NSW NURSES & MIDWIVES' ASSOCIATION

AUSTRALIAN NURSING & MIDWIFERY FEDERATION NSW BRANCH

Professional Issues

Occupational Violence: has no place in my workplace

Report into the experiences of nurses and midwives in NSW

> Recognizing the right of everyone to a world of work free from violence and harassment, including gender-based violence and harassment.
>
> **ILO Convention 190, Violence and Harassment Convention, 2019**

Acknowledgement of Country

The New South Wales Nurses and Midwives' Association acknowledge the Traditional Custodians of this land and recognise their continuing connection to the land, waters and culture. We pay our respects to their Elders past and present. This land was never ceded; it always was and will be Aboriginal land. We also embrace the Uluru Statement from the Heart and stand with Aboriginal and Torres Strait Islander Peoples of this country in enacting their right to self-determination.

Content Warning

This report deals with occupational violence including details of verbal, physical and sexual violence. If you or anyone you know needs assistance with any issues discussed below, you can contact:

NSWNMA
(02) 8595 1234 (metro) or 1300 367 962 (regional) **EMAIL:** gensec@nswnma.asn.au

Nurse and Midwife Support
1800 667 877

Nurse Midwife Health Program Australia
1800 001 060 (9AM-5PM weekdays)

LifeLine
13 11 14

1800-RESPECT
1800 737 732

BeyondBlue
1300 224 636

13-YARN
13 92 76

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Professional Issues

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Introduction

In 2023 Australia ratified the International Labour Organisation (ILO) Convention 190 (Violence and Harassment Convention), which recognises *"the right of everyone to a world of work free from violence and harassment, including gender-based violence and harassment"*. Ratification of the convention requires *"an inclusive, integrated and gender-responsive approach for the prevention and elimination of violence and harassment in the world of work"*.

Despite this ratification, nurses, midwives, and carers in New South Wales are reporting exposure to violence that is increasing in both frequency and severity. This report contributes to a growing body of evidence on the experiences of occupational violence (OV) and workplace injury of nurses and midwives.

Occupational violence must never be seen as part of the job.

Exposure to violence is causing significant physical and psychological injuries and even death. Additionally, occupational violence increases job stress, decreases job satisfaction, increases absenteeism, burnout, sleep disorder, fatigue, post-traumatic stress disorder, fear, and suicide, as well as reducing quality of patient care.[1]

Repeated or prolonged exposure to traumatic events, including low level trauma, in occupations where a high level of empathy is required, can also lead to development of secondary traumatic stress disorder and vicarious trauma.[2]

The human costs of occupational violence for nurses, midwives and carers, are unacceptable. Violence against healthcare workers is unlawful and requires a systemic prevention response.

The impacts of violence extend beyond individual workers to the delivery of safe, high-quality care, and must not be dismissed as an inherent part of front-line work.

Internationally, violence in the health sector has been recognised as an overlooked but critical issue for more than two decades. As early as 2000, the ILO, International Council of Nurses (ICN), World Health Organisation (WHO) and Public Services International (PSI) launched a joint programme to develop guidelines on the prevention of OV in the health sector (*Framework guidelines for addressing workplace violence in the health sector*, WHO).[3] Despite this sustained attention, instances of OV in healthcare continue to increase globally. Overall, 61.9% of healthcare workers report having experienced some form of violence perpetrated by patients and visitors[4] (this number does not capture violence perpetrated by colleagues and co-workers and therefore understates the true scale of the problem).

The Australian worker experience of OV reflects the international upwards trajectory. According to SafeWork Australia, worker's compensation claims related to OV have increased by 56% between 2017-18 and

1 Kafle, S; Paudel, S; Thapaliya, A; Acharya, R. (2022). "Workplace violence against nurses: a narrative review". *Journal of Clinical and Translational Research*. 8(5):421-424. **https://pmc.ncbi.nlm.nih.gov/articles/PMC9536186/**

2 Atkinson-Tovar, L. (2003). "Impact of repeated exposure to trauma". *Law and Order.* 51(9):118-123. **https://www.ojp.gov/ncjrs/virtual-library/abstracts/impact-repeated-exposure-trauma**

3 Di Martino, V. (2002). "Workplace violence in the health sector: Country case studies: Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand and an additional Australian study", World Health Organisation, **https://www.who.int/docs/default-source/documents/violence-against-health-workers/wvsynthesisreport.pdf**

4 Liu, J; Gan, Y; Jiang, H; Li, L; Dwyer, R; Lu, K et al. (2019). "Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis". *Occupational and Environmental Medicine*. 2019;76:927-37. **https://pubmed.ncbi.nlm.nih.gov/31611310/**

Violence against nurses and midwives in NSW is escalating.

Prevalence has risen from 80% in 2019 to 88% in 2025.

Frequent exposure has surged from 2% to 40.11% + 29.68%

non-physical violence **physical violence**[12]

2021-22. By comparison, all serious workers compensation claims have remained relatively steady. The health and community services sector and public administration experience OV at significantly higher rates than other industries, with 40% of health and community services workers exposed to violent or traumatic events at work.[5]

The intersectionality between gender, industry and experience of OV must be given serious consideration when looking for solutions. As an example, registered nurses have the highest female share of employment (88%) and have the highest number of workers compensation claims for exposure to OV (1,848) for the period 2017-18 to 2021-22.[6] Women are also 1.5 times more likely to lodge a workers compensation claim for exposure to OV or being assaulted.[7] We cannot address our goals around reducing violence against women without addressing violence in healthcare.

Occupational violence in healthcare is driven by complex and multifactorial contributing factors, including unmet patient expectations, poor communication, long wait times, chronic understaffing and broader organisational issues, such as resourcing and infrastructure. Addressing these risks requires multilevel stakeholder engagement and sustained organisational and system wide commitment.[8]

SafeWork NSW facilitated and funded exploratory research by the Centre for Human Factors and Sociotechnical Systems,[9] applying systems thinking methods to work-related violence in hospitals in New South Wales. This was participatory research and involved industry stakeholders including representatives from the Ministry of Health, Local Health Districts, private hospital providers and relevant unions as well as SafeWork NSW and systems thinking specialists. The research found that OV arises from multiple interacting factors

5 SafeWork Australia, (2024). "Workplace and work related violence and aggression in Australia report", **https://data.safeworkaustralia.gov.au/report/work-related-violence-aggression-australia#heading6**

6 Ibid

7 Ibid

8 O'Brien, CJ; van Zundert, AAJ; Barach, PR. (2024). "The growing burden of workplace violence against healthcare workers: trends in prevalence, risk factors consequences, and prevention – a narrative review". *eClinical Medicine*. 72:102641. **https://pmc.ncbi.nlm.nih.gov/articles/PMC11152903/**

9 Salmon, P; Coventon, LJ; Read, G. "Understanding and preventing work-related violence in hospital settings: A systems thinking approach" (25 February 2021), SafeWorkNSW

across the hospital system, occurring through diverse causal pathways rather than a single cause, and therefore cannot be managed through isolated or individual interventions. It identified key system wide themes for action:

- Risk management.
- Sufficient and capable staffing.
- Timely incident response.
- Systems supporting the safety and dignity of both patients and healthcare workers.
- Incident reporting and learning.
- Management of patients with a high propensity for violence.
- Hospital design.
- System wide consultation and coordination.
- Broader public attitudes towards healthcare workers.

Unfortunately, these evidence-based recommendations have not been systematically progressed, highlighting a significant implementation and accountability gap, where well-established, evidence and system level insights have not been matched by coordinated leadership, regulatory prioritisation or sustained action across the sector.

Without clear ownership and commitment to advancing system wide interventions, the conditions that give rise to occupational violence remain largely unchanged, despite repeated analysis and warning.

OV remains widespread and underreported[10] (only 46% reported over the past decade in Australia). Young workers and women are disproportionately affected, experiencing higher rates of gendered violence and sexual harassment, while being less likely to report.[11] Addressing reporting barriers – and the perceived or actual inaction that follows – requires an intersectional approach.

Culturally and linguistically diverse (CALD) workers face additional and distinct barriers. The NSWNMA's Standing Together Against Racism (2025) report highlights the hesitancy CALD members feel about reporting and the systemic factors that drive underreporting. This report builds on that body of evidence.

Violence against nurses and midwives in NSW is escalating. Prevalence has risen from 80% in 2019 to 88% in 2025. Frequent exposure (more than 10 incidents) has surged from 2% to 40.11% for non-physical violence and 29.68% for physical violence in 2025.[12] Meanwhile, reporting rates and confidence in workplace systems have slipped further.

These trends show that current measures are not delivering on the NSW Government's zero tolerance commitment and are failing to provide safe workplaces across the health sector.

10 Ibid

11 ACTU, (2023). "Work Shouldn't Hurt: A survey on the state of work health and safety in Australia"

12 Pich, J. (2019). "Violence in Nursing and Midwifery in NSW: Study Report". NSW Nurses and Midwives Association and University of Technology Sydney

Summary

The NSW Nurses and Midwives' Association sought to understand members' experiences of occupational violence (OV) over a six-month period in 2025. To inform this work, a detailed survey, incorporating qualitative and quantitative questions was distributed to all members, generating 1,333 responses, and representing one of the largest surveys undertaken by the NSWNMA on this issue.

DEFINITION OF OCCUPATIONAL VIOLENCE

Any incident where an employee is verbally, physically, or psychologically abused, harassed, or threatened at work, while performing work-related duties or in circumstances relating to work (e.g. by a patient in a public space such as on the way to work).

The survey examined:

- The prevalence, types and frequency of OV experienced by members, including variations by sector and specialty.
- The impacts of OV on workers, including psychological harm and the cumulative effects of repeated low-level exposure to violence and trauma.
- The experiences of culturally and linguistically diverse (CALD) workers.
- Reporting practices, barriers to reporting and gaps in data collection.
- Workplace culture and confidence in organisational and system responses to OV.
- Worker-identified solutions to prevent and manage OV.

