NSW NURSES & MIDWIVES' ASSOCIATION

Review of the 2018 Review of the Model Work Health & Safety Laws

AUGUST 2019

AUSTRALIAN NURSING & MIDWIFERY FEDERATION NSW BRANCH

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Contents

Foreword 4

Make Regulations Dealing With Psychological Health (Recommendation No.2) 5

Effects on Workers of Psychosocial Hazards 5

Practical Impacts of New Regulation 7

State of Knowledge on Psychosocial Hazards 7

Preferred Option 7

Form & Content of Regulation 8

New Arrangments For HSRs In Small Business (Recommendation No.7a) 8

Clarify Entry Of Union Officials Providing Assistance To An HSR (Recommendation No.8) 8

Requiring Inspectors To Deal With Safety Issues When Cancelling A Pin (Recommendation No.9) 9

How are NSWNMA members affected by the problems in the review? 9

What practical impact would the options have on NSWNMA membership? What is your preferred option? 9

Choice Of HSR Training Course (Recommendation No.10) 9

How are NSWNMA members affected by the problems outlined in the review? What do you consider to be the cause and extent of disagreement over HSR training? 9

Practical impact of options on NSWNMA members? 10

What is the preferred option and why? 10

What do you consider the main course of disagreements over HSR training? 10

Referral Of Disputes (Recommendation No.13) 10

How are NSWNMA members affected by the problems identified in the 2018 review findings, and to what extent? 10

What practical impact would the options have on NSWNMA members? 11

What is your preferred option and why? 11

If option 2 is adopted, would you seek to refer issues that are not resolved under S 82 or 89 of the model WHS act to a court or tribunal? Please explain why? 11

Remove 24-Hour Notice Period For Entry Permit Holders (Recommendation No.15) 11

How is the NSWNMA and our membership affected by this problem? 12

What practical impact would requiring or not requiring a WHS entry permit holder to provide prior notice of entry have on the NSWNMA and our membership? 12

What is your preferred option and why? 12

Require Production Of Documents And Answers To Questions After Entry (Recommendation No.17) 12

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Enhance Category 1 Offence (Recommendation No.23A) 12

Prohibit Insurance For WHS Fines (Recommendation No.26) 12

Clarify The Risk Management Process In The Model WHS Act (Recommendation No.27) 13

Add A SWMS Template To The WHS Regulations (Recommendation No.29A) 13

Foreword

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes: registered nurses; enrolled nurses and midwives at all levels including management and education, and assistants in nursing and midwifery.

The NSWNMA has approximately 65,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). NSWNMA strives to be innovative in our advocacy to promote a world class, well-funded, integrated health system by being a professional advocate for the health system and our members. We are committed to improving standards of patient care and the quality of services of all health and aged care services whilst protecting and advancing the interests of nurses and midwives and their professions.

The NSWNMA continues to support the objective of nationally consistent WHS laws provided this lifts safety standards to the highest level for all workers and is not used to diminish protections.

The NSWNMA supports the submission made by the ACTU and welcomes the opportunity to comment on the Recommendations of the 2018 Review of the Model Work Health and Safety Laws (**the Review**) in relation to our membership – nurses and midwives in NSW. The NSWNMA supports all 34 recommendations made by the Review, on the basis that they are reasonable, proportionate and sensible responses to identified problems and challenges in the operation of Australia's WHS regime. The NSWNMA calls on the Workplace Relations Ministers to accept all 34 of the Review recommendations, to instruct Safe Work Australia to amend the Model Laws accordingly, and to work with States and Territories to implement the reforms promptly in each harmonised jurisdiction.

This response is authorised by the Elected Officers of the New South Wales Nurses and Midwives' Association. Please direct any questions or correspondence about this submission to NSWNMA WHS Professional Officer Veronica Black at vblack@nswnma.asn.au.

