbal hostility 15

1.2.3 Physical 16

1.3 Antecedents and precipitants 16

1.3.1 History of violence 16

1.3.2 Clinical presentations 16

1.4 Consequences of episodes of violence on nurses and midwives 17

1.5 Coping strategies 18

1.5.1 Debriefing 18

1.6 Risk management strategies 19

1.7 Reporting 19

1.8 Risk management strategies 19

1.8.1 Training 19

1.8.2 Security ... 20

1.8.3 Environmental measures ... 20

1.8.4 Policies and procedures ... 21

1.9 Conclusion ... 21

Chapter 2 Study aims and objectives ... 23

2.1 Research question ... 23

2.2 Study aims ... 23

2.3 Study objectives ... 23

2.4 Expected Benefits and Outcomes ... 24

2.5 Advisory panel ... 24

Chapter 3 Methods ... 24

3.1 Study Design ... 24

3.2 Study Population and Recruitment ... 25

3.3 Recruitment ... 25

3.4 Study Instrument ... 25

3.5 Promotion of the Survey ... 29

3.6 Ethical Considerations ... 29

3.7 Data Storage ... 29

3.8 Data Analysis ... 30

Chapter 4 Results ... 30

4.1 Sampling results ... 30

4.1.1 Characteristics of participants ... 30

4.1.2 Composition of study sample by clinical area 33
4.2 Incidence and characteristics of episodes of violence 33
4.2.1 Number of episodes of violence 37
4.2.2 Type of violence 37
4.3 The consequences of episodes of violence 46
4.3.1 Injuries 46
4.4 Outcomes following an episode of violence 49
4.4.1 Emotional response 49
4.4.2 Professional responses 52
4.4.3 Coping strategies 52
4.5 Management response to episodes of violence 53
4.6 Reporting 56
4.7 Factors associated with violence – antecedents and precipitants 58
4.7.1 Patient specific factors 58
4.7.2 Staffing specific factors 59
4.7.3 Environmental specific factors 61
4.8 Risk prevention strategies 62
4.8.1 Training 64
4.8.2 Policies and procedures 66
4.9 Risk management 67
Chapter 5 Discussion 67
5.1 Nurse and midwife reported incidence of episodes of violence 68

5.2 Injuries 69

5.3 Outcomes associated with episodes of violence 69

5.4 Factors associated with episodes of violence 72

5.5 Organisational risk prevention and management strategies 73

5.5.1 Reporting 74

5.6 Study strengths and limitations 76

5.7 Achievement of study objectives 76

Conclusions 77

Recommendations 78

Reference list 79

Appendices 87

Table of tables

Table 1: Study aims addressed in questionnaire 27

Table 2: Sampling results 30

Table 3: Characteristics of participants 31

Table 4: Study sample by clinical area 33

Table 5: Episodes of violence compared to demographic data 34

Table 6: Episodes of violence experienced by clinical area 35

Table 7: Epsiodes of violence by work sector and clinical sector 36

Table 8: Number of episodes of violence 37

Table 9: Type of verbal/non-physical violence 39

Table 10: Type of violence experienced by geographical work area 40

Table 11: Type of verbal abuse behaviours compared by work sector 41

Table 12: Types of physical violence 43

Table 13: Type of Physical violence by employment sector 45

Table 14: Type of violence and employment sector and geographical work area. 46

Table 15: Time taken off work due to injury 47

Table 16: Location of injury 48

Table 17: Type of injury 48

Table 18: Emotional responses following episodes of violence 50

Table 19: Professional responses following episodes of violence 52

Table 20: Actions effective for dealing with episodes of violence 53

Table 21: Immediate response 54

Table 22: Reporting byy work sector 55

Table 23: Reporting 56

Table 24: Reporting by work sector. 56

Table 25: Reporting mechanisms 56

Table 26: Factors that influence the reporting of episodes of violence 57

Table 27: Patient-specific factors (ranked) 58

Table 28: Age of perpetrators of violence 58

Table 29: Signs and symptoms of patients 59

Table 30: Staffing-specific factors (ranked) 59

Table 31: Nursing/midwifery activities associated with episodes of violence 61

Table 32: Environmental specific factors (ranked) 61

Table 33: Location of episodes of violence 62

Table 34: Risk prevention strategies 63

Table 35: Training 65

Table 36: Effectiveness of policies by work sector and geogrphical wok location 66

Table 37: Risk management strategies 67

List of appendices

Appendix 1: Email invitation

Appendix 2: Participation Information Statement

Appendix 3: Questionnaire

Appendix 4: Reminder postcard

Chapter 1 Background

Workplace violence is one of the most significant and hazardous issues faced by nurses globally and in response the International Council of Nurses issued a position statement in 2006 condemning "all forms of abuse and violence against nursing personnel" (International Council of Nurses, 2006). It is a potentially life-threatening and life-affecting workplace hazard often downplayed as just "part of the job" (Jones & Lyneham, 2000).

The Australian Institute of Criminology ranked the health industry as the most violent workplace in the country (Perrone, 1999). According to US statistics, healthcare workers are 5 to 12 times more likely to experience violence in the workplace than other workers (OSHA, 2015) and they are more likely to be attacked at work than prison guards and police officers (International Council of Nurses, 2009). Nurses are at the front line of violence in hospitals, particularly those working in the specialities of emergency, aged care and mental health (Phillips, 2016). The frequency and severity of violent incidents are both said to be increasing, however episodes of violence in healthcare remain vastly underreported (OSHA, 2015).

Patients are responsible for most of the violence committed against nurses, and this includes paediatric patients and their parents or carers (Gillespie et al, 2010, Pich et al, 2013). Relatives and friends, including parents and carers, who accompany patients have also been identified as perpetrators of violence (Jackson, Hutchinson, Luck, & Wilkes, 2013; Pich, Kable, & Hazelton, 2017) and this is particularly evident in research originating from non-western countries (Hasani et al., 2010; Senuzun Ergun & Karadakovan, 2005).

1.1 Definition of violence

NSW Health defines violence as any incident in which an individual is abused, threatened or assaulted and includes verbal, physical or psychological abuse, threats or other intimidating behaviours, intentional physical attacks, aggravated assault, threats with an offensive weapon, sexual harassment and sexual assault (SESLHD, 2018). The majority of this violence is service-related, that is violence that arises when providing services to clients,

customers, patients or prisoners, perpetrated by patients or those accompanying them (SafeWork NSW, 2018).

1.2 Types of violence

Violence covers a range of behaviours from verbal abuse and threats through to physical violence.

1.2.1 Verbal abuse

Verbal abuse has been identified as the most common form of violence, experienced by the majority of nurses and midwives, with estimates up to 100% affected in some locations, for example the emergency department where it can be a daily occurrence (Gacki-Smith et al., 2009; J. B. Lau, J. Magarey, & R. Wiechula, 2012).

Swearing has been identified as the most common form of verbal abuse (Pich, Hazelton, Sundin, & Kable, 2011) and demeaning swearing has been identified as the most offensive form of verbal aggression, particularly for female nurses (Stone, McMillan, Hazelton, & Clayton, 2011). Other types of verbal abuse include questioning professional skills and capabilities; and threats: including threats of complaint or legal action (Jackson et al., 2013), and threats of violence such as shooting, killing, blowing up, punching and stabbing with a needle (Jackson et al., 2013). Such abuse can occur face-to-face and over the phone, (Lyneham, 2000) and is not confined to the emergency department with nurses reporting that it can occur outside the department and after working hours (Gacki-Smith et al., 2009).

1.2.2 Non-verbal hostility

Non-verbal hostility refers to overt behaviours by patients designed to intimidate or threaten nurses or gain their attention, for example crossing arms, glaring at staff, throwing their arms up in the air, pacing, and rolling eyes and shaking their heads while talking to staff (Jackson et al., 2013). Other examples include acts of symbolic violence such as punching a wall or throwing furniture (Winstanley & Whittington, 2004), and patients photographing or videoing staff on their mobile phones and threatening to "send it to the media" (Jackson et al., 2013).

1.2.3 Physical

Physical violence is defined as physical contact that is intended to injure or harm another party (Nachreiner, Gerberich, Ryan, & McGovern, 2007). It includes any intentional physical contact, actual or threatened, and does not have to result in an injury to the victim (Victorian Government, 2005). The majority of physical violence occurs concurrently with verbal abuse, and this correlation may indicate that verbal violence can act as a predictor for potential physical violence (Lau, Magarey, & Wiechula, 2012).

Examples of physical violence include being hit, slapped, kicked, pushed, choked, grabbed and sexually assaulted (Nachreiner et al., 2007; SafeWork NSW, 2018). The use of weapons, both traditional and opportunistic, is reported in the literature. Opportunistic weapons refer to items readily available and used to threaten or harm nurses. Examples reported in the literature include intravenous equipment, poles, syringes (sometimes blood-filled), furniture (Lyneham, 2000), scalpels, oxygen flow metres, ophthalmoscopes, stethoscopes and scissors (Pich, Hazelton, Sundin, & Kable, 2010).

1.3 Antecedents and precipitants

1.3.1 History of violence

The greatest risk factor in predicting future violent or threatening behaviour from an individual is reported to be a past history of violence (Ferns, 2005), and the greater the magnitude of violence, the greater the likelihood of future violence (Holleran, 2006). This includes any violence the person has experienced, for example domestic abuse, assault, and any convictions for violent crime (Holleran, 2006).

1.3.2 Clinical presentations

1.3.2.1 Alcohol and substance misuse

Crime statistics for hospital assaults in NSW for the year 2006 listed the top three antecedents as mental health related (32% of incidents), alcohol-related incidents (31%) and drug-related (17%) (Hilliar, 2008). Patients under the influence of alcohol and/or drugs,

including ice, and those with mental health issues are the most likely to become violent, increasing the risk to nurses by up to six times (Pich et al., 2017).

1.3.2.2 Cognitive impairment

Clinical diagnoses that affect cognition are linked to an increased risk for violence. These include temporary organic causes, for example intracranial trauma, delirium and hypoxia, (Chapman & Styles, 2006; Liu & Wuerker, 2005) and those that are permanent in nature, for example dementia . Anxiety and agitation ($p = 0.047$) and delirium ($p = 0.010$) were found to be statistically significant factors associated with episodes of violence in a recent Australian study of 537 emergency department nurses (Pich et al, 2017).

1.3.2.3 Mental health issues

The authors of an Australian study of Australian emergency department nurses reported that mental health issues were significantly predictive of a participant having experienced an episode of violence (Pich et al, 2017). There is strong evidence that the potential for violence in such patients markedly increases in the presence of drug and/or alcohol abuse (Gillies & O'Brien, 2006), meaning that the risk of violence may be amplified where patients with mental health issues also present with alcohol intoxication and/or substance misuse. For the period 1996-2006 the proportion of assaults in NSW hospitals classified as mental health-related increased significantly: from 19% to 32% (Hilliar, 2008).

1.4 Consequences of episodes of violence on nurses and midwives

The impact of violence is far reaching and can have a lasting physical, psychological and professional impact on nurses and midwives. Verbal abuse can cause significant psychological trauma and stress to nurses, even if no physical injury has occurred, and this can persist for up to 12 months following an incident (Gerberich et al., 2004). The types of physical injuries sustained by nurses range from minor scratches and bruises through to serious injuries and even death. In 2011 a mental health nurse was stabbed to death by a patient (ABC News, 2011) and in 2016 a remote area nurse, Gale Woodford was abducted, raped and murdered in northern South Australia (Clark, 2018).

Exposure to patient-related violence can also affect the way nurses interact with their patients, and this includes feeling less empathy and a decline in the quality of care afforded patients (Lau, Magarey, & McCutcheon, 2004; Pich & Kable, 2014). A link between violence experienced by nurses and subsequent adverse events for patients has been identified, and includes the late administration of medications and an increase in the number of patient falls and medication errors (Roche, Diers, Duffield, & Catling-Paull, 2010).

The consequences of episodes of violence on nurses and midwives have a flow on effect to the health care system in terms of increased costs. These costs are reflected in loss of experienced staff (Chapman & Styles, 2006); sick leave, decreased productivity, staff turnover and attrition, and workers' compensation pay outs (Jackson, Clare, & Mannix, 2002). Quantifying the cost of patient violence is difficult as it includes intangible items such as loss of morale, difficulties with retention and recruitment of staff, impact on patient care and therapeutic relationships and negative public relations which are difficult to assign a dollar value.

1.5 Coping strategies

1.5.1 Debriefing

The use of debriefing after episodes of violence is supported in the literature; however informal debriefing is reported to be the most common method employed in the workplace (D. Gates, Gillespie, Smith, et al., 2011). Barriers to formal debriefing cited lack of time and a workplace culture that tolerates violence as part of the job (Farrell, Bobrowski, & Bobrowski, 2006; D. Gates, Gillespie, Smith, et al., 2011).

The National Institute for Health and Clinical Excellence guidelines for the prevention and management of violence recommend that a review should take place within 72 hours for all parties involved, however they provide little guidance on how this should take place (Bonner & McLaughlin, 2007). A lack of attention to the emotional effects of violence can contribute to Post Traumatic Stress Disorder (D. Gates, Gillespie, & Succop, 2011). This is supported by other studies that show that counselling is most effective at the early stages of post-traumatic stress and should be offered to all those affected (Lange, Lange, & Cabaltica,

2000). Failure to acknowledge this can lead to increased costs in terms of workers compensation claims, job dissatisfaction and decreased morale (D. Gates, Gillespie, & Succop, 2011).

1.6 Risk management strategies

A level of management resistance has been reported in acknowledging that health care workers are at risk of patient-related violence despite the fact that nurses consistently report high expectations of assault as a consequence of their job (Nachreiner et al., 2007). At the same time there is a workplace culture perpetuated by a degree of complacency on the part of staff where violence is viewed as just "part of the job" (Jones & Lyneham, 2000; McPhaul & Lipscomb, 2004). Strategies to prevent and manage violence include the use of security guards, duress alarms; workplace design and access to training.

1.7 Reporting

Reporting is an integral component of clinical governance and its primary purpose is to increase the safety of patients, visitors and staff, and ultimately to improve the quality of care. However in the case of episodes of violence, the incidence remains difficult to quantify and is grossly underestimated due to a lack of reporting (Jones & Lyneham, 2000).

1.8 Risk management strategies

The best strategy for managing aggression and violence is prevention; however in clinical environments such as the emergency department this is not always possible. Violence should be dealt with promptly and positively by management, and staff should be supported and followed up with understanding.

1.8.1 Training

Minimisation of violence requires early recognition of signs or cues and timely de-escalation (Presley & Robinson, 2002). De-escalation has been defined as the reduction of the intensity of a conflict or a potentially violent situation, and researchers have described a "turning point", where nurses have the opportunity to act and contain or prevent violence (Lau et al., 2012).

According to the literature the amount and type of training provided to staff varies widely and as a result many staff report that they do not feel that they have the necessary skills to effectively manage episodes of violence (Lee, 2001; Pich et al., 2011). Training is consistently identified as important by nurses (D. Gates, Gillespie, Smith, et al., 2011), however it is reported to be largely sporadic and fragmented in nature with a lack of consistency between trainers and programs (Lee, 2001; Pich & Kable, 2014). While aggression minimisation training is compulsory for those working in high risk clinical areas like the emergency department, there are large numbers of nurses who have either had not completed any training or who have not completed the regular refresher programs required (Pich, 2014).

1.8.2 Security

The use of visible on-site security services is frequently cited as a measure to aid in the management of episodes of violence; however their effectiveness is dependent on their ability to respond in a timely fashion (D. M. Gates, Ross, & McQueen, 2006). This is also true of personal duress alarms worn by nurses (Lyneham, 2001). The presence of security is described as both a preventative strategy, by acting as a deterrent, and a reactive strategy to manage episodes of violence (D. Gates, Gillespie, Smith, et al., 2011). The type of security reported in the literature varied widely and ranged from unarmed security guards based outside the emergency department to security personnel in the emergency department armed with firearms and Tasers (D. Gates, Gillespie, Smith, et al., 2011).

In Australia security guards are not present in all emergency departments, and are often ill equipped to deal with the levels of violence they encounter. In some smaller hospitals there is no security provided after hours, however regional nurses experience the same levels and types of violence as their metropolitan colleagues(Pich et al., 2017).

1.8.3 Environmental measures

Environmental controls such as restricted access to clinical areas (Early & Hubbert, 2006) and the use of security screens at triage can reduce the risk of violence from outside the department; however they do not prevent violence once patients have been admitted into the department (Jones & Lyneham, 2000). In fact it is not possible to have impenetrable

hospital security and zero risk in the context of health care because in the majority of cases they are designed to be accessible to the public (Kelen, Catlett, Kubit, & Hsieh, 2012). Isolation or seclusion of violent patients or those identified as being at risk of violence has also been identified as an important strategy in their management (D. Gates, Gillespie, Smith, et al., 2011)

1.8.4 Policies and procedures

The presence of a definitive policy on the management of violent patients may serve to mitigate the risk of violence and aggression (Anderson, FitzGerald, & Luck, 2009). One such policy incorporates the concept of Zero Tolerance, which originated in the United States and refers to specific actions that will not be tolerated or accepted (Wand & Coulson, 2006).

This concept has been adopted by a number of health departments, for example New South Wales Health, in an attempt to create a safe working environment as required by the Workplace Health and Safety legislation. NSW Health state that a Zero Tolerance Response means that appropriate action will be taken to protect employees, patients and visitors from the effects of violent behaviour (NSW Health, 2003). The intent of this policy is to maintain effective risk management strategies and to avoid inappropriate action where violent behaviour is the result of an underlying medical condition (Hodge & Marshall, 2007). However it has been argued that zero tolerance is an ineffective response to violence in health settings, one that impinges on the rights of patients and the ability of clinicians to develop a therapeutic relationship due to its inflexible nature (Holmes, 2006).