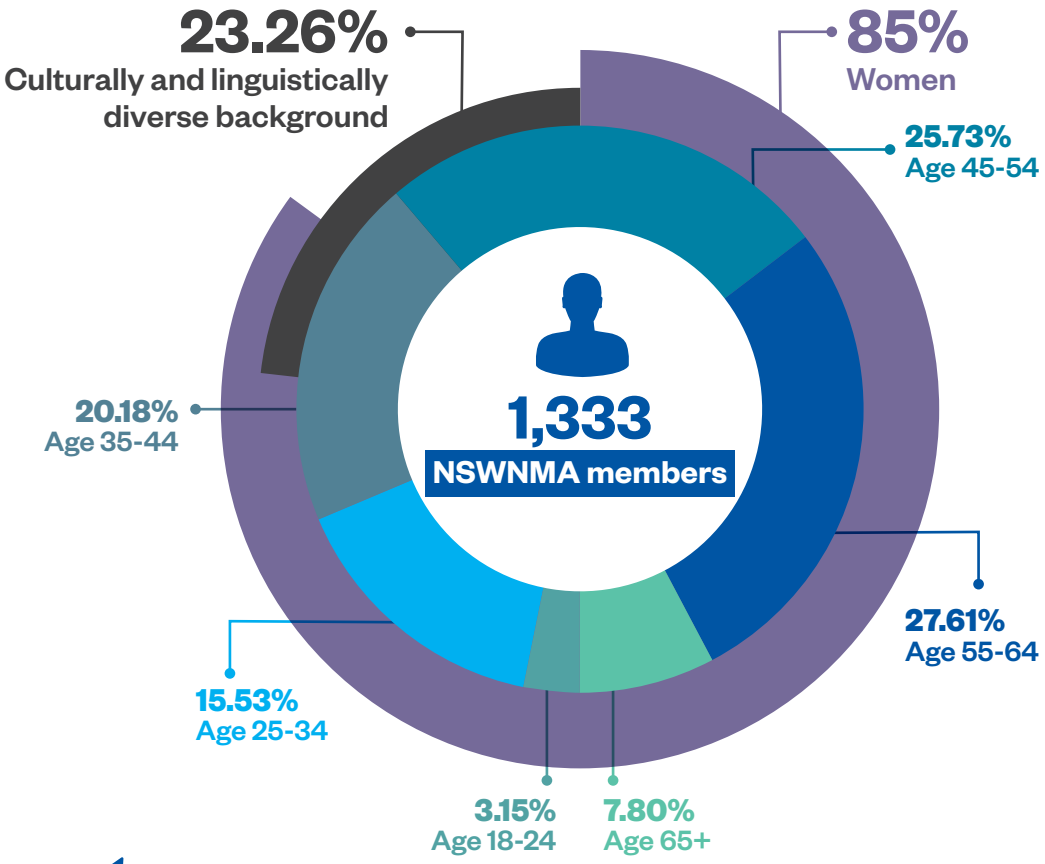
The findings provide a detailed and valuable insight into the lived experiences of nurses and midwives in NSW. These experiences are consistent with national and international evidence, demonstrating that OV remains a widespread and systemic issue across the healthcare sector.

Key findings in the last six months

1. 88% of members had experienced occupational violence (OV).
2. NSW public sector members experienced the highest frequency of OV.
3. Workers in residential aged care were more likely to experience physical violence compared to other types of violence.
4. Specialties with severe workforce shortages (e.g. midwifery) experienced higher worker on worker violence.
5. OV was significantly underreported.
6. Main barriers to reporting included lack of confidence in the system, lack of time, and minimisation of one's experience.
7. OV is having significant impacts on workers, not only when workers are involved in a one-off high-level event, but also through cumulative exposure, including regularly witnessing violence.
8. Hate speech and sexual assault were experienced at a higher rate by CALD members.
9. Adequate nursing and midwifery staffing, more secure physical environments and additional security staff were identified as the most effective violence prevention measures.

Who completed the survey?

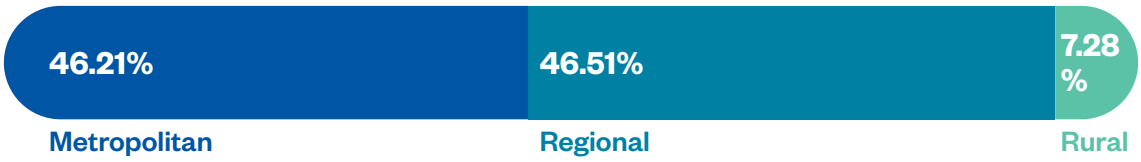
Respondents reflect the nursing and midwifery workforce in NSW.[13]



Length of service

Healthcare sector

Location

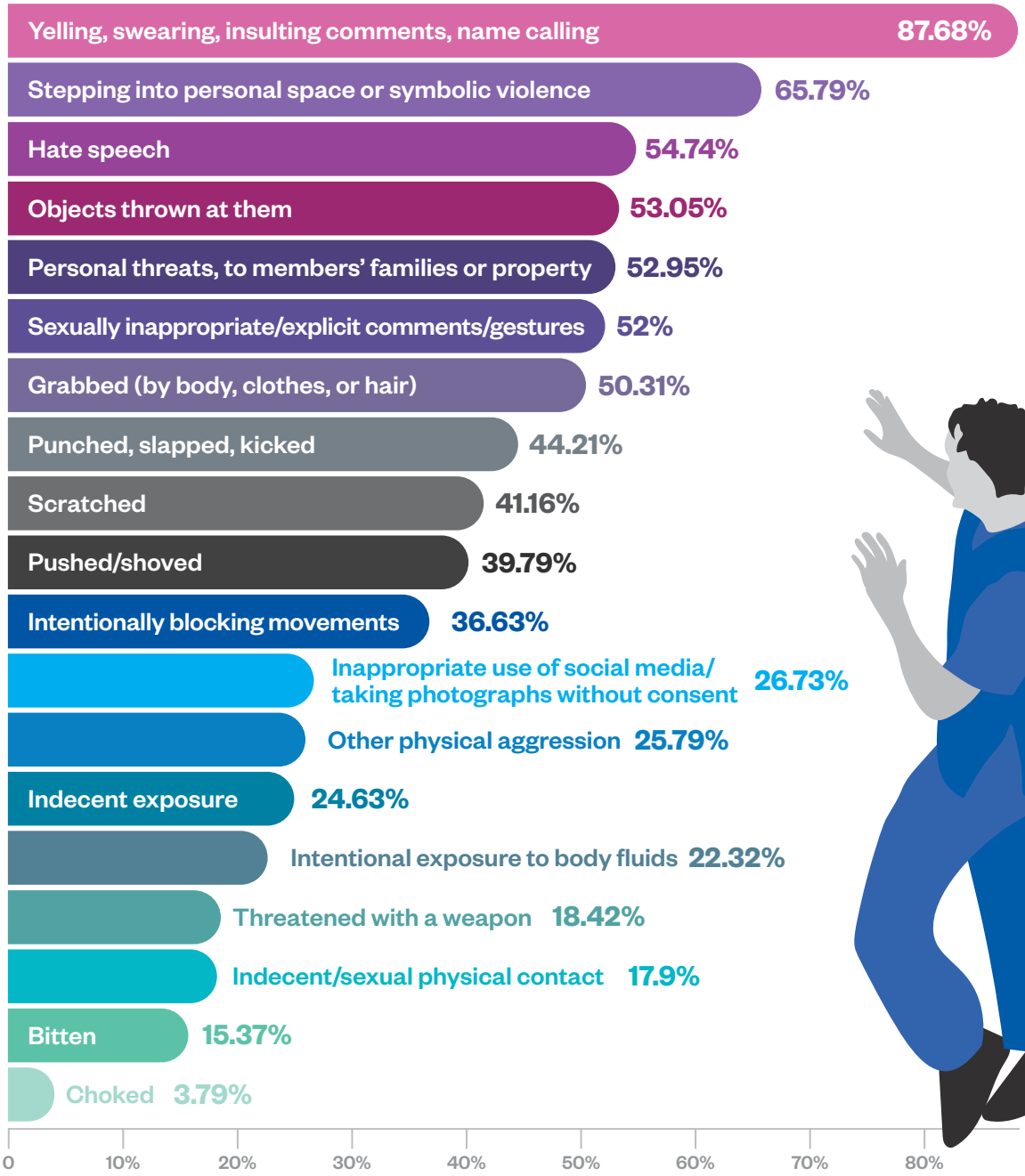


13 AHPRA Registrant Data Report (Oct–Dec 2023)

Experience of occupational violence in the previous six months

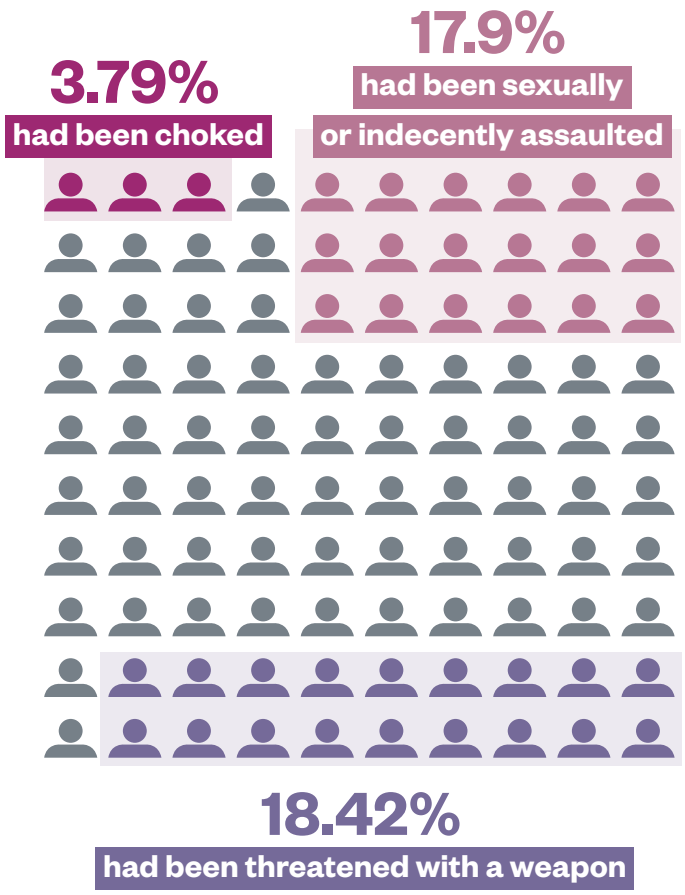
88.32% of respondents had witnessed or experienced occupational violence in the last six months. The following statistics relate to member exposure to violence, including where they have personally been the victim of violence and where they have witnessed violence perpetrated on others.

The types of occupational violence respondents have experienced and witnessed include:



“There have been far too many to single any one out. I’ve been abused, both indecently and racially, been punched, bitten, scratched, kicked, attacked with weapons, spat on, vomited on, bled on, had faeces thrown at me and been urinated on. My family has been threatened, and I was threatened with rape and death, not always in that order. **Registered Nurse, NSW Health**”

The prevalence of high impact occupational violence incidents is extremely concerning. Nurses and midwives report that:



“I was held hostage with a knife to my throat by a “confused” patient.

Registered Nurse, Private hospital

Sexual safety is not taken seriously. The attitude is ”You just have to deal with it.”

Registered Nurse, NSW Health”

Frequency

Nurses and midwives are repeatedly exposed to this behaviour.

76.32% exposed to OV more than two times; **29.68%** exposed to OV ten or more times.

In NSW Health all incidents are ranked from a harm score 1 (highest – death) to a harm score 4 (lowest – no harm or near miss). Under this policy all of the incidents mentioned in the following comments would likely be recorded as a harm score 4, vastly underestimating the real harm caused by the cumulative effects of exposure to such behaviour.