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Yours sincerely

Brett Holmes

BRETT HOLMES
General Secretary
NSW Nurses and Midwives' Association

MAKE REGULATIONS DEALING WITH PSYCHOLOGICAL HEALTH (RECOMMENDATION NO.2)

Effects on Workers of Psychosocial Hazards

Nurses and midwives have very high levels of exposure to psychosocial hazards. Insufficient staffing levels and skill mix in hospitals, aged care, disability and the community, in both public and private sectors, are resulting in increasing quantitative demands (work load), emotional demands and increased work pace. Poorly managed rostering is seeing many nurses working extensive overtime and double shifts, compounding the effects of rotating shift work.

There is a significant culture of bullying within the industry. NSW Government conducts an annual People Matters Employee Survey, NSW Health consistently has the highest rates of workers who report witnessing and/or being subjected to bullying at work of any NSW Government department. In 2018, 39% of respondents reported that they had witnessed bullying at work and 21% reported that they had experienced bullying at work, (in some local health districts this was as high as 51% of employees saying they had witnessed bullying at work).

Another serious psychosocial hazard within the industry is exposure to occupational violence and aggression. Current arrangements for preventing and controlling violence in the health sector in NSW are not effective, with NSWNMA members reporting increasing levels of exposure to violence as well as an increase in the severity of the incidents that are experienced, with members sustaining serious injuries (those physical and psychological), including but not limited to fractured cheekbones, fractured orbital sockets, dislocated shoulders, acquired brain injuries, sexual assault & permanent hearing loss.

While we know that violence towards nurses and midwives is a very serious issue, that is well documented, well researched and widely accepted to be a significant problem, quantifying the true extent of the issue is hampered by the lack of transparency and very poor incident reporting.

In order to better understand the nature and prevalence of violence and aggression currently experienced by nurses and midwives in NSW, the NSWNMA has been involved in a research collaboration with Dr Jacqui Pich from UTS, a nurse academic with a strong research background in this area.

Dr Pich has recently completed a study looking into the experiences of NSW Nurses and Midwives with Violence on the Job, the study involved over 3500 nurses and midwives making it one of the largest studies undertaken on this topic worldwide.
Preliminary results from the study were presented at the 6th International Conference on Violence in the Health Sector in Toronto in October 2018. A copy of the report provided to the NSWNMA on this study is attached at Appendix A.

Key findings from the study include:

- 47% of nurses & midwives had experienced violence at work in the week prior to completing the survey
- 80% of nurses & midwives had experienced violence at work in the 6 months prior to completing the survey
- 76% perceived that the frequency of violent episodes was increasing

The other thing that became very clear from the study is that exposure to violence is not restricted to nurses working in emergency departments or in mental health, with workers in each of the areas of nursing & midwifery shown below reporting exposure to violence in the last 6 months:

Table 1:

Clinical area/specialty	Experienced violence in the last 6 months
Midwifery	58%
Medical/surgical	82%
Emergency Department	94%
ICU, HDU, or CCU	85%
Aged care	79%
Drug and alcohol	94%
Mental health	94%
Community health	59%
Family & child health	56%
Perioperative	64%
Rehabilitation/disability	80%

NSWNMA surveyed members on their views about the recommendations around changes to the Model Act. Members need stronger regulation of psychosocial hazards, particularly occupational violence, and talked about their experiences to illustrate this:

On the morning shift, unprovoked, I was physically assaulted by a patient causing me severe injuries. I sustained a fractured skull, fractured cheekbone and eye socket and a brain bleed.

I was attacked in the bathroom by a patient, I was also charged at with a knife by a patient. I had to barricade myself in a room with other patients. Led to years of rehab and psychiatric help. It took me six years before I was able to return to work.