1.9 Conclusion

Violence remains a significant workplace hazard and something that emergency nurses encounter on a regular basis, however it is often overlooked and rationalised as "part of the job" of being nurse. The strategies currently in place are inadequate and must be reviewed and updated to deal with levels of violence that continue to increase in frequency and severity. The requirements under Work Health and Safety legislation for a safe workplace for all staff mean that this must be a priority. This

will guarantee a safe workplace and bring to an end the tragic headlines involving nurses as victims of violence.

Chapter 2 Study aims and objectives

2.1 Research question

What is the nurse and midwife reported incidence of violence from patients and/or their relatives in a range of health care settings?

2.2 Study aims

The aim of the research broadly is to investigate the experiences of the members of the NSW Nurses and Midwives' Association (NSWNMA) with violence from patients and/or friends or relatives in their workplace to provide a snapshot in time of these experiences.

2.3 Study objectives

To achieve this aim, the objectives of the study are:

1. To measure the frequency of individual nurses and midwives reported exposure to violence from patients and/or family and friends and associated outcomes in the preceding six months;
2. To identify the types of violent behaviours experienced by NSW nurses and midwives;
3. To compare the experiences of NSW nurses and midwives in the private and public sector with this violence;
4. To compare the experiences of NSW nurses and midwives in metropolitan, regional and remote areas with this violence;
5. To identify the experiences of NSW nurses and midwives with this violence in different clinical areas and patient-related services;
6. To identify the risk factors for violent episodes – including perpetrators, geographical location, clinical specialty;

7. To identify NSW nurses' and midwives' perceptions of **risk prevention measures** and **risk management strategies** adopted by their **employers.**

2.4 Expected Benefits and Outcomes

The study was expected to contribute to the development of policies and procedures and their implementation in public and private clinical settings about episodes of violence and the safety of nurses and midwives. It has also contributed to the body of research on this topic.

The potential impact of this study is its contribution to the epidemiological evidence regarding precipitants, antecedents and outcomes associated with violence against nurses and midwives from patients and/or their friends and relatives, including:

- Clinical environments;
- Sector of employment, i.e.: public, private and not for profit;
- Geographical locations, i.e. metropolitan, regional and remote;
- Nursing/midwifery activities associated with episodes of violence.

2.5 Advisory panel

An advisory panel was established to assist the investigator with specialist advise when required. The members included:

1. Veronica Black and Lesley Gibbs from the NSW Nurses and Midwives' Association;
2. Christopher Oldmeadow and Matthew Clapham from the Hunter Medical Research Institute for statistical consultation.

Chapter 3 Methods

3.1 Study Design

This study utilised a cross-sectional design to survey a sample of the membership of the NSW Nurses and Midwives' Association, and was conducted by the University of Technology, Sydney. An online survey was used to establish nurse and midwife reported

incidence of episodes of violence and resultant workplace injury and effects on the nursing and midwifery workforce.

3.2 Study Population and Recruitment

All members of the NSW Nurses and Midwives' Association were emailed a link to an online survey in Survey Monkey©.

3.3 Recruitment

When ethics approval was received the NSW Nurses and Midwives' Association emailed all members in their database with an invitation to take part in the survey on 4 July 2018 (Appendix 1). The email included a link to the Participation Information Statement (Appendix 2) and a link to the online survey in Survey Monkey © (Appendix 3).

Participation was voluntary and consent was deemed to be given through the completion of the questionnaire. All completed questionnaires were non-identifiable.

Two reminder emails were sent on July 13 2018 and 19 August 2018 and Reminder postcards (Appendix 4) were circulated to members of the NSW Nurses and Midwives' Association on July 25 2018 at their 2018 Professional Day.

3.4 Study Instrument

Data relating to episodes of violence were collected using a 74-item questionnaire, divided into six sections (Appendix 3).

Section 1: Study Eligibility;

Section 2: General Information;

Section 3: Violence Experienced or Witnessed by you;

Section 4: Actions Taken After an Episode of Violence;

Section 5: Factors Associated with Violence;

Section 6: Management and Prevention of Episodes of Violence.

The development of the questionnaire was conducted in three stages and designed using Survey Monkey © software.

Stage 1

This stage involved the development of the questions for the purpose of measuring the proposed objectives of the study. It included reference to key literature on the topic as well as some relevant NSW Health policy documents. The study aims and objectives were the primary reference point for development of the questionnaire.

The following definitions were used on the questionnaire to orient participants:

- The term "violence" was modified from a definition by Mayhew and Chappell and defined as verbal abuse and threats, sexual harassment as well as physical assaults (Mayhew & Chappell, 2005). It could involve both explicit and implicit challenges to the well-being, safety or health of nurses and midwives at work.
- The term "patient(s)" also included residents, mothers, consumers and clients.
- The term "residents, friends, visitors" referred to people accompanying or visiting the patient, resident, mother, consumer or client.

Recall bias represents a major threat to the internal validity of studies that rely on self-reported data (Hassan, 2006). Recall of information depends entirely on memory that can often be imperfect and thereby unreliable (Hassan, 2006). Participants may experience interference: that is as an individual experiences an increasing number of events, the probability of recalling any one of those events specifically declines. If information required by a question is not available, the respondent may use other less relevant information to answer the question (Coughlin, 1990). Therefore an optimal recall period is essential to reduce measurement errors and facilitate accurate responses, and short recall periods are preferred (Norquist, Girman, Fehnel, DeMuro-Mercon, & Santanello, 2012). After reviewing similar studies a decision was made to use a six month recall period in an attempt to minimise recall bias in this study, and to also include a question about episodes during the last week (D. M. Gates et al., 2006; Gillespie, Gates, Miller, & Howard, 2010).

Table 1: Study aims addressed in questionnaire

Aim	Study aim	Questions	Content of questions
1	To measure the **frequency** of individual nurses and midwives reported exposure to violence from patients and/or family and friends and **associated outcomes** in the preceding six months..	13-16 20-29 69-70	Involved in an episode of violence in the previous week and/or preceding six months; Estimate how many episodes; Outcomes and impact on participants.
2	To identify the **types of violent behaviours** experienced by NSW nurses and midwives.	17-19	Types of verbal abuse and physical behaviour
3	To compare the experiences of NSW nurses and midwives in the **private** and **public** sector with this violence.	8 13-29 71	Work sector of main nursing/midwifery job Involved in an episode of violence in the previous week and/or preceding six months; Estimate how many episodes; Outcomes and impact on participants Safety at work
4	To compare the experiences of NSW nurses and midwives in **metropolitan**, **regional** and **remote** areas with this violence.	11-12 13-29 71	Type of area and postcode Involved in an episode of violence in the previous week and/or preceding six months; Estimate how many episodes; Outcomes and impact on participants Safety at work
5	To identify the experiences of NSW nurses and midwives with this violence in different **clinical areas** and **patient-related services.**	9 13-29 71	Clinical area or speciality Involved in an episode of violence in the previous week and/or preceding six months; Estimate how many episodes; Outcomes and impact on participants Safety at work
6	To identify the **risk factors** for violent episodes – including perpetrators, geographical location, clinical specialty	2-12 41-51	Diagnoses or clinical signs and symptoms; Nursing activities; Patient specific factors and behaviours; Staffing issues;
7	**To identify NSW nurses' and midwives' perceptions of** risk prevention measures **and** risk management strategies **adopted by their** employers	30-40 52-68 72-73	Measured the organisational reporting of episodes and subsequent response from management; Focused of management response to and prevention of episodes of patient-related violence.

Stage 2

Stage 2 assessed previous studies relevant to this survey. The second stage in the development of the questionnaire included a search of the literature and identification of previous studies relevant to the study. Relevant items were identified and adopted or modified and then incorporated into the survey (Table 1).

The literature was used to construct lists of emotional and professional responses following episodes of patient-related violence. Effects reported in the literature include feelings of guilt, self-doubt, feelings of professional incompetence (Arnetz & Arnetz, 2001); anger, powerlessness, unhappiness, degradation, shame, fear, astonishment, antipathy towards the perpetrator (Astrom et al., 2004) and sleeplessness (Jackson et al., 2002). In addition nurses have reported feeling more cautious as well as being afraid to be at work, leading to a situation where patients are avoided (Pich, 2014) .

In Section 6 of the questionnaire lists were provided of diagnoses or clinical signs/symptoms of patients who displayed violent behaviour. The literature reports that certain diagnoses or medical conditions may be a risk factor for episodes of patient-initiated violence, particularly those associated with cognitive dysfunction (May & Grubbs, 2002), for example hypoxia, confusion and disorientation (Ferns, 2005); traumatic brain injury (Holleran, 2006); organic brain disorders and developmental delay (Quintal, 2002) and dementia (Badger & Mullan, 2004). People with mental health diagnoses have also been also been identified as a risk group for potential violence, (Catlette, 2005), especially involuntary psychiatric patients (Nijman, Bowers, Oud, & Jansen, 2005).

A list was also constructed of nursing and midwifery activities that were reported to be occurring at the time of violent episodes and the location in the department where such episodes occurred. Questions 41 to 51 measured contributing and precipitating factors for patient-related violence and the literature was sourced to compile lists for patient specific factors and behaviours; staffing issues and environmental factors.

Section 3 measured types of violent behaviour and lists of the types of verbal abuse and physical behaviours were constructed from the literature. Verbal behaviours identified in the literature include rudeness, shouting, sarcasm, swearing, unjustified criticism, ridicule in

front of others, threat of personal harm to the person, their family or property, rumour mongering (Farrell et al., 2006) as well as sexual innuendo (Crilly, Chaboyer, & Creedy, 2004). Physical behaviours identified include a range of behaviours, for example being pushed (Crilly et al., 2004); punched, kicked, scratched, slapped, head butted, restrained, choked, bitten and strangled (Farrell et al., 2006; Ferns, 2005).

Section 6 of the questionnaire focussed on the management and prevention of episodes of patient-related violence and lists of risk prevention/minimisation measures and follow up strategies were compiled.

Stage 3

This stage involved testing and validation of the questionnaire and involved the use of an expert panel. The panel was made up of members of clinical speciality groups from the NSW Nurses and Midwives' Association, including aged care, midwifery and mental health. The questionnaire was circulated to all members of the expert panel for testing and to provide advice about the draft questionnaire. These comments were subsequently used to make some minor changes to the form. This stage confirmed both the face and content validity of the questionnaire

3.5 Promotion of the Survey

The survey was promoted by the NSW Nurses and Midwives' Association by the distribution of an email invitation and reminders. In addition a reminder postcard was circulated to members of the association at their annual Professional Day.

3.6 Ethical Considerations

Ethical approval for the study was obtained from the Human Research Ethics Committee of the University of Technology prior to distribution of the survey.

3.7 Data Storage

Data security was maintained by ensuring that the questionnaires on Survey Monkey © were only accessible by the researcher and statistician through a unique log in.

3.8 Data Analysis

Statistical analyses were programmed using SAS v9.4 (SAS Institute, Cary, North Carolina, USA) by a qualified statistician.

Frequencies of answers to non open ended questions were summarised as frequencies and percentages of non-missing responses.

Groups of interest based on survey responses were compared using Chi-square or Fisher's exact tests with p-values and percentages of non missing group responses. Fisher's exact tests was used when there were more than 20% of the expected frequencies less than 5, variable with excessive low counts were left without p-values.

Chapter 4 Results

4.1 Sampling results

The total membership of the NSWNMA at the time of sampling was 62954. The final figures for participation are shown in Table 2. The response rate for this study was 6%. The total number of eligible participants with a completed questionnaire was 3416.

NB: Some respondents did not answer every question in the survey and consequently the denominator varies in the results reported throughout

Table 2: Sampling results

Potential participants	Numbers	Number of participants
Email invitations sent	62954	
Non responders	59328	
Responses	3626	
Returned, Question 1 = ineligible	269	3497
Returned, Question 1 not answered	81	3416
Eligible participants – returned completed questionnaire	3416	

4.1.1 Characteristics of participants

The characteristics of participants are reported in Table 3.

Table 3: Characteristics of participants

Variable	Category	Total (%)*
Employment sector (n = 3545)	Public	2585 (78%)
	Private	517 (16%)
	Not for profit	225 (7%)
Region (n = 3524)	Major city (metropolitan)	1487 (46%)
	Outer regional e.g. Tamworth	804 (25%)
	Inner regional e.g. Newcastle	802 (25%)
	Remote e.g. Broken Hill	140 (4%)
	Very remote	21 (1%)
Mode of employment (n = 3347)	Full-time	1758 (52%)
	Part-time	1295 (39%)
	Casual	249 (7%)
	Agency/temporary	55 (2%)
Gender (n = 3327)	Female	2909 (87%)
	Male	409 (12%)
	Other	21 (1%)
Nursing role (n = 3357)	Registered Nurse	2598 (77%)
	Enrolled Nurse	377 (11%)
	Registered Midwife	224 (7%)
	Assistant in Nursing	158 (5%)

Age (n = 3347)	18-25 years	235 7%)
	26-35 years	531 (16%)
	36-45 years	583 (17%)
	46-55 years	901 (27%)
	56-65 years	981 (29%)
	>65 years	116 (3%)
Number of years nursing/midwifery experience (n = 3446)	1-5	657 (19%)
	6-10	543 (16%)
	11-20	656 (19%)
	21-30	582 (17%)
	>31	1008 (29%)
Hours per week of patient care (n = 3357)	1-10	123 (4%)
	11-20	284 (8%)
	21-30	656 (20%)
	31-40	1560 (46%)
	41-50	367 (11%)
	>50	367 (11%)

4.1.2 Composition of study sample by clinical area

Participants were drawn from a variety of clinical areas as shown in Table 4. There were 401 participants who indicated that they visited patients/clients in their homes as part of their work.

Table 4: Study sample by clinical area

Clinical speciality	Sample count	Sample %
Medical/surgical	750	24
Mental health	547	18
Aged care	483	16
Emergency Department	297	10
Intensive Care Unit/High Dependence Unit/Coronary Care Unit	200	7
Midwifery	224	7
Perioperative	174	6
Community health	135	4
Family & Child health/paediatrics	114	4
Rehabilitation/disability	101	3
Drug & Alcohol	52	2
TOTAL	3077	1

4.2 Incidence and characteristics of episodes of violence

There were 1454 participants (1454/3101, 47%) who had experienced an episode of violence in the previous week and 2460 who had experienced violence in the six months prior to completing the survey (2460/3092, 80%). The majority of participants were of the opinion that violence was an inevitable part of their job and that it was increasing in frequency and severity.

For participants who had experienced an episode of violence in the preceding six months, there was a downward trend with greater years of experience (88% to 72%), with a similar trend with age (94% to 68%). Males were more likely to experience an episode of violence than females (88% to 78%) and midwives less likely (61% versus 79-81%). See Table 5.

Table 5: Episodes of violence compared to demographic data

Question Number	Question	Category	Q15 Have you been involved in one or more episodes of violence in the last 6 months? No (n=632)	Yes (n=2460)	Total (N=3092)	Chi-Square	p-value
q0002	Number of years of nursing/midwifery experience?	1-5	70 (12%)	526 (88%)	596 (19%)	62.9	<0.0001
		6-10	68 (16%)	351 (84%)	419 (14%)	.	
		11-20	122 (20%)	491 (80%)	613 (20%)	.	
		21-30	114 (21%)	422 (79%)	536 (17%)	.	
		30	257 (28%)	670 (72%)	927 (30%)	.	
		Missing	1	0	1	.	
q0003	Average number of hours per week of patient care during the last month?	1-10	45 (44%)	57 (56%)	102 (3.3%)	72.8	<0.0001
		11-20	73 (28%)	186 (72%)	259 (8.4%)	.	
		21-30	156 (26%)	448 (74%)	604 (20%)	.	
		31-40	245 (17%)	1206 (83%)	1451 (47%)	.	
		41-50	59 (18%)	277 (82%)	336 (11%)	.	
		50	54 (16%)	286 (84%)	340 (11%)	.	
		Missing	0	0	0	.	
q0004	Is your main nursing/midwifery job?(Select only ONE option)	Full time	265 (16%)	1358 (84%)	1623 (52%)	41.6	<0.0001
		Part time	284 (24%)	912 (76%)	1196 (39%)	.	
		Casual	68 (30%)	155 (70%)	223 (7.2%)	.	
		Agency/Temporary	15 (30%)	35 (70%)	50 (1.6%)	.	
		Missing	0	0	0	.	
q0005	What is your age?	18-25 years	13 (6.0%)	203 (94%)	216 (7.0%)	61.7	<0.0001
		26-35 years	71 (15%)	417 (85%)	488 (16%)	.	
		36-45 years	99 (18%)	440 (82%)	539 (17%)	.	
		46-55 years	189 (23%)	648 (77%)	837 (27%)	.	
		56-65 years	223 (25%)	676 (75%)	899 (29%)	.	
		66 years	34 (32%)	71 (68%)	105 (3.4%)	.	
		Missing	3	5	8	.	
q0006	What is your gender?	Female	576 (22%)	2096 (78%)	2672 (87%)	19.3	<0.0001
		Male	46 (12%)	339 (88%)	385 (13%)	.	
		Other	2 (25%)	6 (75%)	8 (0.3%)	.	
		Missing	8	19	27	.	
q0007	What type of registration/classification applies to your MAIN nursing/midwifery job?	Registered Nurse	447 (19%)	1941 (81%)	2388 (77%)	50.5	<0.0001
		Registered Midwife	82 (39%)	126 (61%)	208 (6.7%)	.	
		Enrolled Nurse	73 (21%)	282 (79%)	355 (11%)	.	
		Assistant in Nursing	30 (21%)	111 (79%)	141 (4.6%)	.	
		Missing	0	0	0	.	

More than 50% of participants from all clinical areas had experienced an episode of violence in the preceding six months. The rates were highest for those working in the specialities of emergency, drug and alcohol and mental health (Table 6).