> A patient spent six months on my ward where he would verbally abuse staff every day. He would have visitors bring in drugs and alcohol and he was reported to police for hitting staff members more than once. He would throw objects at staff including food, water bottles and even his urine. His visitors would also be aggressive with the staff. **Nurse Manager, NSW Health**

> Have personally been and witnessed others being yelled at and called derogatory names such as sl*t, wh*re, tr*mp, b*tch, c*nt, mother f*cker and many more, spat at in the face while handing someone a coffee they asked for, threatened with violence to myself/family/staff via strangling/machete/gun/knife/bashing, threatened to be raped or have family raped while patient laughed, been grabbed inappropriately on butt and breasts and aggressively yanked back by the shoulders, I have had patients block me from exiting a room while threatening violence or aggression, patients purposefully exposing themselves and touching themselves and propositioning sex. All experienced and witnessed at least one of these EVERY SHIFT. **Registered Nurse, NSW Health**

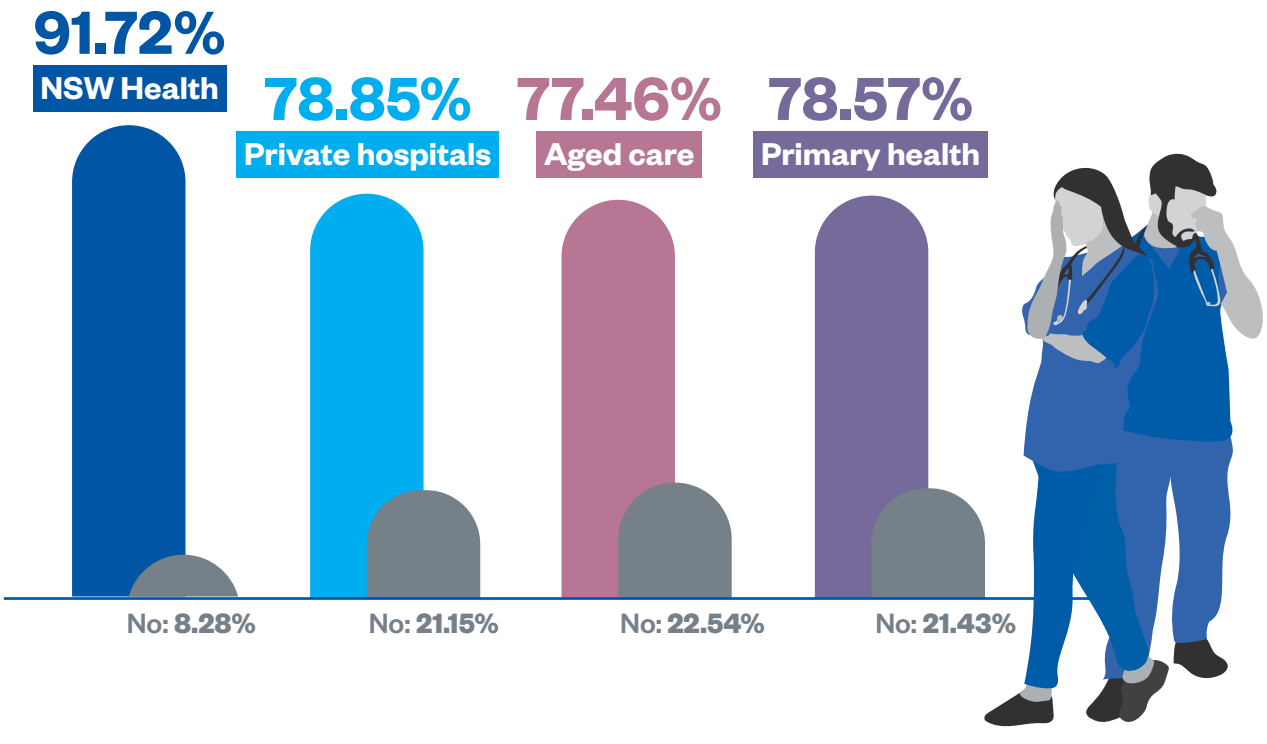
Sector experience of occupational violence

> I was assisting a resident with personal cares, and asked her permission for each stage of showering, which she agreed to. She intentionally waited for me to start washing her feet when she grabbed my head and drove her knee into my nose. My co-worker had to help remove her hands from my hair. This is one incident of many similar with not just this resident, but many and our company seems to ask more what we did wrong than to help put preventions in place.
>
> **Assistant in Nursing, Residential Aged Care**

This section of the report examines member experiences of occupational violence across different healthcare settings including public health, private hospitals, residential aged care and primary health, to identify similarities and differences in how violence is experienced.

Cross sector summary

Reports of experiencing or witnessing occupational violence in the last six months across sectors.



NSW Public Health System

The NSW public health sector is the largest employer within the health system and delivers care to people at their most vulnerable, including those experiencing acute illness, mental health crises, distress, intoxication and cognitive impairment.

Persistent demand pressures, overcrowding and resource constraints shape the conditions in which care is provided, often increasing the risk of occupational violence. As a result, members working in NSW public health report some of the most frequent and severe experiences of violence across the sector.

Of the 76% of respondents from the public health sector, 91.72% had experienced or witnessed violence in the last six months.

The most common types of violence that public sector members tell us they have personally experienced are:

- **89.17%** – yelling, swearing, insulting comments, name calling.
- **68.8%** – people stepping into their personal space or symbolic violence e.g. punching/hitting glass/desk.
- **56%** – threats against them.
- **55.48%** – objects thrown at them .
- **51.44%** – grabbed.

Concerningly:

- **one in four** reported having been intentionally exposed to body fluids (23.11%)
- **one in four** reported experiencing other forms of violence such as headbutting (25.85%)
- **one in five** had been threatened with a weapon (19.97%)
- **more than one in six** had been indecently or sexually assaulted (18.53%)
- **one in 25** had been choked (3.92%).

These are high risk exposures which can have catastrophic and long term physical and psychological consequences.

Private hospitals

Private hospitals deliver a significant volume of acute and elective care across NSW, often operating under tight staffing models and high patient turnover. While patient acuity may differ from public health settings, members report that occupational violence remains a significant concern. Expectations around service delivery, time pressures, and limited security or escalation pathways can heighten the risk of aggression towards workers.

Of the 8% of respondents from private hospitals, 78.85% had experienced or witnessed violence.

The most common types of violence that private sector members tell us they have personally experienced are:

- **80.95%** – yelling, swearing, insulting comments, name calling.
- **46%** – hate speech.
- **44.4%** – people stepping into their personal space or symbolic violence e.g. punching/hitting glass/desk.
- **44.4%** – exposed to sexually inappropriate or explicit comments or gestures.
- **41.27%** – have had objects thrown at them.

Nurses and midwives in private hospitals experienced very high rates of verbal abuse and symbolic violence, but were much less likely than their public sector colleagues to be physically assaulted or exposed to harms like:

- Being threatened with a weapon (PHS 19.97%; private 3.17%).
- Choking (only one respondent reported having witnessed choking, while none reported having experienced it. By comparison, 3.92% of public health system respondents reported being choked).

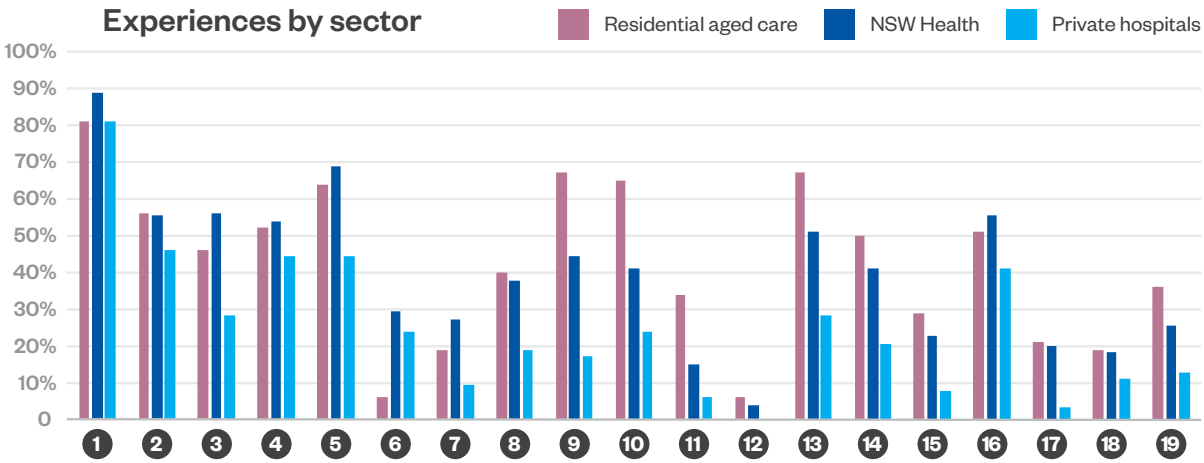
Residential Aged Care

Residential aged care (RAC) workers provide care to residents with complex health needs, cognitive impairment, and behavioural and psychological symptoms of dementia. Occupational violence in this setting is frequent and normalised, taking the form of physical aggression, threats and verbal abuse. Chronic understaffing, limited clinical support, and constrained access to specialist services contribute to heightened risk and ongoing exposure for members.

The number of people living with dementia in Australia is expected to increase from around 500,000 in 2024 to over one million by 2065, and to be affecting younger people.[14] The cognitive function decline which occurs as we age combined with mental illness, regardless of any history of violence, can lead to behavioural changes, making challenging behaviours a foreseeable hazard which must be planned for.[15]

Of the 11% of respondents from RAC, 77.46% reported having experienced or witnessed OV.

A closer look at these experiences provides concerning data on the types of violence experienced by nurses and carers working in RAC.



1. Yelling, swearing, insulting comments, name calling
2. Hate speech
3. Personal threats, or threats to members' families or property
4. Sexually inappropriate/explicit comments/gestures
5. Stepping into personal space or symbolic violence e.g. punching/hitting glass/desk
6. Inappropriate use of social media/taking photographs without consent
7. Indecent exposure
8. Intentionally blocking movements e.g. blocks the doorway
9. Punched, slapped, kicked
10. Scratched
11. Bitten
12. Choked
13. Grabbed (by body, clothes, or hair)
14. Pushed/shoved
15. Intentional exposure to body fluids
16. Objects thrown at them
17. Threatened with a weapon
18. Indecent/sexual physical contact
19. Other physical aggression (e.g. headbutting)

14 Australian Institute of Health and Welfare, "Dementia in Australia", accessed 16/12/2025, **https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/how-many-people-have-dementia/prevalence-of-dementia#NumberofAustralias**

15 *Workplace violence in aged care: part of the job?*, SafeWorkNSW, accessed 16/12/2025, **https://www.safework.nsw.gov.au/resource-library/blogs/blogs-accordions/insider-tips/workplace-violence-in-aged-care-part-of-the-job**

> Two male residents at RACF constantly touch your breasts and bottom every time you attend to the medications or hygiene cares. Another male in memory support tries to hit staff with his walking stick and is verbally abusive every day. Two female residents try to bite, scratch, hit and verbally abuse every day.
>
> **Enrolled Nurse, Residential Aged Care**

> There was a new resident who was still quite fit and strong. I felt as if he had become obsessed with me as he was always following me around and making comments. I was the only RN on one particular night, and I had to lock myself in the office to get away from him. He became very angry and was kicking and punching the door and trying to break it down. I was very frightened. I spoke to the manager about him, and he said "Some residents just take a while to settle in". At the same place and time, another new resident, who was a convicted murderer, was admitted. He was also fit and well, but had mental health issues, and had been released from prison early. I was frightened of him as well. His specialist had written in the notes that he shouldn't be in an aged care facility, he was unsafe.
>
> **Registered Nurse, Residential Aged Care**

There are multifactorial reasons for violence in aged care including:

- Understaffing and poor skill mix.
- High proportion of residents with complex medical conditions including mental health conditions and dementia.
- Insufficient specialty facilities for residents with high-risk behaviours.
- Poorly designed facilities that fail to consider aggression risk.
- Increased focus on resident rights leading to decreased availability of controls for managing more extreme behaviours as these controls are deemed "restrictive practices".
- Culturally and linguistically diverse workforce.
- Expectations of family members, and dealing with psychologically complex situations of having a loved one in aged care.