A recent survey of our membership (n: 1852) conducted July 2019 demonstrated that:

Table 2:

Risk	Response
Believe there should be regulations dealing with mentally healthy workplaces	98%
Know someone seriously injured or ill because of work	80%
Experienced physical or psychological injury at work themselves	78%
In the last 12 mths experienced high workloads	75%
In the last 12 mths experienced exposure to traumatic events, distressing situations or distressed or aggressive clients/customers	72%
In the last 12 mths experienced shift work or unsociable hours	62%
In the last 12 mths experienced occupational violence	53%
Had or witnessed a near miss that could of injured a workmate or self	70%

Practical Impacts of New Regulation

Key WHS issues for nurses and midwives are not currently effectively addressed by the WHS legislation, as evidenced by the high rates of serious injury claims across the sector. The Healthcare and Social Assistance industry is the largest employing industry in Australia. It is rapidly expanding and is projected to continue to do so as the population both grows and ages, amplifying any current work health and safety issues and trends. It has a large number of work-related injuries and illness reported each year.[1]

New regulation on psychosocial hazards would provide for increased focus and understanding of these important health and safety issues and provide an impetus for change.

State of Knowledge on Psychosocial Hazards

Overall the level of understanding of psychosocial hazards and relevant and appropriate controls to manage the risks associated with these hazards is very low within the sector, with most interventions focused on low level administrative controls that are often impractical (e.g. patient only to be nursed by male nurses but then no male nurses rostered on shift).

Preferred Option

The NSWNMA strongly supports **Option 2 - include requirements for managing psychosocial risks in the model WHS Regulations.**

At this stage, there is little reference to psychological health beyond the definition of health within the Model WHS Act providing no certainty to PCBUs about the nature of psychosocial hazards nor appropriate controls for managing risks arising from exposure to psychosocial hazards.

Maintaining the status quo is not an option for nurses and midwives who continue to be seriously injured on a daily basis. True injury rates are masked by workers leaving the sector suffering "burnout" but not making claims. Losing experienced qualified workers imposes a large cost over and above the cost of workers compensation claims on both the PCBU and society as a whole.

[1] Healthcare and Social Assistance Overview, Safework Australia, 2018. Viewed online 1/8/2019 at https://www.safeworkaustralia.gov.au/industry_business/health-care-and-social-assistance

Form & Content of Regulation

The NSWNMA supports new Regulation of psychosocial hazards (as opposed to psychological health). As per Table 2 above 98% of membership who responded to a survey in July 2019 also support *Regulations specifically dealing with mental health conditions and psychological risks and hazards*. There is extensive research that demonstrates that psychosocial hazards impact both the psychological and physical health of workers.

The new Regulation should provide duty-holders with guidance on identifying, assessing and managing psychosocial hazards. It is crucial that the Regulation of psychosocial hazards requires duty-holders to eliminate hazards so far as reasonably practicable and to minimize the risks where hazards cannot be eliminated. Too many of the current interventions seem to focus on the individual and building their "resilience" rather than on ensuring workers are not exposed to the hazard in the first place.

The new regulation must be detailed enough to provide clear and meaningful guidance to duty holders about their duty to ensure the health and safety of workers exposed to psychosocial hazards in the workplace. What these hazards are, how to identify them and how to manage the associated risks. Any new Regulation around psychosocial risk must be supported by quality new codes of practice with explicit information about how PCBUs can meet their obligations in relation to particular psychosocial risks (including but not limited to occupational violence and aggression, sexual harassment, bullying and fatigue).

In addition to a new regulation around psychosocial hazards, changes must be made to Part 3 of the WHS Act "incident notification" specifically to the definitions of *serious injury or illness* in s36 and to *dangerous incident* in s37 in order to ensure that serious psychosocial incidents are reported to the regulator.[2]

NEW ARRANGMENTS FOR HSRS IN SMALL BUSINESS (RECOMMENDATION NO.7A)

The NSWNMA endorses and supports the contents of the ACTU submissions in relation to new arrangements for HSRs in small business.