Table 6: Episodes of violence experienced by clinical area

Clinical area	Number of participants (n = 3092)	% Sample
Mental health	481/514	94%
Drug & Alcohol	44/47	94%
Emergency	264/CHECK	94%
ICU/HDU/CCU	159/187	85%
Medical/surgical	561/681	82%
Rehabilitation/disability	73/91	80%
Aged care	335/424	79%
Perioperative	106/165	64%
Community health	74/126	59%
Midwifery	121/208	58%
Family & Children's health/paediatrics	60/107	56%

The public sector had a higher percentage of participants having been involved in violent episodes in the last six months compared to private (82% compared to 69%). Participants who visited patients or clients in their homes as part of their jobs were less likely to have experienced episodes of violent (65% compared to 82%) (Table 7).

Table 7: Epsiodes of violence by work sector and clinical sector

			Q15 Have you been involved in one or more episodes of violence in the last 6 months?				
Question Number	Question	Category	No (n=632)	Yes (n=2460)	Total (N=3092)	Chi-Square	p-value
q0008	In what sector do you work in your MAIN nursing/midwifery job?NB: The term public refers to employment by the NSW Ministry of Health.The term private refers to employment by a private for profit organisation e.g.	Public	436 (18%)	1973 (82%)	2409 (79%)	41.3	<0.0001
		Private	146 (31%)	323 (69%)	469 (15%)	.	
		Not for Profit	39 (21%)	151 (79%)	190 (6.2%)	.	
		Missing	11	13	24	.	
q0009	What clinical area or specialty is your MAIN nursing/midwifery job?	Midwifery	87 (42%)	121 (58%)	208 (7.3%)	268.5	<0.0001
		Medical/Surgical	120 (18%)	561 (82%)	681 (24%)	.	
		Emergency Department	18 (6.4%)	264 (94%)	282 (10%)	.	
		ICU, HDU or CCU	28 (15%)	159 (85%)	187 (6.6%)	.	
		Aged care	89 (21%)	335 (79%)	424 (15%)	.	
		Drug and Alcohol	3 (6.4%)	44 (94%)	47 (1.7%)	.	
		Mental health	33 (6.4%)	481 (94%)	514 (18%)	.	
		Community health	52 (41%)	74 (59%)	126 (4.4%)	.	
		Family and Child Health or paedatrics	47 (44%)	60 (56%)	107 (3.8%)	.	
		Perioperative	59 (36%)	106 (64%)	165 (5.8%)	.	
		Rehabilitation /disability	18 (20%)	73 (80%)	91 (3.2%)	.	
		Missing	78	182	260	.	
q0010	In your MAIN nursing/midwifery job - do you visit patients in their homes?	Yes	132 (35%)	242 (65%)	374 (12%)	59.0	<0.0001
		No	492 (18%)	2205 (82%)	2697 (88%)	.	
		Missing	8	13	21	.	
q0011	What type of area is your MAIN nursing/midwifery job located?	Major city	295 (21%)	1081 (79%)	1376 (46%)	8.9	0.0630
		Inner Regional e.g. Newcastle	135 (18%)	599 (82%)	734 (24%)	.	
		Outer Regional e.g. Tamworth	137 (18%)	605 (82%)	742 (25%)	.	
		Remote e.g. Broken Hill	26 (19%)	111 (81%)	137 (4.6%)	.	
		Very Remote	7 (41%)	10 (59%)	17 (0.6%)	.	
		Missing	32	54	86	.	
q0017	If YES - what type of violence did you experience?	Verbal abuse and/or non physical behaviours	38 (2.0%)	1844 (98%)	1882 (76%)	2.8	0.0954
		Physical abuse/violence	6 (1.0%)	599 (99.0%)	605 (24%)	.	
		Missing	588	17	605	.	

4.2.1 Number of episodes of violence

Study participants were asked how many episodes of violence they had experienced in the preceding six months. The number of episodes ranged from 1 to 100 with the majority reporting between 1-20 episodes (n = 2014/2488, 81%). See Table 8.

Table 8: Number of episodes of violence

Number of episodes	n = 2488 (%)
1-20	2014 (81%)
21-40	278 (11%)
41-60	89 (4%)
61-80	44 (2%)
81-100	25 (1%)
>100	38 (2%)

4.2.2 Type of violence

4.2.2.1 Verbal abuse

Verbal or non-physical violence was the most common type of violence reported, with 1888/2494, 76% of participants experiencing an episode in the previous six months. Physical abuse/violence was reported by 24% of participants (606/2494).

The most common types of verbal or non-physical violence experienced by participants were:

- Swearing – 84%;
- Rudeness – 80%;
- Anger – 79%;
- Shouting – 74%;
- Making unreasonable demands – 73%.

In addition a quarter had experienced sexually inappropriate behaviour (Table 9). The use of social media (5%) and taking of photographs (9%) was reported by 14% of participants, with the latter was significant for metropolitan nurses and midwives compared to those working in regional and remote areas (11% compared to 7% and 4%, p= 0.0046)..

Participants from metropolitan areas were more likely to experience unreasonable demands from patients that those from regional and remote areas (78% compared to 74% and 67%, p = 0.0163). In addition a statistically a significant difference was noted for "name calling" with regional and remote nurses and midwives more likely to experience this than their metropolitan counterparts (58% and 56% compared to 50%, p = 0.0027).

Participants provided additional details in a comments section – examples are detailed below:

"…demeaning inappropriate personal questions…" (P32); "…stalking me at home…"(P183); "…death threats…"(P1258); "…threatened to kill my kids and family…"(P95); "…in worst instance 23yr old ice user threatened to 'knife rape', also threatened to 'kill my kids and family' and threatened to have his friends follow me home…"(P901); "…Physically beaten by a patient, punched on left check, right side of head and repeated in left shoulder. Ended up with Bursitis in left shoulder and ridiculed by DON for going to A&E for treatment…"(P1704); "…Doused with diesel and threatened with weapon… (P2001);"…racist comments…(P5)"; "…just released ex-prisoner (Manslaughter) allowed to harass staff without boundary by mental health Administration…"(P621).

NB: DON refers to a Director of Nursing.

NB: "P" refers to participant

Table 9: Type of verbal/non-physical violence

Type of verbal/non physical violence	n = 2761 * (%) response
Swearing	2310 (84%)
Rudeness	2214 (80%)
Anger	2181 (79%)
Shouting	2046 (74%)
Making unreasonable demands	2008 (73%)
Insulting/questioning professional ability e.g. incompetent, incapable, threatening registration	1767 (64%)
Sarcasm	1674 (61%)
Name calling	1545 (56%)
Stepping into personal space	1249 (45%)
Threatening comments – to self, family or property	1109 (42%)
Ridicule in front of others	1109 (40%)
Unjustified criticism	1064 (39%)
Symbolic violence e.g. punching/hitting glass/desk at triage	1032 (37%)
Staring	899 (33%)
Gesturing	890 (32%)
Sexually inappropriate behaviour	699 (25%)
Berating	685 (25%)
Formal complaints without cause	512 (19%)
Rumour mongering	462 (17%)
Taunting	461 (17%)
Taking photographs	259 (9%)
Use of social media	128 (5%)

*** Participants could choose multiple responses**

A statistically significant difference was identified between the type of violence experienced and geographical work area (p = 0.0114). There was slightly more physical violence (as opposed to verbal) in regional areas compared to metropolitan (27% compared to 22%) (Table 10).

Table 10: Type of violence experienced by geographical work area

Question Number	Question	Category	Metro (n=1487)	Regional (n=1606)	Remote (n=161)	Chi Sq	P-value
q0017	If YES - what type of violence did you experience?	Verbal abuse and/or non physical behaviours	848 (78%)	897 (73%)	102 (83%)	9.0	**0.0114**
		Physical abuse/violence	246 (22%)	325 (27%)	21 (17%)	.	
		Missing	393	384	38	.	

The majority of verbally abusive behaviours were experienced at higher rates by those participants working in the public sector, see Table 11 for specific details.

Table 11: Type of verbal abuse behaviours compared by work sector

Question Number	Question	Category	Verbal: Public (n=1506)	Verbal: Private (n=260)	Verbal: Chi Sq	Verbal: P-value	Physical: Public (n=485)	Physical: Private (n=73)	Physical: Chi Sq	Physical: P-value
q0018	Please indicate which of the following types of VERBAL ABUSE AND/OR NON-PHYSICAL BEHAVIOURS you have observed and/or witnessed during episodes of violence (Select ALL that apply).	Swearing	1283 (85%)	193 (74%)	19.4	<0.0001	442 (91%)	51 (70%)	27.9	<0.0001
		Not Selected	223 (15%)	67 (26%)	.		43 (8.9%)	22 (30%)	.	
		Name calling	855 (57%)	119 (46%)	10.9	0.0010	346 (71%)	36 (49%)	14.3	0.0002
		Not Selected	651 (43%)	141 (54%)	.		139 (29%)	37 (51%)	.	
		Making unreasonable demands	1159 (77%)	186 (72%)	3.6	0.0582	356 (73%)	40 (55%)	10.7	0.0011
		Not Selected	347 (23%)	74 (28%)	.		129 (27%)	33 (45%)	.	
		Sarcasm	953 (63%)	148 (57%)	3.8	0.0507	300 (62%)	33 (45%)	7.3	0.0069
		Not Selected	553 (37%)	112 (43%)	.		185 (38%)	40 (55%)	.	
		Insulting/questioning professional ability e.g. Incompetent,	986 (65%)	168 (65%)	0.1	0.7888	331 (68%)	40 (55%)	5.2	0.0232
		Not Selected	520 (35%)	92 (35%)	.		154 (32%)	33 (45%)	.	
		Ridicule in front of others	594 (39%)	114 (44%)	1.8	0.1809	201 (41%)	27 (37%)	0.5	0.4702
		Not Selected	912 (61%)	146 (56%)	.		284 (59%)	46 (63%)	.	
		Anger	1202 (80%)	190 (73%)	6.0	0.0141	412 (85%)	51 (70%)	10.2	0.0014
		Not Selected	304 (20%)	70 (27%)	.		73 (15%)	22 (30%)	.	
		Threatening comments to self, family or property	618 (41%)	79 (30%)	10.5	0.0012	311 (64%)	24 (33%)	25.8	<0.0001
		Not Selected	888 (59%)	181 (70%)	.		174 (36%)	49 (67%)	.	
		Shouting	1112 (74%)	175 (67%)	4.8	0.0287	421 (87%)	55 (75%)	6.6	0.0099
		Not Selected	394 (26%)	85 (33%)	.		64 (13%)	18 (25%)	.	
		Rudeness	1246 (83%)	214 (82%)	0.0	0.8663	385 (79%)	47 (64%)	8.2	0.0043
		Not Selected	260 (17%)	46 (18%)	.		100 (21%)	26 (36%)	.	
		Rumour mongering	221 (15%)	58 (22%)	9.7	0.0018	83 (17%)	10 (14%)	0.5	0.4655
		Not Selected	1285 (85%)	202 (78%)	.		402 (83%)	63 (86%)	.	
		Sexually inappropriate behaviour	347 (23%)	53 (20%)	0.9	0.3446	198 (41%)	22 (30%)	3.0	0.0815
		Not Selected	1159 (77%)	207 (80%)	.		287 (59%)	51 (70%)	.	
		Taunting	224 (15%)	31 (12%)	1.6	0.2113	141 (29%)	11 (15%)	6.3	0.0122
		Not Selected	1282 (85%)	229 (88%)	.		344 (71%)	62 (85%)	.	
		Staring	513 (34%)	53 (20%)	19.1	<0.0001	222 (46%)	17 (23%)	13.1	0.0003
		Not Selected	993 (66%)	207 (80%)	.		263 (54%)	56 (77%)	.	
		Berating	351 (23%)	68 (26%)	1.0	0.3190	160 (33%)	15 (21%)	4.6	0.0327
		Not Selected	1155 (77%)	192 (74%)	.		325 (67%)	58 (79%)	.	
		Gesturing	490 (33%)	59 (23%)	10.0	0.0015	219 (45%)	22 (30%)	5.8	0.0157
		Not Selected	1016 (67%)	201 (77%)	.		266 (55%)	51 (70%)	.	
		Unjustified criticism	587 (39%)	126 (48%)	8.3	0.0040	191 (39%)	21 (29%)	3.0	0.0815
		Not Selected	919 (61%)	134 (52%)	.		294 (61%)	52 (71%)	.	
		Stepping into personal space	657 (44%)	93 (36%)	5.6	0.0180	303 (62%)	31 (42%)	10.6	0.0011
		Not Selected	849 (56%)	167 (64%)	.		182 (38%)	42 (58%)	.	
		Symbolic violence e.g. punching/hitting glass/desk at triage	528 (35%)	51 (20%)	24.0	<0.0001	307 (63%)	38 (52%)	3.4	0.0652
		Not Selected	978 (65%)	209 (80%)	.		178 (37%)	35 (48%)	.	
		Formal complaints without cause	257 (17%)	67 (26%)	11.2	0.0008	82 (17%)	7 (9.6%)	2.5	0.1114
		Not Selected	1249 (83%)	193 (74%)	.		403 (83%)	66 (90%)	.	
		Use of social media	62 (4.1%)	11 (4.2%)	0.0	0.9321	31 (6.4%)	4 (5.5%)	.	1.0000[a]
		Not Selected	1444 (96%)	249 (96%)	.		454 (94%)	69 (95%)	.	
		Taking photographs	141 (9.4%)	16 (6.2%)	2.8	0.0932	59 (12%)	5 (6.8%)	1.8	0.1839
		Not Selected	1365 (91%)	244 (94%)	.		426 (88%)	68 (93%)	.	

4.2.2.2 Physical violence

The types of physical violence reported by more than half of those surveyed were:

- Grabbing – 60%;
- Hitting – 60%;
- Destructive behaviour – 55%;
- Spitting – 53%;
- Kicking – 53%;
- Pushing – 53%;
- Punching – 52%.

In addition 805 participants reported inappropriate physical or sexual contact and 35 indicated that they had been sexually assaulted (Table 12).

Participants provided additional detail in a comments sections and quotes included:

"…Lighting a fire in department…" (P18); "…Punching a wall…"(P994); "…Petrol attack…"(P1114); "…Head butting…" (P87); "…have had semen thrown at me…" (P891)'; "attacked by a large confused man. I required surgery and now have a pin in my shoulder…"(P173); "…bleach thrown on me…" (P329); "…petrol attack…" (P500)' "…doused with diesel and threatened with weapon…" (P188).

Table 12: Types of physical violence

Type of physical violence	N = 1957 * (%)
Grabbing	1179 (60%)
Hitting	1166 (60%)
Destructive behaviour e.g. punching safety glass, table etc.	1084 (55%)
Spitting	1038 (53%)
Kicking	1032 (53%)
Pushing	1029 (53%)
Punching	1011 (52%)
Scratching	809 (41%)
Grabbing and twisting a body part	719 (37%)
Throwing/struck with an object	664 (34%)
Use of non-traditional weapons e.g. sharps, IV poles, chair	583 (30%)
Biting	575 (29%)
Inappropriate physical contact	558 (29%)
Body fluids thrown e.g. blood, urine, faeces	388 (20%)
Pulling hair/jewellery/clothing	377 (19%)
Restraining/immobilising staff	250 (13%)
Inappropriate sexual conduct	247 (13%)
Damage to personal property e.g. tyres slashed	175 (9%)
Choking/strangling	168 (9%)
Use of a traditional weapon e.g. knife	105 (9%)
Sexual assault	35 (2%)

* Participants could choose multiple responses

A statistically significant difference was identified for the following physical violent behaviours, which were more common in regional areas compared to metropolitan and remote: “grabbing” (39% versus 32% and 25%, $p = 0.0004$); “hitting” (35% compared to 31% and 25%, $p = 0.0412$); “twisting and pulling a body part” (24% versus 18% and 13%, $p = 0.0007$). Participants who worked in metropolitan areas were more likely to experience “use of a traditional weapon e.g. knife” (11% versus 4.6% and 4.8%, $p = 0.0212$); “use of non-traditional weapons e.g. sharps (77% compared to 70% and 71%, $p = 0.0320$) and “choking/strangling” (15% versus 7.7% and 4.8%, $p = 0.0187$) than those working in regional and remote locations.

Participants working in the public sector reported physically violent behaviours at a higher rate than their colleagues in the private sector, in a finding that was statistically significant, see Table 13 for details.