These reasons are reflected in the responses provided by respondents regarding what measures would be most effective in preventing OV.

44.21%

of aged care workers said the most effective way to address aggression is more staffing.

Worker identified control measures

- **44.21%** said more staff was the most effective way to address aggression in aged care.
- **31.58%** respondents rated a more secure work environment as a control measure.

Primary Health

Primary health services, including general practice and community-based care, are often the first point of contact for people seeking health support. Members working in these settings report exposure to occupational violence linked to patient distress, unmet expectations, substance use and mental health concerns, often in environments with no security measures in place.

Working in small teams and working in isolation can further increase vulnerability to violence and aggression.

Of the 2% of respondents from primary health, 78.57% had experienced or witnessed violence in the last six months.

- **77.77%** reported verbal abuse in the form of yelling etc. This remains the most common type of violence experienced by nurses and midwives working in primary health.
- **44.44%** reported people stepping into their space or symbolic violence (e.g. punching desk/wall etc).
- **38%** reported threats of violence.
- **38%** reported having objects thrown at them.

Occupational violence by specialty

Occupational violence is commonly considered a risk that largely applies to nurses working in hospital emergency departments. While these nurses are certainly exposed to high levels of violence, survey results demonstrate that nurses, midwives and carers across all specialties are exposed to violence.

This section presents comparative data on rates of occupational violence by specialty, before examining selected clinical areas in more detail to better understand how the prevalence and nature of violence vary across different work contexts.

Specialty	% reported in last 6 months
Dialysis*	100%
Drug and alcohol*	100%
Emergency Departments	98.61%
Oncology/haematology*	93.75%
Mental health	92.45%
Medical/Surgical	92.40%
Intensive care/coronary care/high dependency	90%
Paediatrics*	89.29%
Geriatrics**	86.86%
Midwifery*	79.59%
Peri-operative*	79.45%
Primary Care (incl GP clinics)*	78.57%
Other***	77.56%

NOTE:

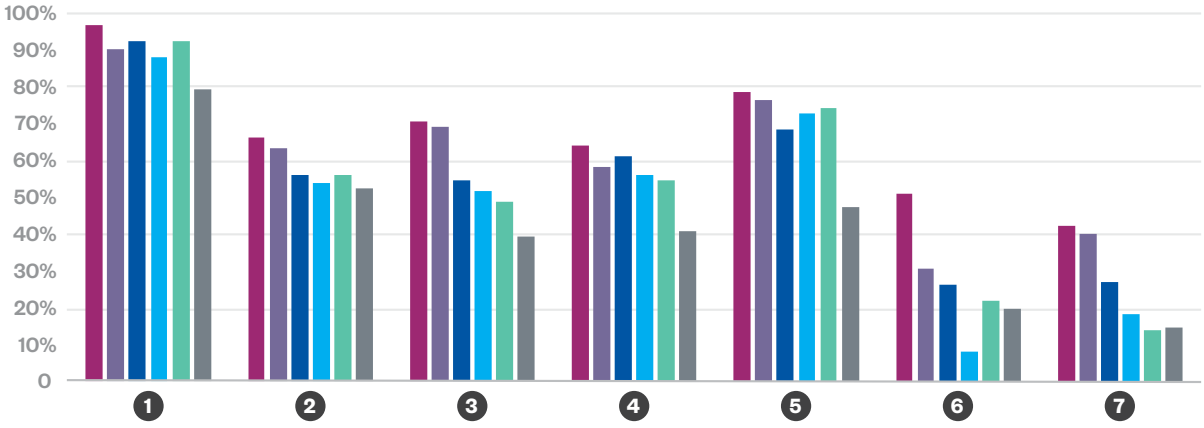
* Responses where n<90 were received should be interpreted with caution due to the low number of responses from these specialties.

** Geriatrics includes equal representation (approx. 48% each) of RAC and PHS.

*** Other includes any unit not specified such as palliative care, dementia/delirium, as well as laser/skin care and other clinics or any other places nurses/midwives may be employed in a clinical capacity.

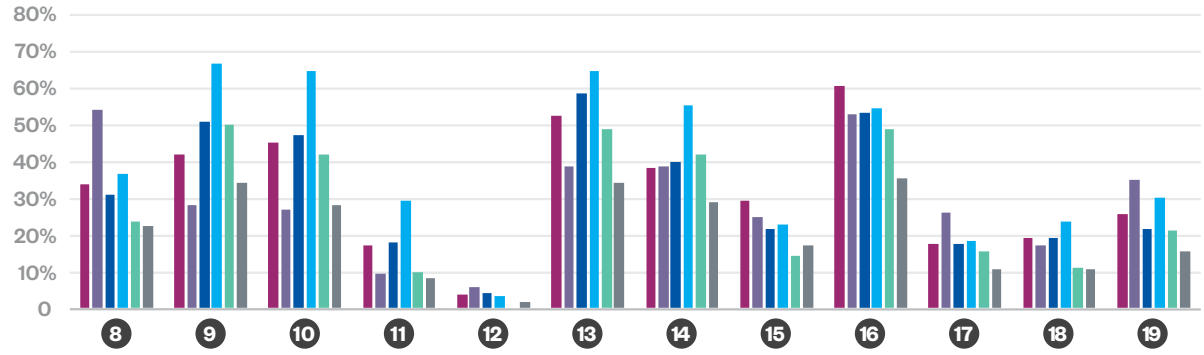
This section presents a comparison of reported violence across five clinical specialties: emergency; mental health; medical/surgical; geriatric; intensive and critical care (ICU/HDU/CCU). The data highlights some of the differences in both the prevalence and nature of violence across specialties, providing important context for understanding where risks are concentrated and how they vary across clinical settings.

Verbal aggression, threatening behaviour and indecent exposure



Cross specialty experience of verbal violence and indecent exposure

Physical violence



Cross specialty experience of physical violence

1. Yelling, swearing, insulting comments, name calling
2. Hate speech
3. Personal threats, or threats to members' families or property
4. Sexually inappropriate/explicit comments/gestures
5. Stepping into personal space or symbolic violence e.g. punching/hitting glass/desk
6. Inappropriate use of social media/taking photographs without consent
7. Indecent exposure
8. Intentionally blocking movements e.g. blocks the doorway
9. Punched, slapped, kicked
10. Scratched
11. Bitten
12. Choked
13. Grabbed (by body, clothes, or hair)
14. Pushed/shoved
15. Intentional exposure to body fluids
16. Objects thrown at them
17. Threatened with a weapon
18. Indecent/sexual physical contact
19. Other physical aggression (e.g. headbutting)

Emergency | Mental Health | Medical/Surgical | Geriatric | ICU/HDU/ CCU | Other

Medical/Surgical

Medical/surgical wards deliver a broad range of inpatient care, often to patients with complex and deteriorating health conditions. Occupational violence in these settings is frequently linked to patient confusion, delirium, cognitive impairment, and frustration, particularly during periods of high workload and staffing pressure.

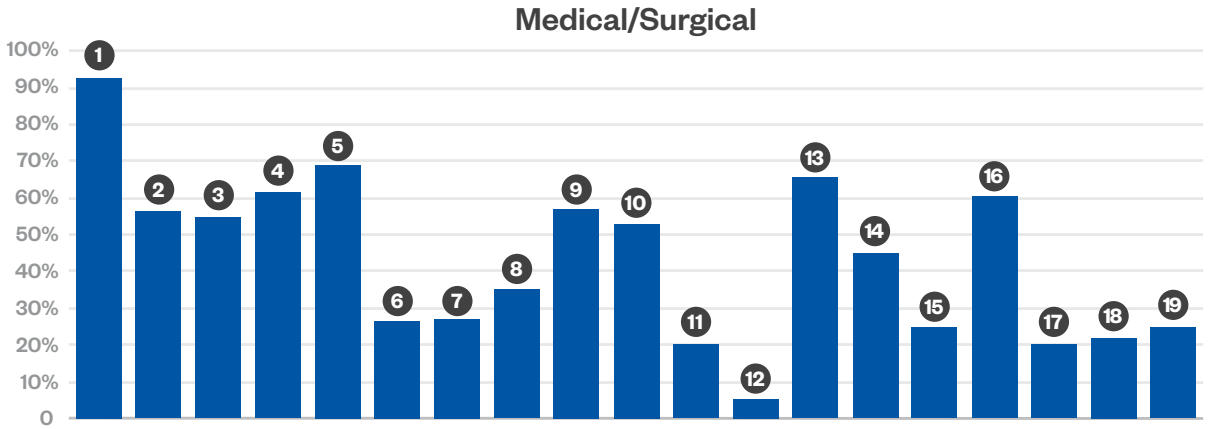
It is not uncommon for these units to receive patients outside of their models of care, while waiting for a bed in the relevant admitting unit, or who may accommodate patients for extended periods of time who do not require acute care but are waiting for a suitable residential aged care or NDIS placement.

Medical/surgical had the highest rates of reported OV across all specialties.

> [Regional] Hospital has averaged two assaults every night shift on a medical ward over my entire employment (years). **Registered Nurse, NSW Health**

Nurses working in medical/surgical units do not receive the same level of violence prevention and de-escalation training as nurses in mental health or emergency departments and rarely have access to personal duress devices.

- **5.1%** reported being choked (second highest after mental health at 7%).



1. Yelling, swearing, insulting comments, name calling
2. Hate speech
3. Personal threats, or threats to members' families or property
4. Sexually inappropriate/explicit comments/gestures
5. Stepping into personal space or symbolic violence e.g. punching/hitting glass/desk
6. Inappropriate use of social media/taking photographs without consent
7. Indecent exposure
8. Intentionally blocking movements e.g. blocks the doorway
9. Punched, slapped, kicked
10. Scratched
11. Bitten
12. Choked
13. Grabbed (by body, clothes, or hair)
14. Pushed/shoved
15. Intentional exposure to body fluids
16. Objects thrown at them
17. Threatened with a weapon
18. Indecent/sexual physical contact
19. Other physical aggression (e.g. headbutting)

> An inappropriate placement of a patient on an acute surgical ward that had severe BPSD. He ripped oxygen off the ward, broke the toilet system, the window fitting damaged, and the paper towel holder ripped from the wall. When he would get out of the room he chased the nurse violently around the ward and pinned them up against the wall... [describes physical and psychological injuries of multiple staff]... It took weeks of code blacks before [anything was done].
>
> **Enrolled Nurse, NSW Health**

- **21%** reported indecent sexual/physical contact (equal to ED and second to geriatrics).
- **57%** reported being punched/kicked/slapped (second to geriatrics).
- **68.9%** reported having people step into their personal space/symbolic violence.
- **65.8%** reported being grabbed.