CLARIFY ENTRY OF UNION OFFICIALS PROVIDING ASSISTANCE TO AN HSR (RECOMMENDATION NO.8)

[2] NSWNMA, 2018. Submission by the New South Wales Nurses and Midwives' Association: Comment on the 2018 Review of the Model WHS laws, NSWNMA, 7. Online: http://www.nswnma.asn.au/wp-content/uploads/2018/04/2018-Review-of-the-model-WHS-laws_April-2018.pdf

The NSWNMA endorses and supports the contents of the ACTU and ANMF submission in relation to entry of union officials providing assistance to an HSR.

REQUIRING INSPECTORS TO DEAL WITH SAFETY ISSUES WHEN CANCELLING A PIN (RECOMMENDATION NO.9)

How are NSWNMA members affected by the problems in the review?

At this stage there have been few PINS issued by nurses and midwives exercising roles as HSRs within the health sector in NSW, and the NSWNMA has no information about any being cancelled by SafeWork NSW inspectors, let alone cancelled without resolving the underlying health and safety issue, (by contrast, we are aware of a number of Improvement Notices issued by SafeWork NSW inspectors that have been cancelled on internal review without any discussion with the inspector or affected workers, without safety issues being addressed, leaving workers very disillusioned about the role of the safety regulator).

What practical impact would the options have on NSWNMA membership? What is your preferred option?

The NSWNMA supports **Option 2 – Require inspectors to deal with safety issue when cancelling a PIN.**

If nurses and midwives had confidence that safety issues would be addressed it would increase the likelihood of them engaging with the mechanisms for resolving workplace health and safety issues in the workplace including electing HSRs and having HSRs exercise powers to issue PINS.

CHOICE OF HSR TRAINING COURSE (RECOMMENDATION NO.10)

How are NSWNMA members affected by the problems outlined in the review? What do you consider to be the cause and extent of disagreement over HSR training?

NSWNMA members elected as HSRs have a range of difficulties in accessing HSR training, these difficulties include:

- Lack of acceptance by the PCBU that they are entitled to attend HSR training, (can sometimes including attempts to send them to other shorter, non HSR courses);
- Availability of training, particularly for more rural/remote workers and a reluctance of PCBUs to pay reasonable costs associated with travel and accommodation to attend;
- Staff shortages creating obstacles for release to attend training particularly for HSRs from smaller facilities;
- Increased numbers of PCBUs becoming authorised to run HSR training and an expectation that workers will attend the training run by their employer;

- Lack of knowledge from HSRs that they are entitled to training (but must request it) and that they have choice of provider.

In review of July 2019 survey responses (n: 1448) greater than 95% of respondents believe that unions should;

- *have a role in work health and safety, 98%*
- *be involved in educating and informing workers, Health and Safety Representatives, employers and companies about work health and safety, 95%*
- *have a role in supporting and assisting Health and Safety Representatives - 98%*
- *be able to represent workers and Health and Safety Representatives in disputes with their employer or company about work health and safety issues. - 99%*

Practical impact of options on NSWNMA members?

Should the status quo remain, this will continue to be a source of unnecessary disagreement and to delay access to HSR training for NSWNMA members.

Clarifying that workers are allowed the choice of training provider will remove unnecessary conflict at the beginning of the HSR term of office and improve working relationships moving forward.

What is the preferred option and why?

The NSWNMA supports **Option 2 – Allow HSR choice of training provider.**

This will remove unnecessary conflict between HSRs and PCBUs.

What do you consider the main course of disagreements over HSR training?

Please see response to question "how are NSWNMA members affected?"

REFERRAL OF DISPUTES (RECOMMENDATION NO.13)

How are NSWNMA members affected by the problems identified in the 2018 review findings, and to what extent?

The current systems in place for resolving WHS issues are often ineffective and significant issues are failing to be addressed for extended periods of time (if they are addressed at all). It takes a lot of bravery for workers to get to the point where they are requesting support from SafeWork and when the response is either not forthcoming, or not timely, this is very

disillusioning and further contributes to a poor reporting culture where workers don't bother raising safety issues as they feel that nothing will be addressed.