Table 13: Type of Physical violence by employment sector

Question Number	Question	Category	Verbal Public (n=1506)	Private (n=260)	Chi Sq	P-value	Physical Public (n=485)	Private (n=73)	Chi Sq	P-value
q0019	Please indicate which of the following PHYSICAL behaviours you have observed or witnessed during episodes of violence (Select ALL that apply).	Pushing	476 (32%)	61 (23%)	7.0	0.0084	310 (64%)	42 (58%)	1.1	0.2921
		Not Selected	1030 (68%)	199 (77%)	.		175 (36%)	31 (42%)	.	
		Destructive behaviour e.g. punching safety glass/table etc	612 (41%)	48 (18%)	46.6	<0.0001	295 (61%)	31 (42%)	8.8	0.0030
		Not Selected	894 (59%)	212 (82%)	.		190 (39%)	42 (58%)	.	
		Damage to personal property e.g. tyres slashed	88 (5.8%)	9 (3.5%)	2.4	0.1196	55 (11%)	2 (2.7%)	5.1	0.0237
		Not Selected	1418 (94%)	251 (97%)	.		430 (89%)	71 (97%)	.	
		Use of a traditional or weapon e.g. knife	46 (3.1%)	3 (1.2%)	3.0	0.0849	39 (8.0%)	2 (2.7%)	2.6	0.1056
		Not Selected	1460 (97%)	257 (99%)	.		446 (92%)	71 (97%)	.	
		Use of non traditional weapons e.g.sharps, IV poles, chair	311 (21%)	15 (5.8%)	32.6	<0.0001	187 (39%)	17 (23%)	6.4	0.0116
		Not Selected	1195 (79%)	245 (94%)	.		298 (61%)	56 (77%)	.	
		Grabbing	546 (36%)	69 (27%)	9.2	0.0024	351 (72%)	53 (73%)	0.0	0.9671
		Not Selected	960 (64%)	191 (73%)	.		134 (28%)	20 (27%)	.	
		Spitting	561 (37%)	59 (23%)	20.6	<0.0001	259 (53%)	31 (42%)	3.0	0.0812
		Not Selected	945 (63%)	201 (77%)	.		226 (47%)	42 (58%)	.	
		Hitting	507 (34%)	61 (23%)	10.6	0.0011	364 (75%)	57 (78%)	0.3	0.5749
		Not Selected	999 (66%)	199 (77%)	.		121 (25%)	16 (22%)	.	
		Kicking	485 (32%)	56 (22%)	11.9	0.0006	311 (64%)	43 (59%)	0.7	0.3880
		Not Selected	1021 (68%)	204 (78%)	.		174 (36%)	30 (41%)	.	
		Punching	445 (30%)	46 (18%)	15.5	<0.0001	344 (71%)	45 (62%)	2.6	0.1075
		Not Selected	1061 (70%)	214 (82%)	.		141 (29%)	28 (38%)	.	
		Grabbing and twisting a body part	317 (21%)	42 (16%)	3.3	0.0701	218 (45%)	37 (51%)	0.8	0.3590
		Not Selected	1189 (79%)	218 (84%)	.		267 (55%)	36 (49%)	.	
		Biting	268 (18%)	24 (9.2%)	11.8	0.0006	164 (34%)	31 (42%)	2.1	0.1484
		Not Selected	1238 (82%)	236 (91%)	.		321 (66%)	42 (58%)	.	
		Scratching	366 (24%)	44 (17%)	6.8	0.0093	240 (49%)	40 (55%)	0.7	0.3976
		Not Selected	1140 (76%)	216 (83%)	.		245 (51%)	33 (45%)	.	
		Choking/strangling	81 (5.4%)	4 (1.5%)	7.1	0.0076	55 (11%)	4 (5.5%)	2.3	0.1290
		Not Selected	1425 (95%)	256 (98%)	.		430 (89%)	69 (95%)	.	
		Pulling hair/jewellery/clothing	167 (11%)	19 (7.3%)	3.4	0.0666	116 (24%)	21 (29%)	0.8	0.3694
		Not Selected	1339 (89%)	241 (93%)	.		369 (76%)	52 (71%)	.	
		Throwing/struck with an object	341 (23%)	25 (9.6%)	22.9	<0.0001	208 (43%)	17 (23%)	10.1	0.0015
		Not Selected	1165 (77%)	235 (90%)	.		277 (57%)	56 (77%)	.	
		Restraining/immobilising staff	124 (8.2%)	7 (2.7%)	9.9	0.0016	79 (16%)	14 (19%)	0.4	0.5369
		Not Selected	1382 (92%)	253 (97%)	.		406 (84%)	59 (81%)	.	
		Inappropriate physical contact	253 (17%)	38 (15%)	0.8	0.3807	179 (37%)	17 (23%)	5.2	0.0230
		Not Selected	1253 (83%)	222 (85%)	.		306 (63%)	56 (77%)	.	
		Inappropriate sexual conduct	107 (7.1%)	16 (6.2%)	0.3	0.5780	85 (18%)	10 (14%)	0.7	0.4173
		Not Selected	1399 (93%)	244 (94%)	.		400 (82%)	63 (86%)	.	
		Sexual assault	15 (1.0%)	1 (0.4%)	.	0.4927*	13 (2.7%)	2 (2.7%)	.	1.0000*
		Not Selected	1491 (99.0%)	259 (99.6%)	.		472 (97%)	71 (97%)	.	
		Body fluids thrown e.g. blood, urine, faeces	202 (13%)	20 (7.7%)	6.6	0.0102	120 (25%)	10 (14%)	4.3	0.0374
		Not Selected	1304 (87%)	240 (92%)	.		365 (75%)	63 (86%)	.	

4.2.2.3 Verbal and physical violence compared

There were no differences identified between participants working in metropolitan areas/major cities in the public or private sector for episodes of verbal abuse, however those working in the public sector reported a higher number of episodes of physical violence. Similarly there were no differences noted for nurses working in remote areas between the public and private employment sector.

In inner regional areas, for example Newcastle, verbal and physical violence were more common in the private sector than the public. In outer regional areas, for example Tamworth, verbal abuse was experienced at higher levels in the public sector, however there were no differences identified for physical violence. Table 14.

Table 14: Type of violence and employment sector and geographical work area.

			Verbal				Physical			
Question Number	*Question*	*Category*	*Public (n=1506)*	*Private (n=260)*	*Chi Sq*	*P-value*	*Public (n=485)*	*Private (n=73)*	*Chi Sq*	*P-value*
q0011	What type of area is your MAIN nursing/midwifery job located?	Major city	684 (46%)	113 (46%)	17.4	**0.0016**	213 (45%)	25 (36%)	.	0.5710*
		Inner Regional e.g. Newcastle	337 (23%)	67 (27%)	.		137 (29%)	26 (38%)	.	
		Outer Regional e.g. Tamworth	378 (26%)	53 (21%)	.		112 (23%)	16 (23%)	.	
		Remote e.g. Broken Hill	81 (5.5%)	10 (4.0%)	.		14 (2.9%)	2 (2.9%)	.	
		Very Remote	2 (0.1%)	4 (1.6%)	.		2 (0.4%)		.	
		Missing	24	13	.		7	4	.	

4.3 The consequences of episodes of violence

In this section we describe the consequences to nurses and midwives following episodes of violence.

4.3.1 Injuries

There were 815/2861 participants (28%) who reported that they had suffered a physical or psychological injury as a result of an episode of violence. A statistically significant difference was identified between geographical work area with those working in metropolitan areas more likely to experience a physical or psychological injury as a result of an episode of

physical violence that their regional and remote colleagues (48% compared to 41% and 19%, p = 0.0231).

Of these 259 participants sought medical attention (259/809, 32%) and 309 took time off work as a result of their injuries. The amount of time taken off ranged from the rest of the shift to more than one year, with 1-6 days the most common time frame (Table 15). There were 78 participants (78/778, 10%) who indicated that their injury or illness resulted in a permanent disability and change of work duties of the inability to work.

Table 15: Time taken off work due to injury

Length of time	n = 309 (%)
Rest of shift	47 (15%)
1-6 days	151 (49%)
1-4 weeks	57 (18%)
1-12 months	46 (15%)
1 or more years	8 (3%)

Participants could also add comments to elaborate on this question and responses included:

"…I ended up resigning…" (P129); "…random days, when too distressed to attend work…" (P52); "…forced retirement…" (P41); and "…remain on leave after 6 weeks…" (P229).

No statistically significant differences were identified between geographical work area or work sector for the outcomes: seeking medical assistance following an episode of violence, time taken off work or permanent disability/inability to work.

The most common location of injuries sustained was listed as injury to psychological state. This was reported by 71% or participants, and this result was in excess of all other responses as illustrated in Table 16.

Table 16: Location of injury

Location	**N = 742* %)**
Psychological state	**526 (71%)**
Shoulders and arms	203 (27%)
Hands and fingers	158 (21%)
Face – including eyes and ears	110 (15%)
Head (other than eye, ear and face)	82 (11%)
Back	78 (11%)
Neck	71 (10%)
Chest	47 (6%)
Abdomen	41 (6%)
Hips and legs	40 (5%)
Feet and toes	10 (1%)

* Participants could choose multiple responses

In a finding similar to that for location of injury, psychological injuries were the most common type of injury reported, with almost three-quarters of those surveyed experiencing this type of injury following an episode of violence (Table 17).

Table 17: Type of injury

Type of injury	**n = 690 (%)**
Psychological	**508 (74%)**
Bruising	248 (36%)
Abrasion/graze	135 (20%)
Muscle damage	95 (14%)
Exposure to hazardous/infectious substance	62 (9%)
Laceration/cut/stab wound	38 (6%)
Tendon damage	33 (5%)
Nerve damage	29 (4%)
Head injury	24 (3%)
Fracture	14 (2%)
Internal injury	6 (1%)
Burn	5 (1%)

* Participants could choose multiple responses

4.4 Outcomes following an episode of violence

In addition to reporting injuries, participants also reported other effects (consequences) associated with episodes of violence. These included emotional and professional responses that impacted on their personal and working lives.

4.4.1 Emotional response

Participants reported a range of ongoing emotional responses following an episode of violence, some of which indicated negative coping strategies, for example "increase in use of alcohol or other substances/medications". A number of the responses were long-term in nature, including those linked to Post Traumatic Stress Disorder (PTSD), for example "weight loss/gain", "nightmares and flashbacks" and "altered sleep patterns". PTSD itself was selected as a response by 8% of participants. In addition some responses impacted the nursing practice of participants, for example "withdrawal from people/situations" and "fear/anxiety re future episodes" (Table 18). No significant differences in emotional responses following an episode of violence were found between metropolitan, regional and remote work locations.

Participants working in the private sector who had experienced verbal abuse were more likely to experience the following emotional responses than their colleagues working in the public sector: "degradation: (29% versus 20%, p = 0.0006); "depression/low mood" (30% versus 21%, p = 0.0008); "altered sleep patterns (33% compared to 26%, p = 0.0343). Those working in the public sector who had experienced an episode of physical violence were more likely to report "unhappiness" than those in the private sector (47% versus 33%, p = 0.0257).

Table 18: Emotional responses following episodes of violence

Response	n = 1851 (%)
Unhappiness	1168 (63%)
Powerlessness	1082 (58%)
Anger	1048 (57%)
Fear/anxiety re future episodes	1028 (56%)
Anxiety	912 (49%)
Shock/surprise	894 (48%)
Altered sleep patterns	737 (40%)
Depression/low mood	605 (33%)
Irritability	588 (32%)
Degradation	560 (30%)
Withdrawal from people/situations	474 (26%)
Emotional blunting	355 (19%)
Self blame	328 (18%)
Nightmares/flashbacks	317 (17%)
Guilt	316 (17%)
Shame	274 (15%)
Increase in use of alcohol or other substances/medications	248 (13%)
Weight loss/gain	238 (13%)
Panic attacks	228 (12%)
Relationship issues	179 (10%)
Post traumatic stress disorder (PTSD)	139 (8%)

* Participants could choose multiple responses

4.4.2 Professional responses

Participants reported a range of professional responses following an episode of violence that impacted on their nursing practice and working lives (Table 19).

Table 19: Professional responses following episodes of violence

Response	n = 1774 (%)
Reduced morale	1029 (58%)
Burnout/stress	918 (52%)
Considered leaving current clinical area/speciality or department and moving to a lower risk unit/department	745 (42%)
Decline in quality of care afforded patients	313 (18%)
Considered leaving nursing/midwifery altogether	719 (41%)
Avoidance of patients	655 (37%)
Lack of empathy	580 (33%)
Diminishing/minimising the event	481 (27%)
Depersonalising the event	335 (19%)
Conflict with co-workers	319 (18%)

* Participants could choose multiple responses

Nurses and midwives working in metropolitan areas who had experienced verbal abuse were found to be more likely to experience “burnout/stress” than those working in regional and remote areas, in a finding that was statistically significant (36% versus 30% and 31%, $p = 0.0207$). Participants from regional areas who had experienced physical violence reported higher rates of “depersonalising the event” than their metropolitan colleagues (18% compared to 13%, $p = 0.0473$).

Nurses and midwives working in the public sector were more likely to experience “avoidance of patients” (23% versus 11%, p , 0.0001) and “lack of empathy towards patients” (23% compared to 11%, $p < 0.0001$) than those in the private sector, in a statistically significant finding.

4.4.3 Coping strategies

Informal methods of coping were favoured by participants following an episode of violence, for example debriefing with other staff or with family and friends. Formal methods such as

formal structured debriefing and counselling were reported by 16% or less of participants (Table 20).

Table 20: Actions effective for dealing with episodes of violence

Action	n = 2368 (%)
Informal debriefing with other staff after an episode	1748 (74%)
Talking with friends and family after an episode	314 (55%)
Talking with Nurse Unit Manager/managers after an episode	828 (35%)
Formal group debriefing after an episode	374 (16%)
Employer counselling services e.g. Employee Assistance Program (EAP)	328 (14%)
Private counselling services	280 (12%)
Took no action	256 (11%)
Talking with union or professional association e.g. NSWNMA	214 (9%)
Nothing helped	87 (4%)
Talking with Human Resources or Work health & Safety Representative	80 (3%)

*participants could choose multiple responses

4.5 Management response to episodes of violence

For the most significant episode of violence in the preceding six months, almost half of participants stated that they were not satisfied with their employer's immediate response (n = 899/1878, 48%) and two-thirds reported that they had not been provided with adequate information, support and follow-up (n = 1489/2220, 67%). Participants reported no response from their employers and being blamed for the episode (Table 21). The majority of participants (n = 1479/1701, 87%) indicated that no immediate changes were implemented by their organisation, department or unit or following an episode of violence. This finding was significant for those working in metropolitan and regional areas compared to those in remote areas (87% versus 75%, p = 0.0329). When asked if they had been offered access to a recognised counselling service following an episode of violence, more than half of participants had not (n = 1018/1704, 60%).

Participants working in remote areas reported less satisfaction with their employer's immediate response that those working in regional and metropolitan areas in a statistically significant finding (85% versus compared to 58% and 47%, p = 0.0389).

Table 21: Immediate response

Response	n = 1568 (%)
No response	663 (42%)
Offered immediate support	554 (35%)
Offered counselling/debriefing	429 ((27%)
Warning given to offender e.g. written or verbal	258 (16%)
Blamed you	172 (11%)
Involved police	92 (6%)

*participants could choose multiple responses

Nurses and midwives from metropolitan areas who had experienced physical violence were more likely to receive "immediate support" (30% versus 21% and 9.5%, p = 0.0091) and "counselling/debriefing" (28% compared to 16% and 24%, p = 0.0022) following an episode than those working in regional and remote areas. For those who had experienced verbal abuse, metropolitan participants were more likely to report that a warning had been given to an offender (13% versus 7.2% and 9.8%, p = 0.0008) while those working in remote areas were statistically more likely to involve the police following an episode of violence than metropolitan and regional participants (8.8% versus 2.9% and 2.2%, p = 0.0009).

Participants from the public sector were more likely to receive support following an episode of violence than their colleagues in the private sector, for episodes of verbal abuse or physical violence (Table 22).

Table 22: Reporting byy work sector

Question Number	Question	Category	Verbal Public (n=1506)	Verbal Private (n=260)	Verbal Chi Sq	Verbal P-value	Physical Public (n=485)	Physical Private (n=73)	Physical Chi Sq	Physical P-value
q0030	For the most significant episode of violence in the last 6 months, were you satisfied with your employer's immediate response?	Yes	323 (33%)	45 (26%)	3.6	0.1629	139 (39%)	12 (24%)	6.7	0.0353
		No	483 (50%)	92 (54%)	.		189 (53%)	28 (57%)	.	
		N/A	160 (17%)	34 (20%)	.		31 (8.6%)	9 (18%)	.	
		Missing	540	89	.		126	24	.	
q0031	For the most significant episode directed at you during the previous 6 months, how did your employer immediately respond? (Select ALL that apply)	Offered immediate support	314 (21%)	35 (13%)	7.6	0.0057	128 (26%)	13 (18%)	.	0.1478'
		Not Selected	1192 (79%)	225 (87%)	.		357 (74%)	60 (82%)	.	
		Offered counselling/debriefing	237 (16%)	26 (10%)	5.8	0.0164	115 (24%)	8 (11%)	.	0.0147'
		Not Selected	1269 (84%)	234 (90%)	.		370 (76%)	65 (89%)	.	
		Warning given to offender e.g. written or verbal	150 (10%)	21 (8.1%)	0.9	0.3430	58 (12%)	8 (11%)	.	1.0000'
		Not Selected	1356 (90%)	239 (92%)	.		427 (88%)	65 (89%)	.	
		Involved police	49 (3.3%)	4 (1.5%)	2.2	0.1344	28 (5.8%)	2 (2.7%)	.	0.4070'
		Not Selected	1457 (97%)	256 (98%)	.		457 (94%)	71 (97%)	.	
		Blamed you	78 (5.2%)	31 (12%)	17.4	<0.0001	29 (6.0%)	5 (6.8%)	.	0.7920'
		Not Selected	1428 (95%)	229 (88%)	.		456 (94%)	68 (93%)	.	
		No response	376 (25%)	59 (23%)	0.6	0.4318	126 (26%)	23 (32%)	.	0.3229'
		Not Selected	1130 (75%)	201 (77%)	.		359 (74%)	50 (68%)	.	
q0032	For the most significant episode of violence in the last 6 months, were you offered access to recognised counselling services?	Yes	380 (41%)	48 (29%)	7.5	0.0061	163 (46%)	13 (28%)	5.1	0.0242
		No	551 (59%)	115 (71%)	.		193 (54%)	33 (72%)	.	
		Missing	575	97	.		129	27	.	
q0033	Thinking of your most significant episode, did your organisation/department/unit introduce any immediate changes subsequently?	Yes	124 (13%)	21 (13%)	0.0	0.8825	40 (11%)	6 (13%)	0.1	0.7170
		No	802 (87%)	141 (87%)	.		316 (89%)	40 (87%)	.	
		Missing	580	98	.		129	27	.	
q0035	For the most significant episode of violence in the last 6 months, do you think that you were provided with adequate information, support and	Yes	415 (34%)	53 (25%)	5.6	0.0176	137 (32%)	15 (25%)	1.1	0.3016
		No	812 (66%)	155 (75%)	.		297 (68%)	45 (75%)	.	
		Missing	279	52	.		51	13	.	