Verbal abuse

41.33% reported experiencing verbal violence between one to four times in the last six months. While **63.27%** reported experiencing it five or more times.

> Was recently asked if I valued my life and that he could end it once he was discharged.
>
> **Nurse Consultant/Specialist, NSW Health**

> During admission of a patient found NOT to be psychotic, diagnosed antisocial personality disorder - threatening to return with unlicensed firearms to "take out" staff one by one as he knows our faces and where we work.
>
> **Registered Nurse, NSW Health**

Physical violence

29% reported experiencing physical violence 10 or more times, while **51%** report experiencing physical violence five to nine times.

> Nurses were in process of de-escalating agitated patient with security standby. Patient then head-butted a security guard, resulting in injury (code blue) for security guard. Blood all over nurses, seclusion for patient and police being called for assistance. In [the] last six months, police have had to be called at least twice for assistance with agitated patients as security reluctant to enter unit based on injuries to their staff in ED or lack of training for agency security, delaying care and increasing risk to staff and co-patients.
>
> **Registered Nurse, NSW Health**

Emergency

Emergency departments (EDs) operate at the frontline of the health system, providing care for people in acute distress, crisis and trauma. High patient volumes, overcrowding, long wait times and frequent exposure to alcohol and drug related presentations contribute to elevated risks of occupational violence for nurses working in emergency settings.

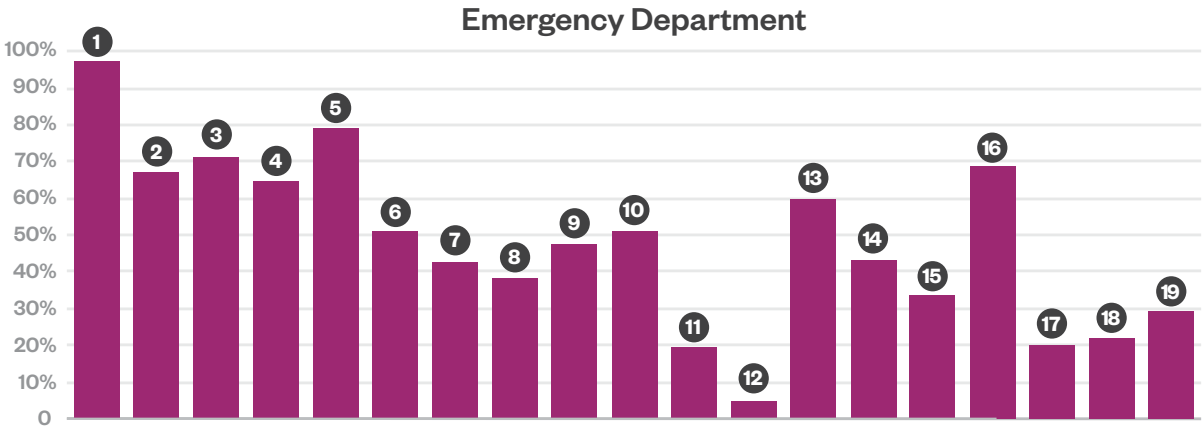
The Australasian College of Emergency Medicine has identified long wait times and bed block as the most common causes of escalating behaviour in EDs.[16] These are symptomatic of broader systemic and societal issues, such as increases in demand due to systemic neglect of community and primary healthcare, underfunding and under resourcing, increasing acuity at presentation due to unmet needs in the community, changes to restrictive practices, a raise in mental illness, associated lack of mental health beds and increase in drug use.

4 in 5
ED nurses experienced verbal violence five or more times in the last six months.

Verbal abuse

ED nurses experienced more verbal aggression than other nurses, with 97% of respondents from emergency departments saying they had experienced this in the last six months.

Four out of five (80%) report experiencing verbal violence five or more times in the last six months.



1. Yelling, swearing, insulting comments, name calling
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15. Intentional exposure to body fluids
16. Objects thrown at them
17. Threatened with a weapon
18. Indecent/sexual physical contact
19. Other physical aggression (e.g. headbutting)

16 Australasian College of Emergency Medicine, (2025). "Breaking Point: An urgent call to action on Emergency Department Safety"

Repeated exposure to low level violence and aggression can have serious long-term mental health impacts on workers[17] and is less likely to be reported.[18] This conduct can also escalate to other types of violence, such as physical violence.

Physical violence

- **64.23%** had experienced physical violence five or more times in the past six months.
- **68.3%** had objects thrown at them.
- **59.35%** had been grabbed.
- **51.22%** had been recorded or had their photo taken without their consent.
- **47.6%** reported having been punched, slapped or kicked.
- **Nearly one in three (29.26%)** reported having been headbutted or suffering other physical aggression.

> “After 25 years of working in mental health, there’s an increasing number of staff injured, particularly in ED and Psych Emergency Services. There’s an expectation that people will get hurt. Every year it increases.”
>
> **Registered Nurse, NSW Health**

Who are the main perpetrators?

We asked ED members who had experienced violence to identify the perpetrators of the violence:

- **98.37%** reported violence from patients.
- **39.84%** reported violence from visitors.

Geriatrics

Nurses and carers working in the specialty of geriatrics are working with older people who may have complex health needs, cognitive impairment, and behavioural and psychological symptoms of dementia within both the residential aged sector and within hospitals.

A closer look at the experiences of nurses in this specialty clearly shows an area in need of significant intervention to address occupational violence.

- **75%** reported being punched, slapped or kicked. This is significantly higher than the other focus specialties.
- **27.08%** reported experiencing indecent/sexual physical contact.

> “I was grabbed and dragged into a patient’s room by a male patient with dementia. He closed the door and forced me into the corner of the room and held me there telling me he was going to hurt me because I was trying to kill him. I activated my duress alarm and screamed until other staff and security came to my aid. Security found that the patient had removed the metal toilet rail from the bathroom, and had it concealed under the bed in the corner that he had forced me into.”
>
> **Registered Nurse, NSW Health**

17 SafeWork Australia, (2021). “Preventing workplace violence and aggression: National guidance material”

18 Hogarth, K.M., J Beatie, and J. Morphet. 2016 (19). “Nurses’ attitudes towards the reporting of violence in the emergency department.” Australasian Energency Nursing Journal 75-81.

Frequency

63.55% reported having experienced physical violence five or more times over the last six months (comparable to emergency departments).

Who are the perpetrators?

We asked geriatrics members who had experienced violence to identify the perpetrators of the violence:

- **95.83%** reported violence from patients.
- **15.63%** reported violence from visitors.

Mental Health

Mental health nursing is a specialised field focused on the care and support of people experiencing acute or chronic psychological distress, mental illness or behavioural disturbance across inpatient units, emergency departments, community settings, and forensic environments.

Nurses in this specialty frequently work with scheduled or involuntary patients who may be frightened, disoriented, traumatised or unwilling to be in care, and can present with complex needs linked to substance use, cognitive impairment, or severe mood and psychotic disorders.

The therapeutic work is relational and safety critical, requiring constant risk assessment, de-escalation skills, and trauma informed practice in environments where the likelihood of occupational violence and aggression is significantly elevated.

Mental health remains a specialty where experiences of OV by nurses remain high. Verbal abuse and threats in mental health are experienced at the second highest rate after emergency departments.

Mental health nurses had more exposure than most specialties to high-risk violence:

- **7%** had been choked in the last six months.
- **29.49%** had been threatened with a weapon.
- **28.21%** had been intentionally exposed to body fluids.
- **39.74%** had experienced aggressive behaviour like headbutting.
- **60.9%** had people intentionally blocking their way.

Frequency

45.51% reported having experienced physical OV 10 or more times in the last six months. Nearly one in two reported experiencing physical OV on a weekly basis.

> “A consumer ran and fly kicked the staff station window, and the pane of glass broke from the socket and hit me in the face resulting in two black eyes.”
>
> **Registered Nurse, NSW Health**

> “Just last night, a new patient in the MHICU kicked a male nurse, dislocating his knee. (I was present). Another patient told staff last week that he would wait outside and kill all of us when discharged. Too many incidents to write! Usually occurs daily.” **Registered Nurse, NSW Health**

ICU/HDU/CCU

Critical care nursing encompasses practice in intensive care (ICU), high dependency (HDU) and coronary care (CCU) units, where nurses care for patients who are critically ill, psychologically unstable, or at immediate risk of life-threatening deterioration.

Care is highly technical and fast paced, involving continuous monitoring, complex equipment, invasive procedures, and urgent interventions, often in emotionally charged situations involving pain, delirium, confusion, substance withdrawal, or sudden clinical decline. These high stress environments, combined with distressed patients and families, can contribute to heightened risks of occupational violence and aggression toward staff.

- **92.31%** reported verbal abuse such as yelling.
- **74.36**% reported they had been threatened with physical violence (three in four workers).
- **56.41%** had been punched/slapped/kicked.
- **55.13%** had been grabbed.
- **21.75%** (one in five) had been recorded or had their photo taken without their consent.
- **24.36%** (one in four) reported experiencing other forms of physical violence such as headbutting.

Frequency

85.9% have experienced OV on multiple occasions, with 17.95% experiencing OV 10 or more times in the last six months.

> “Videoing of a nurse outside of work, making it look like racist behaviour and spreading lies and hate to the point it went viral on social media.”
>
> **Registered Nurse, NSW Health**

Midwifery*

Midwifery is a specialised field providing care during pregnancy, labour, birth, and the early postnatal period in hospital and community settings, in situations that are often intense, time critical and emotionally charged. While care is focused on women and newborns, occupational violence in this specialty is most likely to come from visitors (largely partners). Chronic staffing pressures, workload demands, and resource constraints can also contribute to conflict and aggression between coworkers, adding to the risk profile in maternity services. Midwifery as a specialty is facing a crisis with severe existing workforce shortages. The *Midwifery Futures* report also found that one third of the respondents indicated they are considering leaving the profession prior to retirement age.[19] This would exacerbate the shortfalls to catastrophic levels.

> “I was chased by a father with scissors at a home visit for his newborn baby, police were called.”
>
> **Registered Midwife, NSW Health**

Experiences of violence:

- **64.51%** reported verbal abuse such as yelling.
- **32%** reported threats, stepping into personal space and inappropriate use of social media.
- **29%** reported experiencing hate speech.

Perpetrators

The main perpetrators of violence in midwifery look different to other specialties.