In review of July 2019 survey responses (n: 1442) 77% of respondents believe that *if workers and the company disagree about a work health and safety issue and a safety inspector is not able to help them to resolve the disagreement, either party should be able to go to a court or tribunal.*

What practical impact would the options have on NSWNMA members?

Option 1 – status quo would not address the ongoing issues being faced by NSWNMA members in having safety issues in their workplaces addressed, increasing the risk of further injuries to an industry that already has the highest rate of serious injuries in the country.

Option 2 would provide an avenue for NSWNMA to support our members to have safety matters resolved in a timely manner when discussions at a local level have failed to resolve the issues.

What is your preferred option and why?

The NSWNMA strongly supports **Option 2 – Allow referral to a court or tribunal of outstanding disputes on a WHS or cease work issue after 48 hours** as it would enable the resolution of ongoing WHS issues and reduce member injuries. If option 2 is adopted, it must allow for a trade union representing a party to a WHS issue or whose members are involved in a cease work to refer these matters and represent their members in these jurisdictions.

If option 2 is adopted, would you seek to refer issues that are not resolved under S 82 or 89 of the model WHS act to a court or tribunal? Please explain why?

Provided that trade unions had the authority to refer matters on behalf of members and to represent members in relation to unresolved issues then the NSWNMA would certainly seek to refer unresolved issues under s82 or s89 to a court or tribunal. The NSWNMA takes the safety of our membership very seriously and will exercise all available options to ensure the health and safety of nurses and midwives in NSW.

REMOVE 24-HOUR NOTICE PERIOD FOR ENTRY PERMIT HOLDERS (RECOMMENDATION NO.15)

How is the NSWNMA and our membership affected by this problem?

This matter is not currently an issue for the NSWNMA as the 24 hour notice period for entry permit holders has never been implemented in the NSW jurisdiction.

What practical impact would requiring or not requiring a WHS entry permit holder to provide prior notice of entry have on the NSWNMA and our membership?

The NSWNMA rarely exercises our right to enter a workplace with less than 24 hour notice, but when we do, it is because the health and safety issues affecting our members constitute a serious and imminent risk to our members.

Should the 24 hour notice remain in the Model WHS Act and be implemented at a future date within the NSW jurisdiction this would limit our capacity to support members facing serious and immediate risks to their safety.

What is your preferred option and why?

The NSWNMA supports **Option 2 – remove the 24 hour notice period for entry permit holders.** This would remove a historical anomaly that is not present in any of the harmonised jurisdictions and allow us to continue to provide support to our membership.

REQUIRE PRODUCTION OF DOCUMENTS AND ANSWERS TO QUESTIONS AFTER ENTRY (RECOMMENDATION NO.17)

The NSWNMA endorses and supports the contents of the ACTU submission in relation to requiring the production of documents and answers to questions after entry.

ENHANCE CATEGORY 1 OFFENCE (RECOMMENDATION NO.23A)

The NSWNMA endorses and supports the contents of the ACTU and ANMF submission in relation to enhancing Category One offence

PROHIBIT INSURANCE FOR WHS FINES (RECOMMENDATION NO.26)

The NSWNMA endorses and supports the contents of the ACTU submission in relation to prohibiting insurance for WHS fines.

CLARIFY THE RISK MANAGEMENT PROCESS IN THE MODEL WHS ACT (RECOMMENDATION NO.27)

The NSWNMA endorses and supports the contents of the ACTU submission in relation to clarifying the risk management process in the model WHS Act.