Immediate managers or team leaders were reported to be approachable and supportive following an episode of violence by 45% of participants (n = 832/1848), however the majority reported that they were not supportive (296/1848, 16%) or only sometimes supportive (452/1848, 39%). When asked the same questions about upper management only a quarter of participants perceived them to be supportive and approachable (452/1837, 25%). The majority felt that they were not supportive (720/1848, 39%) or only supportive sometimes (665/1837, 36%).

4.6 Reporting

The majority of participants were selective in their reporting of episodes of violence, while 22% indicated that they did not report any episodes (Table 23).

Table 23: Reporting

	n = 2374 (%)
Reported ALL episodes	794 (33%)
Reported SOME episodes	1063 (45%)
Reported NO episodes	517 (22%)

Participants working in the private sector who had experienced verbal abuse were more likely to report all episodes than those in the public sector (40% versus 28%, p = 0.0001) (Table 24).

Table 24: Reporting by work sector.

			Verbal				Physical			
Question Number	Question	Category	Public (n=1506)	Private (n=260)	Chi Sq	P-value	Public (n=485)	Private (n=73)	Chi Sq	P-value
q0037	Did you report these episodes?	Yes - reportedALL episodes	365 (28%)	89 (40%)	18.2	0.0001	194 (44%)	34 (53%)	2.0	0.3724
		Yes - reported SOME episodes	633 (49%)	76 (35%)	.		204 (47%)	24 (38%)	.	
		No episodes reported	288 (22%)	55 (25%)	.		40 (9.1%)	6 (9.4%)	.	
		Missing	220	40	.		47	9	.	

Where participants did report an episode of violence, a mix of formal and informal reporting mechanisms were used (Table 25). Participants working in metropolitan and remote areas who had experienced an episode of physical violence were more likely to complete an electronic report than those from regional areas (71% and 61%, p = 0.0428).

Table 25: Reporting mechanisms

Reporting mechanism	**n = 1881 (%)**
Verbally to manager/team leader	1396 (63%)
Documented in patient notes	1258 (67%)
Completed an electronic report e.g. IIMS, Riskman	1181 (63%)
Informally at handover	930 (49%)
Completed a paper report	257 (14%)
To police	124 (7%)
Reported to Safework NSW	32 (2%)

*participants could choose multiple responses

Participants working in the private sector who had experienced episodes of verbal and physical violence were more likely to complete a paper report form and electronic report for both verbal and physical episodes of violence than those working in the public sector.

A number of the reasons for non-reporting related to workplace culture, for example the belief that nothing would change in the long-term; that it was an accepted and expected part of the job and lack of follow up. In addition there were 390 participants who perceived that the perpetrator was not responsible for their actions due to their clinical or personal circumstances (Table 26) Nurses and midwives who had experienced verbal abuse were more likely to cite the "too many episodes/too busy" response than their regional and remote counterparts in a finding that was statistically significant (17% versus 13%, p = 0.0480).

Table 26: Factors that influence the reporting of episodes of violence

Factor	n = 1025 (%)
Don't expect anything to change in the long-term	576 (56%)
It is an accepted/expected part of the job	419 (41%)
Lack of follow up/don't expect anything to change	397 (39%)
Feel person was not responsible for their actions or had a diminished responsibility e.g. cognitively impaired, substance abuse, mental health issues, emotional distress	390 (38%)
Time constraints	389 (38%)
Too many episodes/too busy to report	381 (37%)
Process too complicated	228 (22%)
Feel you can manage these episodes effectively	212 (21%)
Fear of being blamed for the episode	181 (18%)
Fear of lack of support from colleagues	146 (14%)
Not sure how to report	72 (7%)

* Participants could choose multiple responses

4.7 Factors associated with violence – antecedents and precipitants

4.7.1 Patient specific factors

Participants were asked to rank a range of patient specific factors from highest to lowest in terms of the risk for potential episodes of violence (Table 27).

Table 27: Patient-specific factors (ranked)

Rank	**Factor** (n = 1895)
1	Past history of violence
2	Illicit substance misuse
3	Alcohol intoxication
4	Mental health diagnoses
5	Unrealistic expectations of staff and health system
6	Dementia
7	Acute pain
8	Cognitive dysfunction e.g. hypoxia
9	Cultural issues

Participants reported that patients and family or friends responsible for episodes of violence came from all age groups (Table 28) and that episodes occurred across all time periods and days of the week and no one period was a higher risk than others in terms of perception of risk for violence.

Table 28: Age of perpetrators of violence

Age group	**n = 1857 (%)**
<16 years	21 (1%)
16-25 years	172 (9%)
26-35 years	533 (29%)
36-45 years	325 (18%)
46-55 years	178 (10%)
56-65 years	156 (8%)
66-75 years	194 (10%)
>76 years	278 (15%)

A range of signs and symptoms were identified by participants as risk factors for potential violence and mental health issues, anxiety and agitation and substance misuse were reported by more than half of the sample. Table 29.

Table 29: Signs and symptoms of patients

Sign/symptom	n = 1742 (%)
Mental health issues	1260 (72%)
Anxiety and agitation	1059 (61%)
Substance misuse	936 (54%)
Dementia	943 (48%)
Delirium	689 (40%)
Alcohol intoxication	646 (37%)
Disorientation/confusion	622 (36%)
Pain	459 (26%)
Fear	376 (22%)
Cognitive dysfunction e/g/ hypoxia	275 (16%)
Trauma	184 (11%)

* Participants could choose multiple responses

Mental health issues (78%) and substance misuse (57%) were also identified as risk factors for violence from family or friends of patients, with alcohol intoxication the third most common response (46%).

4.7.2 Staffing specific factors

Participants were asked to rank a number of staffing issues from highest to lowest in terms of the risk of potential violence they perceived them to have. The responses related to the numbers of staff, the experience and skill of staff and workload (Table 30).

Table 30: Staffing-specific factors (ranked)

Rank	**Factor** (n = 1895)
1	Inadequate staffing
2	Workload and time management
3	Inadequate skills mix
4	Lack of staff skills to manage episodes of violence
5	Nursing practice and attitudes of individual nurses
6	Inadequate communication with patients and relatives, friends or visitors e.g. about waiting times
7	Lack of training e.g. in de-escalation techniques, restraint, dementia care
8	Professional communication issues e.g. handover/documentation

The main nursing or midwifery activities associated with episodes of violence were not invasive or intrusive and were often associated with communication, with 18% not involved in a nursing/midwifery activity when they encountered violent behaviour (Table 31). These activities included:

- Communicating with patients and/or relatives, friends or visitors of patients – 61%;
- Assisting with Activities of Daily Living – 36%;
- Managing reactions to delays – 34%;
- Giving oral medications – 31%;
- Assessing patients/taking patient history – 24%.

Table 31: Nursing/midwifery activities associated with episodes of violence

Activity	**n = 1806 (%)**
Communicating with patients and/or relatives, friends or visitors of patients	1093 (61%)
Assisting with Activities of Daily Living	653 (36%)
Managing reactions to delays	607 (34%)
Giving oral medications	557 (31%)
Assessing patient/taking history	434 (24%)
Positioning/turning/lifting patients	446 (25%)
Mobilising or transferring patients	420 (23%)
Giving injectable medications	334 (18%)
Restraining patients	349 (19%)
Not engaged in any nursing/midwifery activities at the time of the event	321 (18%)
Assisting patients and/or relatives, friends or visitors of patients in waiting room	294 (16%)
Assisting patients at meal times	272 (15%)
Conducting invasive procedures e.g. cannulation. Dressings	215 (12%)
Triaging	208 (12%)
Moving patients in and out of seclusion	174 (10%)

* Participants could choose multiple responses

4.7.3 Environmental specific factors

Participants were asked to rank a range of environmental factors as risk factors for violence from highest to lowest risk for potential violence and these results are shown in Table 32.

Table 32: Environmental specific factors (ranked)

Rank	**Factor** (n = 1895)
1	Long waiting times/delays
2	Noise levels
3	Personal space issues
4	Lack of privacy
5	Environmental factors e.g. lighting and temperature
6	Over-crowding
7	Workplace design

Participants encountered episodes of violence in a variety of areas, including those outside of the clinical environment, for example car parks. Table 33. There were 45 midwives who reported episodes of violence in the birthing suite.

Table 33: Location of episodes of violence

Location	n = 1741 (%)
Rooms or wards	1292 (74%)
Corridors	653 (38%)
Shared communal spaces e.g. dining room, garden	459 (26%)
Waiting room	373 (21%)
Bathrooms	336 (19%)
Observation/seclusion room	312 (18%)
Ambulance bay	124 (7%)
Resuscitation room	106 (6%)
Transferring patient to another department/hospital	97 (6%)
Patient's home	94 (5%)
Birthing suite	45 (3%)
Not in the department e.g. car park	44 (3%)

* Participants could choose multiple responses

4.8 Risk prevention strategies

A number of risk prevention strategies were reported by participants, related to the use of security personnel, workplace design and training (Table 34). The most common strategies were:

- Duress alarms – 77%;
- Access to training paid by the employer – 59%;
- Restricted access – 57%;
- Signage e.g. Zero Tolerance posters – 52%;
- Security personnel based outside the department – 46%.

Table 34: Risk prevention strategies

Strategy	N = 1772 (%)
Duress alarms – hardwired and/or personal	1370 (77%)
Access to training paid for by employer e.g. aggression minimisation training, dementia management	2054 (59%)
Restricted access to the department e.g. key or card access	1008 (57%)
Signage e.g. Zero Tolerance posters	914 (52%)
Security personnel available but based elsewhere in hospital	814 (46%)
Police called if a situation deteriorates	759 (43%)
Use of patient management plans	640 (36%)
CCTV	614 (35%)
Clear policies for management of aggression	606 (34%)
Safety glass at triage	481 (27%)
Enclosed nurses' station	474 (27%)
Consultation with management about prevention	377 (21%)
Increased security after hours	304 (17%)
Security personnel based in department	228 (13%)
Increased security measures after hours	228 (13%)
Access to training not paid for by employer e.g. course to be completed at external organisation	207 (12%)

* Participants could choose multiple responses

4.8.1 Training

Participants were asked to comment on three main type of training: dementia training, de-escalation training and takedown training. The aim of takedown training is to physically restrain a patient by bringing them to a horizontal position, something typically seen in mental health, including forensic, areas.

In cases where training was noted to be mandatory, not all participants had completed this training and others had completed this training at their own expense outside their place of work. Training was often online or mix of face to face and online, which has implications given the hands on nature of these training techniques and the potential risks associated with them. Table 35.

Table 35: Training

Type of training	Available at main workplace	Is this training mandatory?	Mode of completion	Mode of delivery(
Dementia training	YES (41%)	YES (11%) NO (53%) N/A (37%)	Place of work (35%) Outside work (at own expense) (16%) Not completed (49%)	Face to face (11%) Online (43%) Mix of face to face and online (46%)
De-escalation training	YES (71%)	YES (52%) NO (32%) N/A (17%)	Place of work (67%) Outside work (at own expense) (6%) Not completed (27%)	Face to face (32%) Online (21%) Mix of face to face and online (47%)
Takedown training	YES (34%)	YES (27%) NO (30%) N/A (43%)	Place of work (46%) Outside work (at own expense) (4%) Not completed (50%)	Face to face (52%) Online (8%) Mix of face to face and online (4%)

4.8.2 Policies and procedures

Participants were of the opinion that their organisations' policies and procedures related to the prevention and management of violence were only somewhat effective or not effective as detailed below:

- Effective – 12.4%;
- Somewhat effective – 46.2%;
- Not effective – 41.4%.

The public sector had a lower proportion of participants who perceived the policies to not be effective than those working in the private and not for profit sectors (40% compared to 45% and 47%), in a result similar to those working in regional areas compared to major cities (43-47% to 38%). Participants who had been involved in an episode of violence in the preceding six months were more likely to say that the policies were ineffective (44% compared to 22%) No statistically significant difference was found between the type of violence experienced and the effectiveness of policies (Table 36).

Table 36: Effectiveness of policies by work sector and geogrphical wok location

Question Number	Question	Category	Q68 Do you think that your organisations policies and procedures related to prevention and management of violence are effective? Yes (n=219)	No (n=732)	Somewhat (n=817)	Chi Sq	P-value
q0008	In what sector do you work in your MAIN nursing/midwifery job?NB: The term public refers to employment by the NSW Ministry of Health.The term private refers to employment by	Public	166 (12%)	579 (40%)	687 (48%)	20.1	0.0005
		Private	28 (13%)	100 (45%)	93 (42%)	.	
		Not for Profit	24 (23%)	49 (47%)	31 (30%)	.	
		Missing	1	4	6	.	
q0011	What type of area is your MAIN nursing/midwifery job located?	Major city	116 (15%)	295 (38%)	375 (48%)	18.7	0.0166
		Inner Regional e.g. Newcastle	40 (9.2%)	188 (43%)	205 (47%)	.	
		Outer Regional e.g. Tamworth	42 (10%)	199 (47%)	179 (43%)	.	
		Remote e.g. Broken Hill	11 (13%)	39 (44%)	38 (43%)	.	
		Very Remote	1 (25%)	1 (25%)	2 (50%)	.	
		Missing	9	10	18	.	
q0015	Have you been involved in one or more episodes of violence in the last 6 months?	Yes	158 (10%)	685 (44%)	705 (46%)	69.5	<0.0001
		No	59 (28%)	47 (22%)	108 (50%)	.	
		Missing	2	0	4	.	
q0017	If YES - what type of violence did you experience?	Verbal abuse and/or non physical behaviours	121 (10%)	500 (43%)	535 (46%)	1.4	0.5069
		Physical abuse/violence	41 (10%)	190 (47%)	177 (43%)	.	
		Missing	57	42	105	.	

4.9 Risk management

There were a number of risk management strategies that participants reported were being used in their place of work (Table 37). Patient specials, where a dedicated staff member is assigned to care for a patient, was the top response, listed by more than half of those surveyed.

Table 37: Risk management strategies

Risk management strategy	n = 1335 (%)
Patient specials	684 (51%)
Use of restraint – chemical and/or physical	549 (41%)
Changes to physical environment e.g. additional exits, swipe card access	349 (26%)
Review of policies/procedures	641 (26%)
Skills mix e.g. replace like with like (RN with RN)	329 (25%)
Limiting/banning visitors	321 (24%)
Use of seclusion	309 (23%)
Increased training opportunities	263 (20%)
Increase staffing levels	246 (18%)
Increased security personnel	225 (17%)
Refusal of service	215 (16%)
More stringent admission criteria	106 (8%)

* Participants could choose multiple responses

Chapter 5 Discussion

This aim of this study was to survey the members of the NSWNMA on their experiences with episodes of violence from patients and or their relatives and friends in the workplace. While the final response rate was relatively low (6%), the total number of participants in this study was 3416, making it one of the largest surveys of nurses and midwives on this topic. This highlights the importance that nurses and midwives place on this issue.

The demographic profile of the study sample is consistent with workforce statistics for nurses in Australia. .For example 59% of participants were over the age of 45, with 32% aged 56 or older, indicative of an ageing workforce. The average age of nurses and midwives registered in Australia is 44.4 years, and the proportion aged 50 and over grew from 38.3% to 39.0% during the period 2011-2014, (AIHW, 2016). The majority of participants were female (87%) and this is consistent with workforce statistics which show that in 2015, 90% of

practising nurses and midwives registered in Australia were female (AIHW, 2016). The majority of participants were registered nurses (77%) with lesser numbers of registered midwives (7%), enrolled nurses (11%), and assistants in nursing (5%). This is consistent with nursing workforce statistics. In 2015, 76.4% of employed nurses registered in Australia were registered nurses, 8.4% were midwives and 15.2% enrolled nurses (AIHW, 2016).

In this study the survey sample contained a similar number of participants from metropolitan (n =1487) and regional areas (n = 1606) with 161 participants from remote areas.. Census data shows that the per capita ratio of nurses to population in remote areas (915.4 per 100, 000) was lower than in metropolitan areas (1,175.8 per 100,000) and regional areas (1,272.9 per 100,000) (Australian Bureau of Statistics, 2013).

5.1 Nurse and midwife reported incidence of episodes of violence

The majority of nurses and midwives (80%) had experienced violence in the six months prior to the study, and for many this had occurred as recently as the week preceding the survey (47%). Age and years of experience were associated with a decrease in the likelihood of experiencing an episode of violence, while males were more likely to experience an episode of violence than females and midwives less likely than all classifications of nurses. Participants reported experiencing between one and 100 episodes in the six months prior to completing the survey . The majority of nurses and midwives (81%) reported between one and 10 episodes, however 38 (2%) reported experiencing more than 10 episodes. These results were consistent across metropolitan and regional/remote areas. The public sector had a higher percentage of participants having been involved in violent episodes in the last six months compared to private (82% compared to 69%).

The types of episodes reported included both verbal and physical violence as per the definition of violence provided to participants. Verbal abuse was the most common form of violence experienced, reported by 76% of participants, with 24% indicating that they had experienced physical violence in the six months prior to completing the survey. These findings are consistent with the literature where reported rates for verbal abuse against nurses as high as 98% (D. M. Gates et al., 2006) and 100% have been reported (Catlette, 2005;

May & Grubbs, 2002). These high levels of verbal abuse are not isolated to the Australian context, but are consistently reported in studies from around the world (Atawneh, Zahid, Al-Sahlawi, Shahid, & Al-Farrah, 2003; Crilly et al., 2004; Lyneham, 2000; Winstanley & Whittington, 2004).

A US study of 7,169 emergency nurses reported that 12% had experienced physical violence and 43% verbal abuse, during a seven-day period (Emergency Nurses' Association, 2011). A large study of 6,300 US nurses found that rates of violence were a concern with over 13 per 100 nurses reporting at least one episode of physical assault in the past year, and at least 38 per 100 nurses reporting at least one episode of threat, sexual harassment or verbal abuse (Nachreiner et al., 2007). A study of Tasmanian nurses reported that 64% (n = 1540) of respondents had experienced some form of aggression at work in the preceding four weeks (Farrell et al., 2006).