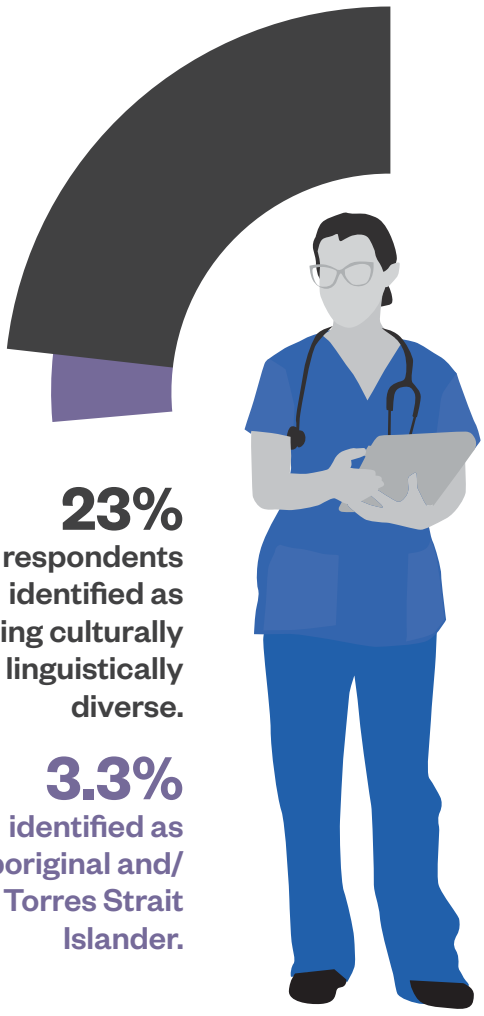
- **61.29%** reported violence from visitors.
- **35.49%** reported experiencing OV perpetrated by a colleague (and in one in four of these cases this came from a midwifery/nursing colleague).

19 Homer CSE, Small K, Warton C, Bradfield Z, Baird K, Fenwick J, Gray JE, Robinson M. (2024). *Midwifery Futures – Building the future Australian midwifery workforce.* A research project commissioned by the Nursing and Midwifery Board of Australia, Burnet Institute, Curtin University and the University of Technology Sydney.

* Due to the low number of survey responses from midwifery, analysis should be interpreted with caution.

Experiences of members from culturally and linguistically diverse backgrounds

> “Racially abusive patient, refusing care, yelling nasty, racial slurs at nurse who was allocated. I tried to attend to care (as white nurse) & patient insightful enough to change abusive language to suit me. Still refused care. Asian nurse [allocated], so abuse changed back to racial slurs. Staffing not really allowing rotation out so nurse left listening to racial abuse for eight hours ... **Nurse Consultant/Specialist, NSW Health**”



23%
of respondents identified as being culturally and linguistically diverse.

3.3%
identified as Aboriginal and/or Torres Strait Islander.

Who are CALD nurses, midwives and carers?

- Proportionally **younger** than members from non-CALD backgrounds – 30% are between 35-44 years old, compared to 18% of non-CALD members
- Predominantly **female** – 84%
- **Experienced** – 63% have 10+ years of experience
- Employed predominantly in the **public health system** (63.5%) and **residential aged care** (23.55%)
- Work **outside major cities** – one in three work regionally (33%)
- **81.37%** have experienced occupational violence in the last six months

> Patient yelling and saying to me, "You are black, and you think you can make laws to control me", all because I was following the medication chart standing orders. The patient wanted to get an extra dose of the medication.
>
> **Registered Nurse, Private hospital**

2 in 3
experienced
hate speech

Higher rate
indecent/
sexual assault

Less
OV reporting

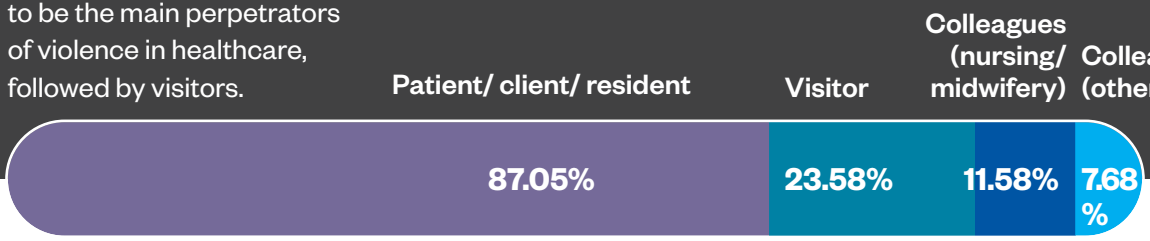
The experiences of CALD members who reported having experienced occupational violence in the last six months closely reflected the experiences of the general cohort. Of note are two main differences:

- **Two in three (62.57%)** reported experiencing hate speech – this is experienced at a higher rate than the general cohort which reported as one in two (54.74%).
- **Indecent/sexual assault was experienced at a higher rate** amongst CALD members (21.27%) compared to the general cohort (17.9%).

CALD members were less likely to report occupational violence, with 34.10% saying they had experienced violence in the last six months and not reported it. This is compared to 27.28% of the general cohort.

Who are the perpetrators of violence?

Patients/residents continue to be the main perpetrators of violence in healthcare, followed by visitors.



> Nurses working in correctional settings frequently experience hostility from correctional officer with whom they are required to work with at all times.
>
> **Registered Nurse, Correctional Health**

> An anaesthetist at my workplace has a 10 year history of grabbing, slapping, pinching, shouting, unwelcome touching. All frequently reported and he still works there.
>
> **Registered Nurse, NSW Health**

> The doctors in rural are considered an endangered species and action must be taken to address behaviour.
>
> **Nurse Manager, NSW Health**

Significantly, worker on worker violence accounted for 19.26% of reported incidents.#

Differences of note by cohort

In emergency, 98.37% experienced occupational violence from patients, and 39.84% experienced violence from visitors.

Racism in the workplace is a reality for nurses and midwives in NSW.[20] CALD members were more likely to experience occupational violence from nursing and midwifery colleagues (18.72%) and from other colleagues (13.37%) compared to the general cohort (11.58% and 7.68% respectively).

Midwifery members also reported that more than one in three (35.49%) have experienced OV perpetrated by a colleague and in one in four cases (25.81%) this came from a midwifery/nursing colleague.

When combined with the high emotional labour required by nursing and midwifery professions, severe staffing shortages create a high stress environment. Occupational stress has direct and negative impacts on interpersonal relationships at the workplace and is a significant contributor to staff burn out.[21]

> I think employee to employee violence needs to be recognised and called out and given honest analysis. I have experienced this more than violence from patients.
>
> **Nurse Manager, Private hospital**

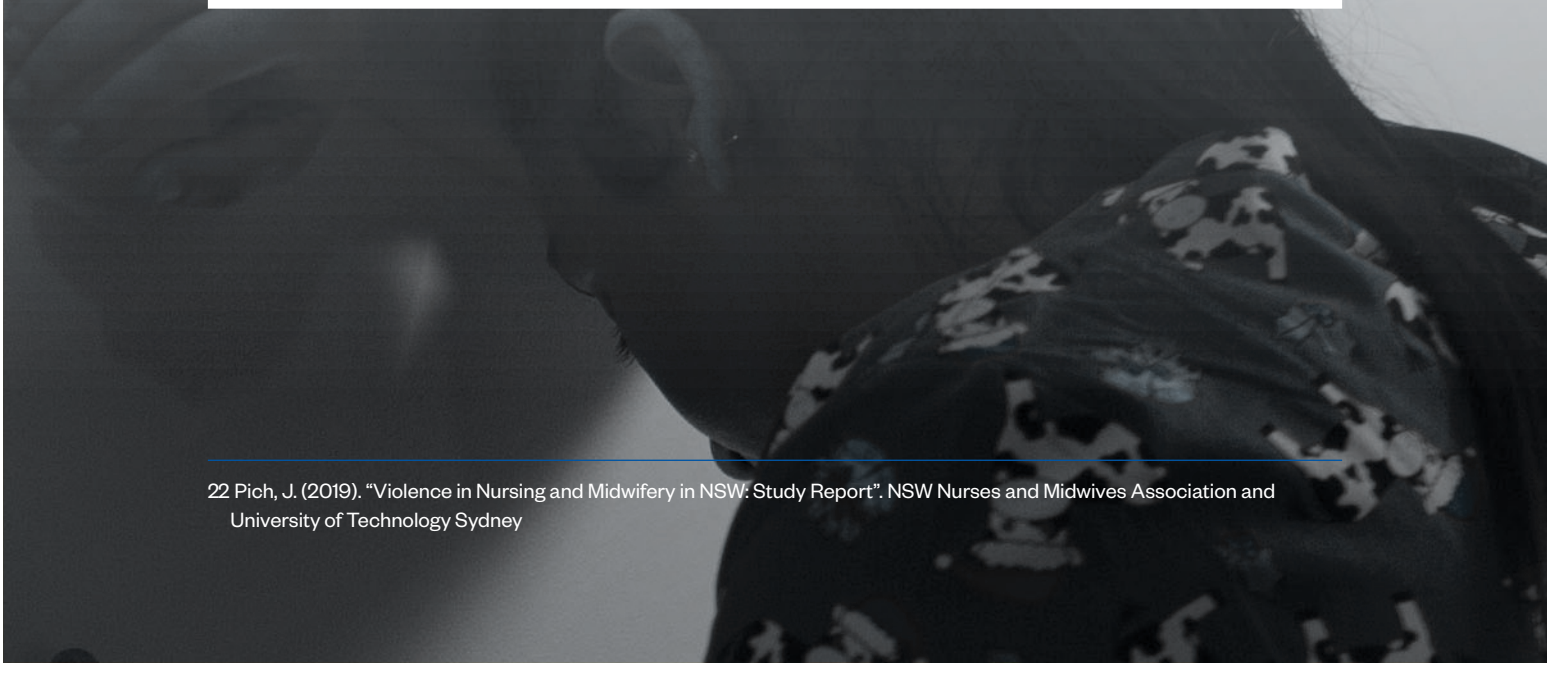
20NSWNMA (2025) "Standing Together Against Racism".

21 Da Costa, JS; Leite, DG; Sales, WB; Lima Coutinho, MD. (2023). "Influence of occupational stress on interpersonal and organizational relationships: an integrative review". *Open Journal of Pain Medicine* 7(1): 001-005. DOI: **https://dx.doi.org/10.17352/ojpm.000032**

Respondents were able to select more than one response to this question.

Changes over time

	2019[22]	2025
Experience of OV in preceding six months	80%	88%
Worker attitude to OV – violence is part of the job	41%	30.21%
Specialties with the highest rates of OV	Emergency, mental health and drug and alcohol	Emergency, mental health, medical/surgical
Frequency (>10 occasions)	2%	Non-physical violence – 40.11% Physical violence – 29.68%
Experience by gender	Females – 88% Males – 78%	Females – 88.27% Males – 88.62%
Public sector experience of OV	82%	91.72%
Private sector experience of OV	69%	78% (consistent across sectors)
Geographical prevalence	Metro	Consistent prevalence across locations



22 Pich, J. (2019). "Violence in Nursing and Midwifery in NSW: Study Report". NSW Nurses and Midwives Association and University of Technology Sydney

Reporting violence

Accurate and consistent reporting of occupational violence is critical to understanding the true risk profile of a workplace. Reliable data helps identify patterns, repeat behaviors, and early warning signs of escalation, enabling proactive intervention before incidents become more serious. It also provides the evidence base needed to inform decisions about staffing levels, skill mix, environmental design, security measures, training and other risk controls, ensuring that prevention strategies and resources are aligned with the actual level and nature of risk faced by workers.