ADD A SWMS TEMPLATE TO THE WHS REGULATIONS (RECOMMENDATION NO.29A)

The NSWNMA endorses and supports the contents of the ACTU submission in relation to adding a SWMS template to the WHS regulations

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

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

			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*
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				Physical			
			Public (n=1506)	Private (n=260)	Chi Sq	P-value	Public (n=485)	Private (n=73)	Chi Sq	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	0.8321	31 (6.4%)	4 (5.5%)	.	1.0000'
		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				Physical			
			Public (n=1506)	Private (n=260)	Chi Sq	P-value	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	548 (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

			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
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%)	46 (26%)	3.6	0.1629	139 (38%)	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

			Q68 Do you think that your organisations policies and procedures related to prevention and management of violence are effective?				
Question Number	*Question*	*Category*	*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.

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Appendices

Appendix 1: Email invitation

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 on 9514 5124 or 0438460745 or by email at jacqueline.pich@uts.edu.au.

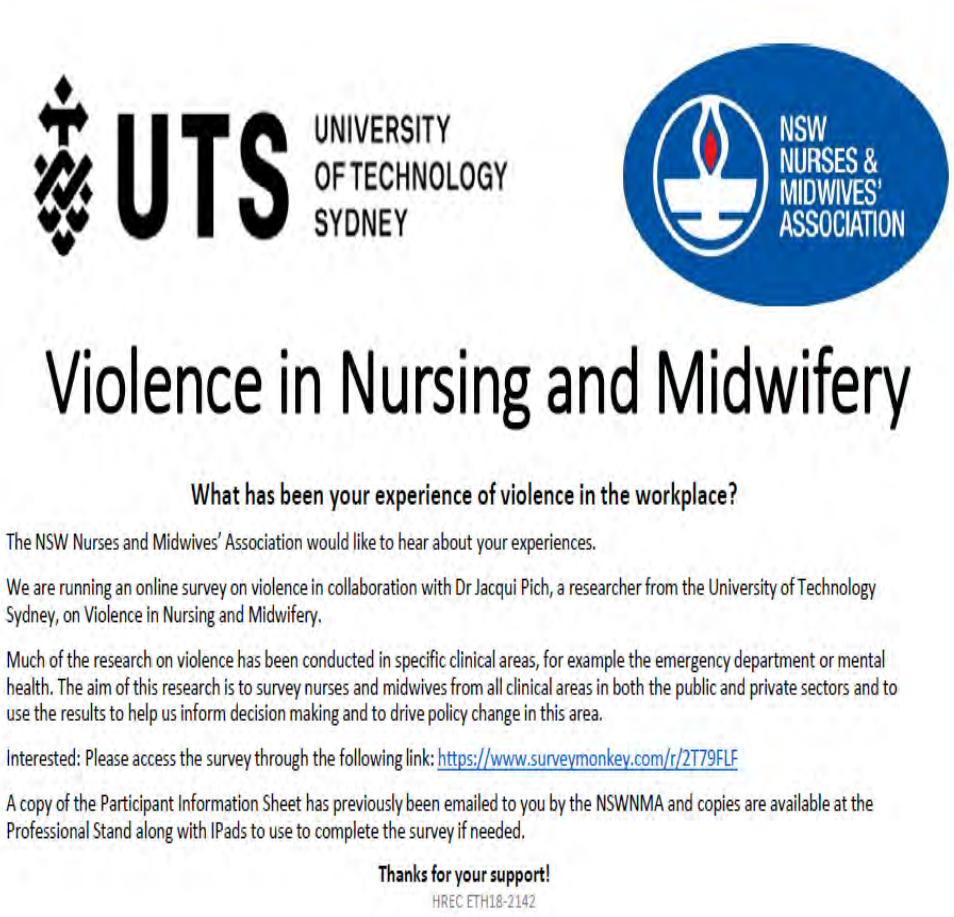
If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772 or Research.ethics@uts.edu.au and quote this number : **Reference number ETH18-2142.**

Thanks

Appendix 3: Questionnaire

(attached separately)

Appendix 4: Reminder Postcard



Violence in Nursing and Midwifery

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 paedatrics
- 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

Violence in Nursing and Midwifery

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.