Although these studies collected data over a variety of time periods, all of them report unacceptably high rates of episodes of violence towards nurses.

5.2 Injuries

There was a reported injury rate of 28% as a result of an episode of violence, with participants from metropolitan areas more likely to report a physical or psychological injury than their regional and remote colleagues. Researchers in a US study reported that health care support occupations had an injury rate of 20.4 per 10,000 workers due to assaults, and health care practitioners had a rate of 6.1 per 10,000; compared with the general sector rate of only 2.1 per 10,000 (D. Gates, Gillespie, & Succop, 2011).

5.3 Outcomes associated with episodes of violence

In addition to reporting injuries, participants also reported emotional and professional responses, as a consequence of exposure to violent episodes, that impacted on their personal and working lives. The evidence on the topic supports this finding, and illustrates that the consequences of patient-related violence are far reaching (Chapman & Styles, 2006) and include both physical and psychological harm to nurses as well as a financial cost to the

health care sector and a negative impact on the quality of patient care (Howerton Child & Mentes, 2010).

Psychological injuries were the most common type of injury reported by participants, in a result that was consistent across geographical work areas and work sector. Verbal abuse is reported to have more negative and longer lasting ramifications for nurses, with both short and long term effects reported in the literature (Howerton Child & Mentes, 2010). Even in the absence of physical injury, nurses have been found to experience moderate to severe psychological reactions for up to 12 months following an episode of patient-related violence (Gerberich et al., 2004).

Participants reported a range of ongoing emotional responses following an episode of violence, some of which impacted their nursing practice, for example "withdrawal from people/situations" and "fear/anxiety re future episodes". No significant differences in emotional response following an episode of violence was found between metropolitan, regional and remote work locations.

The personal lives of participants were also affected by problems such as altered sleep patterns; increased use of alcohol or other substances/medications; relationship issues; weight changes; depression or low mood and feelings such as anger, powerlessness, unhappiness, degradation and shame as well as PTSD. Similar outcomes have been reported in other studies, including antipathy towards the perpetrators, shame, fear, astonishment, powerlessness, unhappiness, degradation, a sense of resignation, indifference and guilt (Astrom et al., 2004); anger, frustration and intrusive thoughts about the episode (Gillespie et al., 2010); self-doubt, feelings of professional incompetence ; and sleeplessness . Long-term effects such as Post Traumatic Stress Disorder and burnout have also been reported (Camerino, Estryn-Behar, Conway, van Der Heijden, & Hasselhorn, 2008; Pich, 2014).

In addition participants reported a range of professional responses following an episode of violence that impacted on their nursing practice and working lives. Those working in metropolitan areas who had experienced verbal abuse were found to be more likely to experience "burnout/stress" than those working in regional and remote areas, while participants from regional areas who had experienced physical violence reported higher

rates of “depersonalising the event” than their metropolitan colleagues. Nurses and midwives working in the public sector were more likely to experience “avoidance of patients” and “lack of empathy towards patients” than those in the private sector. Turkish researchers in one study reported that 84% of nurses were of the perception that nurses would be less productive after experiencing verbal and/or physical violence (Senuzun Ergun & Karadakovan, 2005). Thus patient-related violence has significant implications for patient safety, the quality of care that is provided and can indirectly lead to a deterioration in the care provided, not just for the patient involved but for all subsequent patients cared for by the affected nurse (Lau et al., 2004). This can take the form of increased medication, and the use of seclusion and restraints (Astrom et al., 2004). A link has also been proposed between abuse from patients and care-giving errors, further suggesting that nurses’ role may be compromised as a consequence of abuse (Shields & Wilkins, 2009). A link to patient safety was reported in an Australian study, that found that over two-thirds of nurses who had experienced aggression reported that it “frequently” or “occasionally” contributed to their potential to make errors or affect their productivity (Farrell et al., 2006).

More than half of the participants reported feelings of burn out and over 40% considered leaving their current clinical area or the nursing profession. Nurses who “burn out” suffer from emotional and physical symptoms, lose joy in providing care, distance themselves from others and can go on to view their patients as objects and spend less time with patients who they perceive as abusive (D. M. Gates et al., 2006).Thus the negative effects of patient-related violence extend to the workplace and can lead to difficulties with the recruitment and retention of nurses, decreased productivity and efficiency, increased absenteeism and fewer resources for nurses (Howerton Child & Mentes, 2010). In addition these issues have a flow on effect to increased costs related to the recruitment of additional nurses and through workers compensation claims.

Informal methods of coping were favoured by participants following an episode of violence, for example debriefing with other staff or with family and friends. Formal methods such as formal structured debriefing and counselling were reported by 16% or less of participants. These findings were consistent across geographical work areas and work sector. A lack of attention to the emotional effects of violence can contribute to PTSD symptoms which has a

negative impact on the productivity of nurses. Immediate intervention, during the first hours or days following exposure to a traumatic event, can prevent such serious, long-term complications (D. Gates, Gillespie, & Succop, 2011). Researchers in one US study reported that while management and employee participants supported the use of debriefing after violent incidents, it was rarely done, and when it did occur it was informal in nature. Barriers to debriefing reported in the literature included lack of time and a workplace culture that tolerated violence as "part of the job" (D. Gates, Gillespie, Smith, et al., 2011; Pich, 2014)

5.4 Factors associated with episodes of violence

Participants from all clinical areas had experienced an episode of violence in the preceding six months at rates of over 50%. The rates were highest for those working in the specialities of emergency, drug and alcohol and mental health. This finding is consistent with the literature on the topic that e occurrence of patient-related violence varies substantially between clinical environments, with the specialities of emergency, aged care and mental health reporting the highest rates of violence (Estryn-Behar et al., 2008).

A range of signs and symptoms were identified by participants as risk factors for potential violence and mental health issues, anxiety and agitation and substance misuse were reported by more than half of the sample. Mental health issues (78%) and substance misuse (57%) were also identified as risk factors for violence from family or friends of patients, with alcohol intoxication the third most common response (46%).

These factors are consistently reported in the literature as being causative factors in patient-related violence (D. M. Gates et al., 2006). Crime statistics for hospital assaults in NSW for the year 2006 listed the top three antecedents as mental health related (32% of incidents), alcohol-related incidents (31%) and drug-related (17%) (Hilliar, 2008). In addition for the period 1996-2006 the proportion of assaults classified as mental health-related increased significantly: from 19% to 32% (Hilliar, 2008). An Australian study found that patients under the influence of alcohol and/or drugs, including ice, and those with mental health issues are the most likely to become violent, increasing the risk to nurses by up to six times (Pich et al., 2017).

The main nursing or midwifery activities associated with episodes of violence were typically associated with communication, with 18% of participants not involved in any activity when they encountered violent behaviour.

The most common types of verbal or non-physical violence experienced by participants were swearing, rudeness, anger, shouting and making unreasonable demands with the majority of these behaviours experienced at higher rates by those participants working in the public sector. These results are consistent with the body of literature on the topic with swearing or "being cursed at" typically reported as the most common type of behaviour in verbal abuse (Crilly et al., 2004; Emergency Nurses' Association, 2011). In addition a quarter had experienced sexually inappropriate behaviour. A study of 3,465 US emergency department nurses reported that 70% had been harassed with sexual language and innuendo (Gacki-Smith et al., 2009). The use of social media (5%) and taking of photographs (9%) was reported by 14% of participants, with the latter significant for metropolitan nurses and midwives. This finding illustrates how these behaviours can extend beyond the work environment for participants.

The types of physical violence reported by more than half of those surveyed included grabbing, hitting, destructive behaviour, spitting, kicking, pushing and punching, with participants working in the public sector reporting these behaviours at a higher rate than their colleagues in the private sector. In addition 805 participants reported inappropriate physical or sexual contact and 35 indicated that they had been sexually assaulted.

These findings are consistent with physical behaviours reported in the literature which include being pushed/shoved, punched, kicked, scratched, slapped, hit, spat on, head butted and having hair pulled (Crilly et al., 2004; Ferns, 2005; Gacki-Smith et al., 2009; Pich, 2014); being grabbed and pulled (Emergency Nurses' Association, 2011).

5.5 Organisational risk prevention and management strategies

This section discusses data from all participants about organisational risk prevention and management of episodes of violence.

5.5.1 Reporting

Participants reported episodes of violence selectively to their organisations, with more than two-thirds admitting that they only reported some" and not "all" episodes. Significant differences were identified between the public and private sector, with privately employed nurses and midwives who had experienced verbal abuse were more likely to report all episodes. Reporting mechanisms included a mix of formal and informal methods with some statistically significant differences identified. Participants working in metropolitan and remote areas were more likely to complete an electronic report than those from regional areas, while those working in the private sector were more likely to complete a paper and electronic report for both verbal and physical episodes of violence than those working in the public sector.

The reasons provided for non-reporting were often related to workplace culture, for example the belief that nothing would change in the long-term; that it was an accepted and expected part of the job and lack of follow up. Metropolitan nurses and midwives who had experienced verbal abuse were more likely to cite the "too many episodes/too busy" response than their regional and remote counterparts in a finding that was statistically significant.

These findings are is consistent with the literature on the topic where patient-related violence is said to be inadequately documented, under-reported and poorly managed when it is reported (Howerton Child & Mentes, 2010; Sato, Wakabayashi, Kiyoshi-Teo, & Fukahori, 2013). Under-reporting of violent events occurs when an individual is victimised and does not report the event to an employer, police or through other means (Findorff, McGovern, Wall, & Gerberich, 2005). Under-reporting of episodes of patient-related violence is acknowledged consistently in the literature to the point where it is referred to as a "global phenomenon" (Ferns, 2005). Estimations of under-reporting range from 20% (Lyneham, 2000) to 90% (Mayhew & Chappell, 2005) and it has been referred to as the "dark figure" of workplace violence (Farrell et al., 2006).

The consequences of under-reporting are far-reaching. Accurate and consistent reporting is important to measure the true scope of the phenomenon and to inform and facilitate the

development of policies and programs to adequately address violent behaviour. Voluntary incident reporting is an integral part of clinical governance programs, designed to increase the safety of patients, visitors and staff and consequently to improve the quality of care

Almost 50% of participants were not satisfied with their employer's immediate response while two-thirds reported that they had not been provided with adequate information, support and follow-up following an episode of violence. This finding was significant for those working in metropolitan and regional areas compared to those in remote areas. Participants working in remote areas reported less satisfaction with their employer's immediate response that those working in regional and metropolitan areas. The majority of participants indicated that no immediate organisational changes were implemented following an episode of violence. The majority of participants also perceived that their organisations' policies and procedures related to the prevention and management of violence were only somewhat effective or not effective at all.

Policy and practice interventions may mitigate the risk of violence and aggression while concomitantly addressing staff dissatisfaction with the status quo (Anderson et al., 2009). The policy of Zero Tolerance towards violence has been adopted in health services internationally including the United Kingdom and Australia. The origins of the policy date back to the zero tolerance approach used in New York in the 1970s to manage and reduce crime in the city (Bond, Paniagua, & Thompson, 2009). Many participants in the study commented on an apparent disconnect between the policy ideal and its implementation in the workplace.

In cases where training was noted to be mandatory, not all participants had completed this training and others had completed this training at their own expense outside their place of work. Training was often online or mix of face to face and online, which has implications given the hands on nature of these training techniques and the potential risks associated with them.

5.6 Study strengths and limitations

Strengths

This study had a large sample size that was representative of the nursing and midwifery workforce in Australia, in terms of gender, age, years of experience and work fraction. The large sample size makes this one of the largest studies of violence against nurses and midwives in Australia and globally. While previous studies have largely focused on the clinical specialities of emergency, mental health and aged care, this study has extended into other clinical contexts in an attempt to capture the experiences of all nurses and midwives. It has identified that self-reported rates of violence are over 50% for all clinical areas.

Limitations

Due to the type of data collection, there is a potential for non-response bias and self-selection bias. Under-reporting may be an issue, which is consistent with previously reported studies, however is expected to be better than the reporting rates based on routine monitoring and voluntary reporting of violent episodes in healthcare organisations. A retrospective approach was utilised in the study and involved respondents reporting data for a period of six months prior to completing the questionnaire. This approach might be subject to recall bias and associated under-reporting however it is considered to be unlikely to substantially affect the results and is a limitation of many similar studies with which the current study has been compared.

5.7 Achievement of study objectives

This study has achieved the following objectives, including reporting:

To achieve this aim, the objectives of the study are:

8. Nurse/midwife reported incidence of episodes of violence from patients and/or family and friends and associated outcomes in the preceding six months;
9. Nurse/midwife reported incidence of the types of violent behaviours experienced;

10. Compared of the experiences of NSW nurses and midwives in the private and public sector with this violence;
11. Compared the experiences of NSW nurses and midwives in metropolitan, regional and remote areas with this violence;
12. Identified the experiences of NSW nurses and midwives with this violence in different clinical areas and patient-related services;
13. Identified the risk factors for violent episodes – including perpetrators, geographical location, clinical specialty;
14. Identified NSW nurses' and midwives' perceptions of risk prevention measures and risk management strategies adopted by their employers.

Conclusions

NSW nurses and midwives experience workplace violence from patients and/or their relatives and friends at high levels and are subjected to verbal abuse and physically violent behaviours on a regular basis. The impact of these episodes is far reaching and can have a long-lasting effect both personally and professionally. This can lead to a flow on effect to the care provided to patients under their care, potentially compromising patient safety.

The levels of violence experienced by nurses and midwives working in healthcare in NSW would not be tolerated in other industries and goes against the requirements of workplace health and safety guidelines to provide a safe working environment. This violence is reported to be increasing in both severity and frequency and therefore must be viewed as a priority by all healthcare employers, including NSW Health, to ensure the future safety of . the nursing and midwifery workforce.

There is an obligation to act on the information that nurses and midwives have provided in this study and in the words of one participant: *"…please actually act on this information you collect and improve our working conditions, Too many good nurses are being harmed and no one seems to care…" (P198).*

Recommendations

1. Healthcare employers in all sectors need to review current violence prevention nd management strategies and update and amend them accordingly to ensure that nurses and midwives are afforded a safe work place.
2. Where policies and procedures exist to protect nurses and midwives, these should be enforced and penalties imposed on employers who do not comply.
3. Mandatory training should be made available for all nurses and midwives as applicable and provided at the place of employment at the employers' expense. Employers should be monitored regularly for compliance and appropriate actions taken where this does not occur.
4. Training should be offered in a face to face format where possible.
5. Reporting of episodes of violence should be encouraged and acted on in a timely manner by employers with feedback provided to affected nurses and midwives and consequences for perpetrators.
6. Reporting records should be made freely available to independent organisations like the NSWNMA.
7. Nurses and midwives should be offered immediate and ongoing support by their employer following all episodes of violence.
8. Nurses and midwives should be included in all planning and policy development on the topic of violence as they represent the largest group in healthcare and are most vulnerable to violence from patients and their relatives and friends.
9. NSW Health must take the lead on this issue and make a serious commitment to the prevention and management of episodes of violence to ensure the safety of the future nursing and midwifery workforce.

Reference list

ABC News. (2011). Nurse Dies after psychiatric ward stabbing. *ABC News.*

AIHW. (2016). *Nursing and Midwifery workforce, 2015.* https://www.aihw.gov.au/reports/workforce/nursing-and-midwifery-workforce-2015/contents/who-are-nurses-and-midwives.

Anderson, L., FitzGerald, M., & Luck, L. (2009). An integrative literature review of interventions to reduce violence against emergency department nurses. *Journal of Clinical Nursing, 19*, 2520-2530.

Arnetz, J. E., & Arnetz, B. B. (2001). Violence towards health care staff and possible effects on the quality of patient care. *Social Science and Medicine, 52*(3), 417-427.

Astrom, S., Karlsson, S., Sandvide, A., Bucht, G., Eisemann, M., Norberg, A., & Saveman, B. I. (2004). Staff's experience of and the management of violent incidents in elderly care. *Scandinavian Journal of Caring Science, 18*(4), 410-416.

Atawneh, F. A., Zahid, M. A., Al-Sahlawi, K. S., Shahid, A. A., & Al-Farrah, M. H. (2003). Violence against nurses in hospitals: prevalence and effects. *British Journal of Nursing, 12*(2), 102-107.

Australian Bureau of Statistics. (2013). *Australian Social Trends*. Canberra Retrieved from http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features20April+2013.

Badger, F., & Mullan, B. (2004). Aggressive and violent incidents: perceptions of training and support among staff caring for older people and people with head injury. *Journal of Clinical Nursing, 13*(4), 526-533.

Bond, P., Paniagua, H., & Thompson, A. (2009). Zero tolerance of violent patients: policy in action. *Practice Nursing, 20*(2), 97-99.

Bonner, G., & McLaughlin, S. (2007). The psychological impact of aggression on nursing staff. *British Journal of Nursing, 16*(13), 810-814.

Camerino, D., Estryn-Behar, M., Conway, P. M., van Der Heijden, B. I., & Hasselhorn, H. M. (2008). Work-related factors and violence among nursing staff in the European NEXT study: a longitudinal cohort study. *International Journal of Nursing Studies, 45*(1), 35-50.

Catlette, M. (2005). A descriptive study of the perceptions of workplace violence and safety strategies of nurses working in level I trauma centers. *Journal of Emergency Nursing, 31*(6), 519-525.

Chapman, R., & Styles, I. (2006). An epidemic of abuse and violence: nurse on the front line. *Accident and Emergency Nursing, 14*(4), 245-249.

Clark, M. (2018). Lured to her death while on call, but SafeWork SA says nurse Gayle Woodford's murder 'wasn't work-related'. *ABC News*.

Coughlin, S. S. (1990). Recall bias in epidemiologic studies. *Journal of Clinical Epidemiology, 43*(1), 87-91.

Crilly, J., Chaboyer, W., & Creedy, D. (2004). Violence towards emergency department nurses by patients. *Accident and Emergency Nursing, 12*(2), 67-73.