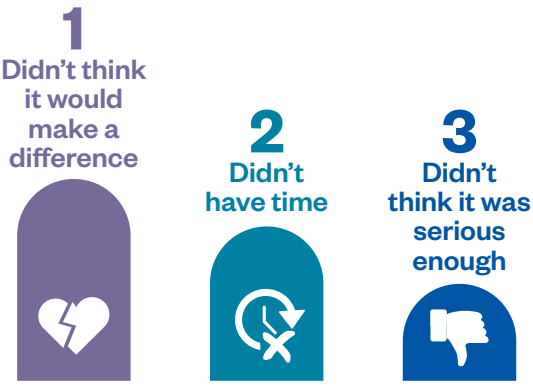
Survey respondents were asked a series of questions about reporting.

Reporting violence – internal reporting systems

93.42% of respondents said they know how to report violence in their workplace, yet only 25% said they had reported all incidents of violence. While 68% admitted to experiencing violence and not reporting it.

> “Incidents not reported, or if they are, no action is taken to prevent further incidents.”
>
> **Nurse Consultant/Specialist, NSW Health**

> “If you report in (public mental health facility), you are targeted to the extent that you have to resign from job.”
>
> **Nurse Consultant/Specialist, NSW Health**



Barriers to reporting

The three biggest barriers identified are:

- **Lack of faith in the system** (didn't think it would make a difference) – 72.96%
- **Workloads** (didn't have time) – 55.87%
- **Minimising personal experience/lack of understanding of the system** (didn't think it was serious enough) – 35%

Barriers to reporting by CALD workers need to be examined further due to the lower rates of reporting by this group.

Workplace support for reporting

- **17.53%** of respondents reported being discouraged from reporting specific incidents they believe should have been reported.
- **39%** not encouraged to report all incidents.
- **23.83%** are only encouraged when there has been an injury sustained.

> “My immediate manager seemed to take any reports personally and refused to engage in any conversations about incidents.”
>
> **Nurse Consultant/Specialist, NSW Health**

> Visitor threatened nursing staff with violence. Threatened to return to hospital and stab all the nurses caring for patient and then bomb the hospital. Police were contacted and visitor was arrested at place of residence. Detained overnight. Sergent contacted myself (who contacted police) and suggested that although visitor had a criminal record, the person had recently been "behaving" and was under significant stress. The charges were dropped after police spoke with NUM. I still look over my shoulder every time I go to my car.
>
> **Nurse Consultant/Specialist, NSW Health**

> I was physically assaulted in the workplace by a 30yo male. I had him charged with assault. Security camera footage was very clear and he was jailed for nine months. The impact on me has lasted much longer than his sentence.
>
> **Nurse Manager, NSW Health**

This systematic underreporting of violence minimises the extent of the problem, limits access to important information needed to make robust decisions about controlling risk and prevents proper consideration of risks to workers arising from the prolonged cumulative exposure to violence. Cumulative exposure to direct and indirect exposure to OV can lead to significant increases in mental health problems, including post-traumatic stress disorder, anxiety, depression and burn out.[23]

Reporting violence to police

While recent years have seen legislative changes to introduce increased penalties for assaulting healthcare workers, the reality is that most assaults are not reported to police, and limited action is taken in relation to those assaults that are.

NSW Health, as the largest employer in NSW of nurses and midwives, has a policy requiring that all incidents of violence and serious threats of violence are reported to police by the facility. **The data clearly shows that this policy is not implemented.**

- **86.33%** of members reported that police were not contacted following any physical assault or serious threat of assault they had experienced in the last six months.
- **13.8%** reported that police were contacted, however this was done by the employer only 6.7% of the time.
- **Only 4.7%** reported they were provided with assistance in contacting police and giving a statement.

Charges were laid in only 4.13% of the cases reported to police.

23Havaei, F. (2021). "Does the Type of Exposure to Workplace Violence Matter to Nurses' Mental Health?" *Healthcare* 9, no. 1: 41. **https://doi.org/10.3390/healthcare9010041.**

Impacts on workers

> “The patient jumped on my back and wrapped his arm around my throat strangling me, he pinned both my arms against my sides which meant I could not pull my duress that was connected to my left side waist. He pulled me into him, squeezing my throat tight. Seconds later, I saw two nurses running to me, as I looked at them, they both pulled their duresses. I could feel the pressure going into my head, I couldn't talk, nothing. The last thing I thought "Am I going to make it".
>
> Till this day I'm still not sure how I was released. All I know is I saw myself dying, as my hearing decreased, so did my sight… nurses who saw me told me my eyes were being squashed outside of my eyeballs.
>
> I am still on workcover, no one has taken accountability for what happened to me and the two nurses that saved me. I feel that, internally this has been swept under the carpet. My story needs to be heard. I still have headaches, the odd cough, and worse **a memory of the attack, that will stay with me forever**…
>
> **Registered Nurse, NSW Health**”

Members who had been exposed to violence in the last six months reported the following harms:

- **30.9%** had sustained a physical and/or a diagnosed psychological injury.
- **39.29%** reported undiagnosed psychological injury/impacts such as difficulty sleeping, crying, hypervigilance etc.
- **28.4%** had used their own leave after occupational violence (NOT taken workers compensation).

Workers compensation

According to a 2023 ACTU survey, only 20% of workers in the health and social assistance sector who reported being injured at work submitted a workers compensation claim[24] (across all injuries, not only those arising from violence).

This violence survey found that workers were even less likely to make a claim for injuries arising from violence.

Concerningly, **only 6.52% report accessing time off as workers compensation, compared with 28.4% using their own personal leave.**

24ACTU, (2023). “Work Shouldn't Hurt: A survey on the state of work health and safety in Australia”

> .... a small number of large male staff are used for all the patient restraints. The legislation says restraints should be led by nurses and that gets interpreted as nurses being the first hands on patients. There's almost no security guards and instead of rotating people who've been in heavy repeated violence you get sent straight back in. The guys who last in that environment a while - it becomes invisible to them. They say it doesn't damage them, but you can see the way they treat the patients or new guys who are starting. It's like going to war. It strips your soul away. It is awful beyond words. There's also no conversation with people who leave due to being injured or harmed. Lots of them are damaged and they disappear with those injuries; their experiences are never heard.
>
> **Registered Nurse, NSW Health**

Despite the significant limitations of relying on workers compensation data, (given people are often not putting in workers compensation claims), workers compensation figures also show increasing rates of violence.

SafeWork Australia data (not industry specific) reports a 56% increase in the number of serious workers compensation claims resulting from workplace violence and assault for the period 2017/18 – 2021/22. With mental health conditions as the most common injury resulting from exposure to occupational violence.[25]

The NSW Workers Compensation scheme shows a 52.8% increase in mental health condition claims between the 22-23 and 24-25 financial years,[26] with the health and education sectors having the largest year on year increases.

Workers compensation claims for NSW Health for physical injury from, "being assaulted by a person or persons" has seen a steady increase of 224% between 18/19 and 24/25 financial years.[27]

Psychological injury claims in NSW Health for exposure to traumatic events and exposure to occupational violence have increased by 308% and 15% respectively between 18/19 and 24/25 financial years.[28] Interestingly, the increase in claims relating to exposure to occupational violence is concentrated in the last three years (22/23 – 24/25 financial years).

Another challenge in analysing violence related workers compensation data is that the mechanism of injury is not always reported as "being assaulted by a person or persons" and may also be included in other categories such as:

- being hit by a person accidentally
- being hit by a moving object
- muscular stress while handling objects other than lifting, carrying or putting down
- contact with, or exposure to, biological factors of human origin.

In the context of the low claim reporting rates indicated by our members, despite significant increases in workers compensation claims, the actual injury rates are significantly higher than the workers compensation statistics reveal.

25 SafeWork Australia, (2024). "Workplace and work related violence and aggression in Australia report", **https://data.safeworkaustralia.gov.au/report/work-related-violence-aggression-australia#heading6**

26 SIRA, Open Data, **https://www.sira.nsw.gov.au/open-data/claims-data**, accessed 8/01/2026

27 Ibid

28 iCare NSW, (2025) Legislative Council Public Accountability and Works Committee inquiry into the Workers Compensation Legislation Amendment Bill 2025 RESPONSES TO SUPPLEMENTARY QUESTIONS FROM HEARING ON 29 JULY 2025 (29 August 2025)

Culture and confidence in the system

NSW Health has a stated policy position of zero-tolerance to occupational violence, recognising it as a significant workplace hazard requiring a risk management approach and mandating reporting of all violence and threat of violence incidents to police. Similar policies exist across all sectors.

Despite this:

- **41.67%** of respondents were told by management that violence is "part of the job"
- **30.21%** believed that violence is "part of the job"
- **38.39%** were not encouraged to report all incidents of violence internally and
- **only 24.23%** said they reported all violence.

Lack of confidence in the system is identified as the major barrier to reporting.

- **68%** had experienced violence and not reporteded it.
- **72.96%** of respondents who had experienced violence and not report it gave the reason as "didn't think it would make a difference".

This lack of confidence is perpetuated by how reports are handled once submitted or the perception of how they are handled.

> "After an aggressive incident, with a Code Black, an after-hours manager stated that it's my job and that's what I'm trained for!!"
>
> **Registered Nurse, NSW Health**

> "We need leaders who are ethical and professional. My experience of our MH service is a culture of leaders who are bullies, so it feels there is no-one to go to... When we have spoken out and tried to advocate for our service, managers just get heavy handed with threats. Our strategy has just been to keep united together as a team."
>
> **Nurse Consultant/Specialist, NSW Health**

- **72.58%** had made a report of occupational violence.
- Of those, **81.27%** did not feel anything was done as a result of their report.

Consultation on how to address work health safety matters is a legal requirement under the *Work Health Safety Act 2011* (NSW). Aside from being a legal requirement, consultation serves a vital role in building trust and confidence in the system.

Less than **two in 10** of respondents who reported violence believed any action was taken as a result.

Of the 20% that believed action was taken following their report:

- majority were consulted (77.78%)
- but only half believed the action taken was adequate (53.85%).

The most common actions taken are:

- meetings/debriefs/huddles
- management plans
- duress alarms and
- review of Code Black procedures.

Additional visitor screening is also reported as a common action taken; however, this was associated with an increase in workload for nurses, midwives and carers, especially overnight as no clerical support or additional staff were available.

> “Listen to staff when saying the resources available including security are insufficient to address violence perpetrator [sic] by patient in inpatient MH… **Registered Nurse, NSW Health**”

Support provided following an incident

Immediate support following an incident plays a significant role in recovery. We sought to understand the support provided to members by their employers following exposure to violence.