Early, M. R., & Hubbert, A. O. (2006). Violence in the Emergency Department: A culture care perspective. *Theoria, Journal of Nursing Theory, 15*(3), 3-10.

Emergency Nurses' Association. (2011). *Emergency Department Violence Surveillance Study*. Retrieved from Des Plaines, IL:

Estryn-Behar, M., van der Heijden, B., Camerino, D., Fry, C., Le Nezet, O., Conway, P. M., & Hasselhorn, H. M. (2008). Violence risks in nursing--results from the European 'NEXT' Study. *Occupational Medicine, 58*(2), 107-114.

Farrell, G. A., Bobrowski, C., & Bobrowski, P. (2006). Scoping workplace aggression in nursing: findings from an Australian study. *Journal of Advanced Nursing, 55*(6), 778-787.

Ferns, T. (2005). Violence in the accident and emergency department--an international perspective. *Accident and Emergency Nursing, 13*(3), 180-185.

Findorff, M. J., McGovern, P. M., Wall, M. M., & Gerberich, S. G. (2005). Reporting violence to a health care employer: a cross-sectional study. *AAOHN Journal, 53*(9), 399-406.

Gacki-Smith, J., Juarez, A. M., Boyett, L., Homeyer, C., Robinson, L., & MacLean, S. L. (2009). Violence against nurses working in US emergency departments. *Journal of Nursing Administration, 39*(7-8), 340-349.

Gates, D., Gillespie, G., Smith, C., Rode, J., Kowalenko, T., & Smith, B. (2011). Using action research to plan a violence prevention program for emergency departments. *Journal of Emergency Nursing, 37*(1), 32-39.

Gates, D., Gillespie, G. L., & Succop, P. (2011). Violence against nurses and its impact on stress and productivity. *Nursing Economics, 29*(2), 59-66.

Gates, D. M., Ross, C. S., & McQueen, L. (2006). Violence against emergency department workers. *Journal of Emergency Medicine, 31*(3), 331-337.

Gerberich, S. G., Church, T. R., McGovern, P. M., Hansen, H. E., Nachreiner, N. M., Geisser, M. S., . . . Watt, G. D. (2004). An epidemiological study of the magnitude and consequences of work related violence: the Minnesota Nurses' Study. *Occupational and Environmental Medicine, 61*(6), 495-503.

Gillespie, G. L., Gates, D. M., Miller, M., & Howard, P. K. (2010). Violence against healthcare workers in a pediatric Emergency Department. *Advanced Emergency Nursing Journal, 32*(1), 68-82.

Gillies, D., & O'Brien, L. (2006). Interpersonal violence and mental illness: a literature review. *Contemporary Nurse, 21*(2), 277-286.

Hasani, A., Zaheri, M. M., Abbasi, M., ASaeedi, H., Hosseini, M., & Fathi, M. (2010). Incidence rate of phsyical and verbal violence inflicted by patients and their companions on the emergency department staff of Hazrate-e-Rasoul Hospital in the

fourth trimester of the year 1385 [Farsi]. *Journal of Iran University Medical Sciences, 16*(67), 51.

Hassan, E. (2006). Recall Bias can be a Threat to Retrospective and Prospective Research Designs. *The Internet Journal of Epidemiology, 3*(2). doi:10.5580/2732

Hilliar, K. (2008). Police-recorded assaults on hospital premises in New South Wales: 1996-2006. *Crime and Justice Bulletin, 116*, 1-12.

Hodge, A. N., & Marshall, A. P. (2007). Violence and aggression in the emergency department: A critical care perspective. *Australian Critical Care, 20*, 61-67.

Holleran, R. S. (2006). Preventing staff injuries from violence. *Journal of Emergency Nursing, 32*(6), 523-524.

Holmes, C. A. (2006). Violence, zero tolerance and the subversion of professional practice. *Contemporary Nurse, 21*(2), 212-227. doi:10.5555/conu.2006.21.2.212

Howerton Child, R. J., & Mentes, J. C. (2010). Violence against women: the phenomenon of workplace violence against nurses. *Issues in Mental Health Nursing, 31*(2), 89-95.

International Council of Nurses. (2006). *Position Statement: Abuse and violence against nursing personnel*. Retrieved from http://www.icn.ch/images/stories/documents/publications/position_statements/C01_Abuse_Violence_Nsg_Personnel.pdf.

International Council of Nurses. (2009). Violence: a worldwide epidemic. Nursing Matters. .

Jackson, D., Clare, J., & Mannix, J. (2002). Who would want to be a nurse? Violence in the workplace--a factor in recruitment and retention. *Journal of Nursing Management, 10*(1), 13-20.

Jackson, D., Hutchinson, M., Luck, L., & Wilkes, L. (2013). Mosaic of verbal abuse experiences by nurses in their everyday work. *Journal of Advanced Nursing*. doi:10.1111/jan.12074

Jones, J., & Lyneham, J. (2000). Violence: part of the job for Australian nurses? *Australian Journal of Advanced Nursing, 18*(2), 27-32.

Kelen, G. D., Catlett, C. L., Kubit, J. G., & Hsieh, Y. H. (2012). Hospital-based shootings in the United States: 2000 to 2011. *Annals of Emergency Medicine, 60*(6), 790-798.

Lange, J. T., Lange, C. L., & Cabaltica, R. B. (2000). Primary care treatment of post-traumatic stress disorder. *American Family Physician, 62*(5), 1035-1040.

Lau, Magarey, & Wiechula. (2012). Violence in the emergency department: an ethnographic study (part II). *International Emergency Nursing, 20*(3), 126-132.

Lau, J., Magarey, J., & McCutcheon, H. (2004). Violence in the ED: A literature review. *Australasian Emergency Nursing Journal, 7*(2), 27-37.

Lau, J. B., Magarey, J., & Wiechula, R. (2012). Violence in the emergency department: an ethnographic study (part I). *International Emergency Nursing, 20*(2), 69-75.

Lee, F. (2001). Violence in A&E: the role of training and self-efficacy. *Nursing Standard, 15*(46), 33-38.

Liu, J., & Wuerker, A. (2005). Biosocial bases of aggressive and violent behavior--implications for nursing studies. *International Journal of Nursing Studies, 42*(2), 229-241. doi:10.1016/j.ijnurstu.2004.06.007

Lyneham, J. (2000). Violence in New South Wales emergency departments. *Australian Journal of Advanced Nursing, 18*(2), 8-17.

Lyneham, J. (2001). Workplace violence in New South Wales Emergency Departments. *Australasian Emergency Nursing Journal, 4*(1), 5-9.

May, D. D., & Grubbs, L. M. (2002). The extent, nature, and precipitating factors of nurse assault among three groups of registered nurses in a regional medical center. *Journal of Emergency Nursing, 28*(1), 11-17.

Mayhew, C., & Chappell, D. (2005). Violence in the workplace. *Medical Journal of Australia, 183*(7), 346-347.

McPhaul, K. M., & Lipscomb, J. A. (2004). Workplace violence in health care: recognized but not regulated. *The Online Journal of Issues in Nursing, 9*(3), 7.

Nachreiner, N. M., Gerberich, S. G., Ryan, A. D., & McGovern, P. M. (2007). Minnesota nurses' study: perceptions of violence and the work environment. *Industrial Health, 45*(5), 672-678.

Nijman, H., Bowers, L., Oud, N., & Jansen, G. (2005). Psychiatric nurses' experiences with inpatient aggression. *Aggressive Behavior, 31*(3), 217-227. doi:10.1002/ab.20038

Norquist, J. M., Girman, C., Fehnel, S., DeMuro-Mercon, C., & Santanello, N. (2012). Choice of recall period for patient-reported outcome (PRO) measures: criteria for consideration. *Quality of Life Research, 21*(6), 1013-1020.

NSW Health. (2003). *Zero Tolerance: Response to violence in the NSW Health workplace.* North Sydney, NSW Australia: NSW Department of Health.

OSHA. (2015). Workplace Violence in Healthcare: Understanding the Challenge. Retrieved from https://www.osha.gov/Publications/OSHA3826.pdf website:

Phillips, J. P. (2016). Workplace Violence against Health Care Workers in the United States. *New England Journal of Medicine, 374*, 1661-1669.

Pich, J. (2014). *The VENT Study: Violence in Emergency Nursing and Triage.* (PhD), University of Newcaslte, Australia, Newcastle, Australia.

Pich, J., Hazelton, M., Sundin, D., & Kable, A. (2010). Patient-related violence against emergency department nurses. *Nursing & Health Sciences, 12*(2), 268-274.

Pich, J., Hazelton, M., Sundin, D., & Kable, A. (2011). Patient-related violence at triage: A qualitative descriptive study. *International Emergency Nursing, 19*(1), 12-19.

Pich, J., & Kable, A. (2014). Patient-related violence against nursing staff working in emergency departments: A systematic review. *JBI Database of Systematic Reviews and Implementation Reports, 12*(9), 398-453.

Pich, J., Kable, A., & Hazelton, M. (2017). Antecedents and precipitants of patient-related violence in the emergency department: Results from the Australian VENT Study(Violence in Emergency Nursing and Triage). *Australasian Emergency Nursing Journal, 20*(3), 107-113.

Presley, D., & Robinson, G. (2002). Violence in the Emergency Department: nurses contend with prevention in the Health Care Arena. *Emergency Nursing, 37*(1), 161-169.

Quintal, S. A. (2002). Violence against psychiatric nurses. An untreated epidemic? *Journal of Psychosocial Nursing and Mental Health Services, 40*(1), 46-53.

Roche, M. A., Diers, D., Duffield, C., & Catling-Paull, C. J. (2010). Violence toward nurses, the work environment, and patient outcomes. *Journal of Nursing Scholarship, 42*(1), 13-22. doi:doi: 10.1111/j.1547-5069.2009.01321.x

SafeWork NSW. (2018). *Violence*. https://www.safework.nsw.gov.au/hazards-a-z/violence.

Sato, K., Wakabayashi, T., Kiyoshi-Teo, H., & Fukahori, H. (2013). Factors associated with nurses' reporting of patients' aggressive behavior: a cross-sectional survey. *International Journal of Nursing Studies, 50*(10), 1368-1376. doi:10.1016/j.ijnurstu.2012.12.011

Senuzun Ergun, F., & Karadakovan, A. (2005). Violence towards nursing staff in emergency departments in one Turkish city. *International Nursing Review, 52*(2), 154-160.

SESLHD. (2018). *Work Health and Safety – Violence Prevention and Management in the Workplace Procedure.* https://www.seslhd.health.nsw.gov.au/sites/default/files/documents/SESLHDPR341%20-%20Violence%20Prevention%20and%20Management.pdf.

Shields, M., & Wilkins, K. (2009). Factors related to on-the-job abuse of nurses by patients. *Health Report, 20*(2), 7-19.

Stone, T., McMillan, M., Hazelton, M., & Clayton, E. H. (2011). Wounding words: swearing and verbal aggression in an inpatient setting. *Perspectives in Psychiatric Care, 47*(4), 194-203.

Victorian Government. (2005). *Victorian taskforce of violence in nursing: Final report*. Melbourne: Victorian Government.

Wand, T. C., & Coulson, K. (2006). Zero tolerance: A policy in conflict with current opinion on aggression and violence management in health care. *Australasian Emergency Nursing Journal, 9*(7), 163-170.

Winstanley, S., & Whittington, R. (2004). Aggression towards health care staff in a UK general hospital: variation among professions and departments. *Journal of Clinical Nursing, 13*(1), 3-10.

Appendices

Appendix 1: Email invitation

NSW Nurses and Midwives' Association
PROFESSIONAL ISSUES

Dear *member name*,

The NSW Nurses and Midwives' Association (NSWNMA) would like to invite you to take part in an online survey being conducted in collaboration with Dr Jacqui Pich, a researcher from the University of Technology Sydney, on Violence in Nursing and Midwifery.

We are interested in hearing about your experiences and analysing the results to help us better understand how violence impacts you in your day to day working lives. Much of the research on violence has been conducted in specific clinical areas, for example the emergency department or mental health. The aim of this research is to survey nurses and midwives from all clinical areas in both the public and private sectors and to use the results to help us inform decision making and to drive policy change in this area.

Please click here to read the Participation Information Statement for additional details and if you are interested in taking part please click the link below:

Violence in Nursing and Midwifery Survey

If you raise an unresolved issue, we encourage you to also contact the NSW Nurses and Midwives' Association on 02 8595 1234 (metro) or 1300 367 962 (rural) for advice. Please see video below.

Yours sincerely,

Brett Holmes

General Secretary, NSWNMA

Appendix 2: Participant Information Statement

INFORMATION SHEET AND CONSENT FORM FOR ONLINE SURVEYS

VIOLENCE IN NURSING & MIDWIFERY

My name is Dr Jacqui Pich and I am a Registered Nurse and an academic at The University of Technology, Sydney.

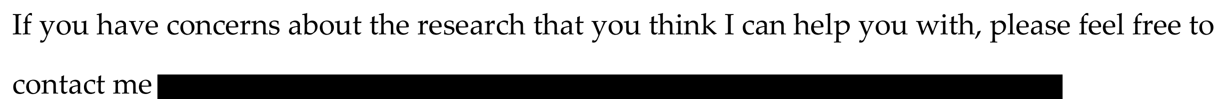
The purpose of this research /online survey is to find out about the experiences of NSW nurses and midwives with violence from patients and/or their friends and relatives at work. This research represents a joint project with the **NSW Nurses' and Midwives' Association.**

I will ask you to complete an online survey on the topic that will take approximately 20-25 minutes to complete.

Your participation in this research is voluntary and you are free to pass over any question that you feel uncomfortable with and/or stop the survey entirely if you choose. If you experience any distress while completing this survey please contact the support services listed that best suit you. The Employees Assistance Program (EAP) at your workplace, The NSW Nurses and Midwives Association or your general practitioner.

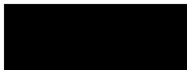
If an unresolved issue is disclosed you should contact the NSW Nurses' and Midwives' Association on 1300 367 962 for advice.

Once you have completed all or part of the survey it will not be possible to remove your responses, as you are not identifiable by the research team and it is not possible to locate any individual survey. If you agree to be part of the research, and to data gathered in this survey to be published in a form that does not identify you, please continue with answering the survey questions.

If you have concerns about the research that you think I can help you with, please feel free to contact me 

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772 or Research.ethics@uts.edu.au and quote this number : **Reference number ETH18-2142.**

Thanks



Appendix 3: Questionnaire

(attached separately)

Appendix 4: Reminder Postcard

Violence in Nursing and Midwifery

What has been your experience of violence in the workplace?

The NSW Nurses and Midwives' Association would like to hear about your experiences.

We are running an online survey on violence in collaboration with Dr Jacqui Pich, a researcher from the University of Technology Sydney, on Violence in Nursing and Midwifery.

Much of the research on violence has been conducted in specific clinical areas, for example the emergency department or mental health. The aim of this research is to survey nurses and midwives from all clinical areas in both the public and private sectors and to use the results to help us inform decision making and to drive policy change in this area.

Interested: Please access the survey through the following link: https://www.surveymonkey.com/r/2T79FLF

A copy of the Participant Information Sheet has previously been emailed to you by the NSWNMA and copies are available at the Professional Stand along with IPads to use to complete the survey if needed.

Thanks for your support!

HREC ETH18-2142

Violence in Nursing and Midwifery

1. STUDY ELIGIBILITY

1. Have you worked as a nurse or midwife in a clinical environment - including inpatient, outpatient or community settings - in the last 6 months?
NB: This includes PAID employment only and so excludes nursing/midwifery students attending clinical placement.
If NO - you do not have to answer any more questions.
Thank you for your interest.

- ◯ Yes
- ◯ No

Violence in Nursing and Midwifery

2. GENERAL INFORMATION

NB: The term “patient(s)” also includes residents, mothers, consumers and clients.
The term "residents, friends, visitors" refers to people accompanying or visiting the patient, resident, mother, consumer or client.

* 2. Number of years of nursing/midwifery experience?

- ◯ Please select from the drop-down menu.
- ◯ <1-5
- ◯ 6-10
- ◯ 11-20
- ◯ 21-30
- ◯ >30

* 3. Average number of hours per week of patient care during the last month?

- ◯ 1-10
- ◯ 11-20
- ◯ 21-30
- ◯ 31-40
- ◯ 41-50
- ◯ >50

* 4. Is your main nursing/midwifery job?
(Select only ONE option)

- ◯ Full time
- ◯ Part time
- ◯ Casual
- ◯ Agency/Temporary

5. What is your age?

- ◯ 18-25 years
- ◯ 26-35 years
- ◯ 36-45 years
- ◯ 46-55 years
- ◯ 56-65 years
- ◯ > 66 years

6. What is your gender?

- ◯ Female
- ◯ Male
- ◯ Other

* 7. What type of registration/classification applies to your MAIN nursing/midwifery job?

- ◯ Registered Nurse
- ◯ Registered Midwife
- ◯ Enrolled Nurse
- ◯ Assistant in Nursing

8. In what sector do you work in your MAIN nursing/midwifery job?

NB: The term **public** refers to employment by the NSW Ministry of Health.

The term **private** refers to employment by a private for profit organisation e.g. BUPA

The term **Not for Profit** refers to employment by a private not for profit organisation e.g. Anglicare

- ◯ Public
- ◯ Private
- ◯ Not for Profit

Other (please specify)

[ ]

9. What clinical area or specialty is your MAIN nursing/midwifery job?

- ◯ Midwifery
- ◯ Medical/Surgical
- ◯ Emergency Department
- ◯ ICU, HDU or CCU
- ◯ Aged care
- ◯ Drug and Alcohol
- ◯ Mental health
- ◯ Community health
- ◯ Family and Child Health or paediatrics
- ◯ Perioperative
- ◯ Rehabilitation /disability

Other (please specify)

[ ]

10. In your MAIN nursing/midwifery job - do you visit patients in their homes?

- ◯ Yes
- ◯ No

11. What type of area is your MAIN nursing/midwifery job located?

- ◯ Major city
- ◯ Inner Regional e.g. Newcastle
- ◯ Outer Regional e.g. Tamworth
- ◯ Remote e.g. Broken Hill
- ◯ Very Remote

Other (please specify)

12. What is the postcode of your MAIN place of work?

Violence in Nursing and Midwifery

3. VIOLENCE EXPERIENCED OR WITNESSED BY YOU.

Please read this definition of violence and answer the questions that follow:

For the purposes of this study, the term "violence" refers to verbal abuse and threats, sexual harassment as well as physical assaults. It can involve both an explicit and implicit challenge to your well-being, safety or health at work (Mayhew & Chappell, 2005).

NB: The questions in this section relate to episodes of violence in which you were directly involved - either as a victim or witness or responder.
Please answer ALL questions that are applicable to your experiences.

13. Have you been involved in one or more episodes of violence in the last week?

- ◯ Yes
- ◯ No

14. If YES - what type of violence did you experience?

- ◯ Verbal abuse and/or non physical behaviours
- ◯ Physical abuse/violence

15. Have you been involved in one or more episodes of violence in the last 6 months?

- ○ Yes
- ○ No

16. If YES please estimate how many episodes of violence you were involved in during the last 6 months.

- ○ 1-20
- ○ 21-40
- ○ 41-60
- ○ 61-80
- ○ 81-100
- ○ >100

17. If YES - what type of violence did you experience?

- ○ Verbal abuse and/or non physical behaviours
- ○ Physical abuse/violence

18. Please indicate which of the following types of VERBAL ABUSE AND/OR NON-PHYSICAL BEHAVIOURS you have observed and/or witnessed during episodes of violence (Select ALL that apply).

- ☐ Swearing
- ☐ Name calling
- ☐ Making unreasonable demands
- ☐ Sarcasm
- ☐ Insulting/questioning professional ability e.g. Incompetent, incapable, threatening registration
- ☐ Ridicule in front of others
- ☐ Anger
- ☐ Threatening comments – to self, family or property
- ☐ Shouting
- ☐ Rudeness
- ☐ Rumour mongering
- ☐ Sexually inappropriate behaviour
- ☐ Taunting
- ☐ Staring
- ☐ Berating
- ☐ Gesturing
- ☐ Unjustified criticism
- ☐ Stepping into personal space
- ☐ Symbolic violence e.g. punching/hitting glass/desk at triage
- ☐ Formal complaints without cause
- ☐ Use of social media
- ☐ Taking photographs

Other (please elaborate)

19. Please indicate which of the following PHYSICAL behaviours you have observed or witnessed during episodes of violence (Select ALL that apply).

- [ ] Pushing
- [ ] Destructive behaviour e.g. punching safety glass/table etc
- [ ] Damage to personal property e.g. tyres slashed
- [ ] Use of a traditional or weapon e.g. knife
- [ ] Use of non traditional weapons e.g. sharps, IV poles, chair
- [ ] Grabbing
- [ ] Spitting
- [ ] Hitting
- [ ] Kicking
- [ ] Punching
- [ ] Grabbing and twisting a body part
- [ ] Biting
- [ ] Scratching
- [ ] Choking/strangling
- [ ] Pulling hair/jewellery/clothing
- [ ] Throwing/struck with an object
- [ ] Restraining/immobilising staff
- [ ] Inappropriate physical contact
- [ ] Inappropriate sexual conduct
- [ ] Sexual assault
- [ ] Body fluids thrown e.g. blood, urine, faeces

Other (please elaborate)

20. Did any of these episodes of violence directed at you in the last 6 months result in a physical or psychological injury/illness to you?
If NO please skip to question 28

- ○ Yes
- ○ No

4.

21. Did you seek medical attention as a result of an episode of violence?

- ◯ Yes
- ◯ No

22. Did your injury/illness require you to take time off work?

- ◯ Yes
- ◯ No

23. If YES - How much time did you take off work?

- ◯ Rest of shift
- ◯ 1-6 Days
- ◯ 1-4 Weeks
- ◯ 1-12 Months
- ◯ 1 or more Years

Other (please specify)

24. Thinking of your most serious injury/illness that occurred as a result of an episode of violence - which of the following were affected?(Select ALL that apply)

- [ ] Face – including eyes and ears
- [ ] Head (other than eye, ear and face)
- [ ] Neck
- [ ] Back
- [ ] Chest
- [ ] Abdomen
- [ ] Shoulders and arms
- [ ] Hands and fingers
- [ ] Hips and legs
- [ ] Feet and toes
- [ ] Psychological state

Other (please elaborate)

25. Did your injury/illness result in permanent disability and change of work duties or inability to work?

- ○ Yes
- ○ No

26. If YES - please elaborate.

27. Thinking of your most serious injury/illness that occurred as a result of an episode of violence - what type of injury did you sustain?(Select ALL that apply)

- [ ] Exposure to hazardous/infectious substance
- [ ] Abrasion/graze
- [ ] Laceration/cut/stab wound
- [ ] Psychological
- [ ] Nerve damage
- [ ] Tendon damage
- [ ] Bruising
- [ ] Muscle damage
- [ ] Dislocation
- [ ] Fracture
- [ ] Burn
- [ ] Head injury
- [ ] Internal injury

Other - please list

28. Following these episodes – did you experience any of the following EMOTIONAL responses? (Select ALL that apply)

- [ ] Guilt
- [ ] Anger
- [ ] Powerlessness
- [ ] Unhappiness
- [ ] Degradation
- [ ] Shame
- [ ] Fear/anxiety re future episodes
- [ ] Shock/surprise
- [ ] Anxiety
- [ ] Depression/low mood
- [ ] Self blame
- [ ] Nightmares/flashbacks
- [ ] Increase in use of alcohol or other substances/medications
- [ ] Relationship issues
- [ ] Altered sleep patterns
- [ ] Panic attacks
- [ ] Weight loss/gain
- [ ] Irritability
- [ ] Withdrawal from people/situations
- [ ] Post traumatic stress disorder (PTSD)
- [ ] Emotional blunting

Other (please specify)

29. Following these episodes did you experience any of the following PROFESSIONAL responses? (Select ALL that apply)

- [ ] Feelings of professional incompetence and self doubt
- [ ] Reduced morale
- [ ] Avoidance of patients
- [ ] Decline in quality of care afforded patients
- [ ] Lack of empathy towards patients
- [ ] Considered leaving current clinical area/specialty or department and moving to a lower risk unit/department
- [ ] Considered leaving nursing/midwifery altogether
- [ ] Burnout/stress
- [ ] Conflict with co-workers
- [ ] Depersonalising the event
- [ ] Diminishing/minimising the event

Other (please specify)

Violence in Nursing and Midwifery

5. ACTIONS TAKEN AFTER AN EPISODE OF VIOLENCE

This section deals episodes of violence experienced and/or witnessed by you in the last 6 months.

30. For the most significant episode of violence in the last 6 months, were you satisfied with your employer’s immediate response?

- ○ Yes
- ○ No
- ○ N/A

31. For the most significant episode directed at you during the previous 6 months, how did your employer immediately respond? (Select ALL that apply)

- [ ] Offered immediate support
- [ ] Offered counselling/debriefing
- [ ] Warning given to offender e.g. written or verbal
- [ ] Involved police
- [ ] Blamed you
- [ ] No response

Other (please specify)

32. For the most significant episode of violence in the last 6 months, were you offered access to recognised counselling services?

- ( ) Yes
- ( ) No

33. Thinking of your most significant episode, did your organisation/department/unit introduce any immediate changes subsequently?

- ( ) Yes
- ( ) No

34. If Yes - please describe these changes.

35. For the most significant episode of violence in the last 6 months, do you think that you were provided with adequate information, support and follow-up after the episode?

- ( ) Yes
- ( ) No

36. What actions have YOU found to be effective in dealing with the PSYCHOLOGICAL consequences of violence? (Select ALL that apply)

- [ ] Informal debriefing with other staff after an episode
- [ ] Talking with friends and family after an episode
- [ ] Talking with NUM/managers after an episode
- [ ] Formal group debriefing after an episode
- [ ] Employer counselling services e.g. EAP
- [ ] Private counselling services
- [ ] Talking with union or professional association e.g. NSWNMA
- [ ] Talking with Human Resources or Work Health & Safety Representative
- [ ] Nothing helped
- [ ] Took no action

Other (please elaborate e.g. physical exercise)

37. Did you report these episodes?

- ○ Yes - reported ALL episodes
- ○ Yes - reported SOME episodes
- ○ No episodes reported

38. If YES - Why did you decide to report these episodes?

39. If YES - How did you report these episodes? (Select ALL that apply)

- [ ] Completed a paper report form
- [ ] Completed an electronic report e.g. IIMS, Riskman
- [ ] Verbally to my manager/team leader
- [ ] Documented in patient notes
- [ ] Informally at handover
- [ ] Reported to SafeWork NSW
- [ ] To police

Other (please elaborate)

40. If NO - Why did you decide not to report these episodes? (Select ALL that apply)

- [ ] Not sure how to report
- [ ] Time constraints
- [ ] Process too complicated
- [ ] Lack of follow up/response from management
- [ ] Don't expect anything to change in the long-term
- [ ] Fear of lack of support from colleagues
- [ ] Fear of being blamed for the episode
- [ ] Too many episodes/too busy to report
- [ ] It is an accepted/expected part of the job
- [ ] Feel you can manage these episodes effectively
- [ ] Feel person was not responsible for their actions or had a diminished responsibility e.g.cognitively impaired, substance abuse, mental health issues, emotional distress

Other (please elaborate)

Violence in Nursing and Midwifery

6. FACTORS ASSOCIATED WITH VIOLENCE

This section deals with episodes you have both experienced and/or witnessed in the last 6 months.

41. In which age group have you observed the majority of violent episodes from patients and/or family/friends/visitors of patients? (select ONE option)

- ○ <16 years
- ○ 16-25 years
- ○ 26-35 years
- ○ 36-45 years
- ○ 46-55 years
- ○ 56-65 years
- ○ 66-75 years
- ○ >76 years

42. For patients who exhibited violence - please indicate if they exhibited any of the following signs or symptoms. (Select ALL that apply).

- ☐ Alcohol intoxication
- ☐ Substance misuse
- ☐ Mental health issues
- ☐ Delirium
- ☐ Dementia
- ☐ Pain
- ☐ Fear
- ☐ Anxiety & agitation
- ☐ Head injury
- ☐ Cognitive dysfunction e.g. Hypoxia
- ☐ Disorientation/confusion
- ☐ Trauma

Other (please elaborate)

43. For relatives/friends/visitors of patients who exhibited violence - please indicate if they exhibited any of the following signs or symptoms. (Select ALL that apply).

- [ ] Alcohol intoxication
- [ ] Substance misuse
- [ ] Mental health issues

Other (please elaborate)

44. What time of day did the majority of these episodes occur? (Select ONE option).

- ○ 0700-1500
- ○ 1500-2300
- ○ 2300-0700

Other (please specify)

45. When did the majority of these episodes occur? (Select ONE option)

- ○ Weekday
- ○ Weekend
- ○ Public Holidays

Other (please elaborate)

46. Please indicate the nursing/midwifery activities that were occurring at the time of these episodes. (Select ALL activities that apply).

- [ ] Triaging
- [ ] Communicating with patients and/or relatives, friends or visitors of patients
- [ ] Managing reactions to delays
- [ ] Assisting patients and/or relatives, friends or visitors of patients in the waiting room
- [ ] Giving injectable medications
- [ ] Giving oral medications
- [ ] Conducting invasive procedures e.g. cannulation, dressings
- [ ] Assessing patients/taking patients' history
- [ ] Mobilising or Transferring patients
- [ ] Restraining patients
- [ ] Assisting with Activities of Daily Living
- [ ] Positioning/turning/lifting patients
- [ ] Moving patients in and out of seclusion
- [ ] Assisting patients at meal times
- [ ] Not engaged in any nursing/midwifery activities at the time of the event

Other nursing activity (please elaborate)

47. Please list 3 common activities during your working day, which you consider to be high risk activities for violence.

1

2

3

48. Where did these episodes occur? (Select ALL that apply).

- [ ] Waiting room
- [ ] Observation/seclusion room
- [ ] Shared communal spaces e.g. dining room, garden
- [ ] Corridors
- [ ] Bathrooms
- [ ] Ambulance bay
- [ ] Patient's home
- [ ] Rooms or wards
- [ ] Resuscitation room
- [ ] Not in the department e.g. car park
- [ ] Birthing suite
- [ ] Transferring patient to another department/hospital

Other (please elaborate)

____

49. Which of the following PATIENT SPECIFIC factors do you think may be contributing risk factors for violence?
Please rank in order from 1 (highest risk) to 9 (lowest risk)

- [ ] Past history of violence
- [ ] Illicit substance misuse
- [ ] Alcohol intoxication
- [ ] Mental health diagnoses
- [ ] Acute pain
- [ ] Cognitive dysfunction e.g. hypoxia
- [ ] Dementia
- [ ] Unrealistic expectations of staff & health system
- [ ] Cultural issues

50. Which of the following STAFFING ISSUES do you think may be contributing/precipitating factors for violence? (Select ALL that apply)
Please rank from 1 (highest risk) to 8 (lowest risk)

- Workload and time management
- Inadequate staffing
- Inadequate skill mix
- Lack of staff skills to manage episodes of patient-related violence
- Nursing practice and attitudes of individual nurses
- Inadequate communication with patients and relatives, friends or visitors e.g. about waiting times
- Professional communication issues e.g. handover/documentation
- Lack of training e.g. in deescalation techniques, restraint, dementia care

51. Which of the following factors SPECIFIC TO THE PHYSICAL ENVIRONMENT do you think may be contributing/precipitating factors for violence?
Please rank from 1 (highest risk) to 7 (lowest risk).

- Noise levels
- Environmental factors - Lighting and temperature
- Lack of privacy
- Personal space issues
- Over-crowding
- Long waiting times/delays
- Workplace design

7. MANAGEMENT AND PREVENTION OF EPISODES OF VIOLENCE

This section deals with your organisations approach to the management and prevention of violence.

52. Do you think your immediate managers/team leaders are approachable and supportive following an episode of violence?

- Yes
- No
- Sometimes

53. Do you think upper management are approachable and supportive following an episode of patient-related violence?

- Yes
- No
- Sometimes

54. Which of the following risk prevention/minimisation measures are present at your place of employment? (Select ALL that apply)

- [ ] Access to training paid for by employer e.g. Aggression minimisation training, dementia management
- [ ] Access to training not paid for by employer e.g. course to be completed at external organisation
- [ ] Duress alarms - hardwired and/or personal
- [ ] Signage e.g. Zero Tolerance posters
- [ ] Fixing of moveable objects that could be used as weapons e.g. chairs
- [ ] Safety glass window at triage
- [ ] Restricted access to the department e.g. key or card access
- [ ] Enclosed nurses/ station
- [ ] Increased security measures after hours
- [ ] Security personnel based in the department
- [ ] Security personnel available but based elsewhere in the hospital
- [ ] CCTV
- [ ] Police called if a situation deteriorates
- [ ] Availability of restraints and policies for their use - physical and/or chemical
- [ ] Use of patient management plans
- [ ] Consultation with management about prevention
- [ ] Clear policies for management of aggression

Other (please elaborate)

55. Is dementia training available at your MAIN workplace?

- ○ Yes
- ○ No

56. Is this training mandatory?

- ○ Yes
- ○ No
- ○ N/A

57. IF YES have you?

- ◯ Completed the training at your place of work
- ◯ Completed the training at your own expense outside your place of work
- ◯ Not completed this training

58. In what format is this training offered?

- ◯ Face to face only
- ◯ Online only
- ◯ Mixture of face to face and online

59. Is aggression minimsation/deescalation training available at your MAIN workplace?

- ◯ Yes
- ◯ No

60. Is this training mandatory?

- ◯ Yes
- ◯ No
- ◯ N/A

61. If YES – have you?

- ◯ Completed the training at your place of work?
- ◯ Completed the training at your own expense outside of your place of work
- ◯ Not completed this training

62. In what format is this training offered?

- ◯ Face to face
- ◯ Online only
- ◯ Mixture of face to face and online

63. Is "takedown" training available at your main place of work?

- ◯ Yes
- ◯ No

64. Is this training mandatory?

- Yes
- No
- N/A

65. If YES - have you?

- Completed the training at your place of work
- Completed the training at your own expense outside your place of work
- Not completed this training

66. In what format is this training offered?

- Face to face
- Online only
- Face to face and online

67. Which risk management follow-up strategies have been adopted by your employer? (Select ALL that apply)

- [ ] More stringent admission criteria
- [ ] Changes to physical environment e.g. additional exits, swipe card access
- [ ] Patient specials
- [ ] skills mix e.g. replace like with like (RN with RN)
- [ ] Increase staffing levels
- [ ] Increased security personnel
- [ ] Increased training opportunities
- [ ] Refusal of service
- [ ] Review of policies/procedures
- [ ] Limiting/banning visitors
- [ ] Use of restraint - physical and/or chemical
- [ ] Use of seclusion

Other (please elaborate)

68. Do you think that your organisations policies and procedures related to prevention and management of violence are effective?

- ◯ Yes
- ◯ No
- ◯ Somewhat

Please elaborate.

[ ]

69. In your opinion is violence an inevitable part of your job?

- ◯ Yes
- ◯ No
- ◯ Somewhat

Please elaborate

[ ]

70. Thinking back over your career, do you think the frequency of violence is...? (Select ONE option).

- ◯ Increasing
- ◯ Decreasing
- ◯ Staying the same

71. Please comment on how safe you feel at work?

[ ]

72. What measures do you believe can be used to more effectively manage violent patients/episodes?

[ ]

73. In your opinion, what would be the most effective way to prevent/minimise the occurrence of violence in your department?

[ ]

74. Thank you for completing the survey.

If you have any additional comments please add below.