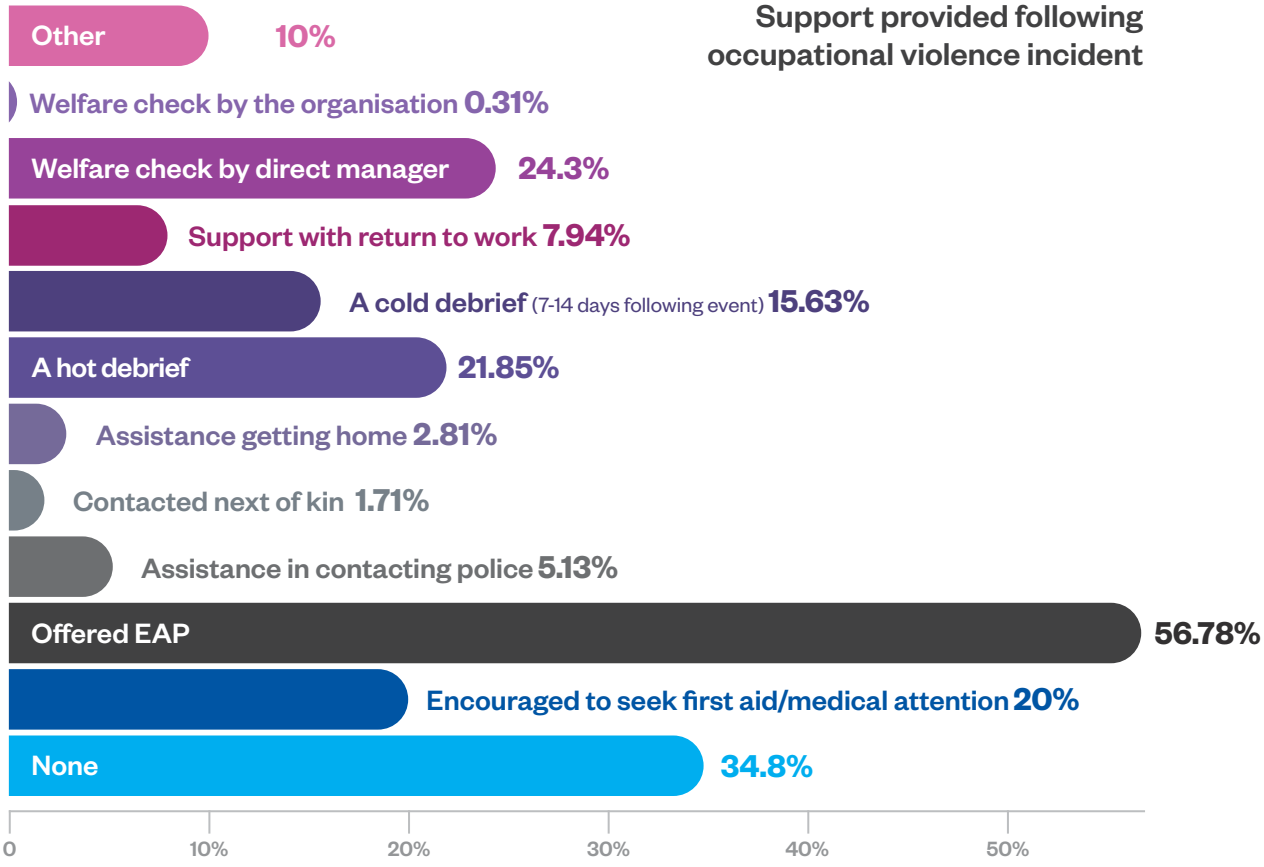
> “[They] made me work the remaining five hours of my shift before I was allowed to seek medical attention due to low staffing levels. **Nurse Consultant/Specialist, NSW Health**”

34.8% report NO SUPPORT was provided following an incident. This was the second most common response after offers of the Employee Assistance Program (EAP).

The offer of EAP is commonly part of the debriefing process and is a standard inclusion in letters and communication going out to staff following incidents.

Despite a mandate by the Ministry of Health that all incidents of violence and threats of violence be reported to police, only 5.13% of respondents were offered assistance with contacting the police.

Support provided following occupational violence incident



> Management saying 'oh well, it's the job. We can't cuddle everyone who gets scared or hurt' after staff had been seriously hurt by a patient in a premeditated attack with a makeshift weapon. **Enrolled Nurse, NSW Health**

Assistance with return to work also remains concerningly low, especially in light of the extremely low numbers of workers who lodge workers compensation claims (and hence employers have a legal obligation to assist with return to work).

What respondents want to see happen

Members were asked, in an open-ended question, what could have been improved in relation to the support they were provided following an incident of OV. The responses painted a picture of a system which is not designed to support workers. Members reported being blamed, having their experiences minimised and disregarded, not being listened to and not supported if they wished to take matters to police.

Emotional and psychological support in a person-centered trauma-informed manner was identified as the main way support can be provided following an incident. Some of these include:

- Not questioning the validity of the experience or reaction to the incident.
- Being offered/given time off to recover.
- Being asked if they are doing ok and better check-in processes.
- Better acknowledgement of events by management and executive.

Other areas of improvement include incident response and support, management communication/feedback post incident and legal and reporting assistance. Some of these include:

- Proactive action, such as banning aggressive visitors and providing additional staff (nursing or security) when issues are raised.
- Taking the time to listen.
- Providing follow-up to staff involved on what has been done to prevent further recurrence.
- Maintaining confidentiality.

Handling of incidents after hours was repeatedly identified as a problem. Members report handling of OV incidents, such as welfare checks, reporting to police, and hot debriefs tend to be left to the following day when the NUM is there. These delays compound the effects of the incident.

> Listen and validate my experience. The verbal abuse I experienced was turned against me and I became the problem. **Registered Nurse, NSW Health**

> The support I need is to do my job safely. Another nurse on the floor would help that. Another survey and a bunch of promises post the event doesn't do anything to help. I'm sick of being asked if I'm ok and being thanked for an amazing job … just help me do my job safely and keep your praise. **Registered Nurse, NSW Health**

What helps?

More staff

Safer physical work spaces

More security

Greater availability of patient specials
(additional to numbers)

Face to face VPM training

Individual violence risk management plans

We asked nurses and midwives to rate from one (most effective) to nine (least effective) what, in their view, is the most effective in reducing occupational violence.

More nursing and midwifery staff, a safer physical work environment and more security staff were rated as the **most effective measures** to reduce workplace violence by majority of respondents.

The lack of attention to these matters was described in multiple member responses as creating further serious risk of harm.

Reactive measures such as personal duress alarms, better communication about risk and controls to manage it, and clear escalation pathways following an incident while considered important, were rated as less effective in preventing workplace violence.

Nurses and midwives in community services called repeatedly for more direct and appropriate violence and aggression training, noting these staff are often working in isolation in people's homes and do not have access to the security and safety measures available to their colleagues in hospital.

> "Having unwell acute patients admitted to a rehabilitation unit. 3:20 ratio. Without additional staffing support and without security or a secure holding area."
>
> **Registered Nurse, NSW Health**

> "At my last place of employment we had hands on education: how to respond to verbal and physical aggression. The empowerment from this education was wonderful ..."
>
> **Nurse Consultant/Specialist, NSW Health**

Violence prevention training was rated as a somewhat effective measure for the prevention of violence. This largely appeared to relate to the nature and frequency of training and whether staffing levels allowed for implementation of what has been taught. The training provided was identified as being inadequate with members reporting it can take years for them to complete it; no refreshers are offered and an increasing reliance on online training.

Conclusion

> It is not solely the responsibility of managers. The health system is falling apart with no real action by executives and the government to improve this…
>
> **Registered Nurse, NSW Health**

Occupational violence is rife across the health sector and is leading to significant harm to individuals and contributing to pressure on service delivery. This is a systemic problem.

Existing data, while horrifying, provides a limited picture of the reality of violence experienced by nurses and midwives. This report, together with existing international and national research[29] highlights the significant underreporting of OV. We must remove barriers to reporting to truly understand the nature and extent of risk and be best placed to make appropriate risk management decisions.

Reduction in OV towards nurses and midwives requires a coordinated multi-level approach across the system. This work must be prioritised and resourced to allow for necessary measures such as additional staffing, security, and improvements in the physical environment.

Actions to address occupational violence within health can be categorised within the focus area identified by Salmon et al.[30]

Specifically, these include:

- risk management
- the provision of sufficient and capable staffing
- timely and effective incident response
- promoting the safety and dignity of patients and healthcare workers
- incident reporting and learning systems
- managing the risk of patients with a high propensity of violence
- the design of hospital environments
- collaboration, consultation and coordination across the hospital settings system, and
- public attitudes and behaviours towards healthcare workers.

Regrettably the recommendations from this report have not been translated to practice.

29 Hogarth, K.M.; Beatie, J; Morphet, J. (2015). "Nurses' attitudes towards the reporting of violence in the emergency department", *Australasian Emergency Nursing Journal* 2016: 19 (75)
Cai J, Ying Y, Wang H, et al. Exploring barriers and facilitators in nurses' reporting of patient and visitor violence: a cross-sectional study in China. BMJ Open 2024;14: e091232. doi:10.1136/ bmjopen-2024-091232
Pompeii LA, Schoenfisch AL, Lipscomb HJ, Dement JM, Smith CD, Upadhyaya M. Physical assault, physical threat, and verbal abuse perpetrated against hospital workers by patients or visitors in six U.S. hospitals. *Am J Ind Med*. 2015;58(11):1194-1204. doi:10.1002/ajim.22489

30 Salmon and Coventon, "Understanding and preventing work-related violence in hospital settings" (2021)

Recommendations

The following recommendations are directly aligned with the nine priority areas identified through the systems thinking research facilitated by SafeWork NSW. That work highlighted the complex, interconnected drivers of occupational violence and the need for coordinated action across policy, organisational systems, workforce capability and frontline practice. The union's recommendations are therefore structured to respond to these system-level factors, not just individual incidents, with the aim of achieving sustained, sector-wide risk reduction for workers and safer environments for the people in their care.

These are not the only changes required but would go a long way in improving the current management of risk.

Key theme 1: Risk management

Effective risk management must be the foundation of any serious strategy to prevent occupational violence, yet the current regulatory framework does not reflect the complexity, predictability and severity of these risks in healthcare. Unlike other high-risk industries, there are no specific WHS regulations that establish minimum, enforceable requirements for the assessment and management of occupational violence risk. By contrast, hazards such as confined spaces are subject to clear regulatory duties – including requirements for risk assessments to be conducted by a competent person. In healthcare, where the drivers of violence are often multifactorial, dynamic, and clinically linked, there is not even an explicit requirement for occupational violence risk assessments, let alone a requirement that they be undertaken by suitably trained and competent persons.

This regulatory gap must be addressed through the development of a dedicated WHS regulation supported by a detailed Code of Practice that sets out minimum standards for risk identification, assessment, control and review. This should include the use of standardised, evidence-based tools for facility level risk profiling, ward or unit specific risk assessments and individualised patient specific risk assessments where relevant. Importantly, the problem is not only that risk assessments are inconsistently undertaken, but that even where risks are identified, the control measures implemented are frequently inadequate to manage the level of risk present. Clearer guidance is required on effective control measures – including environmental design, staffing, security measures, work practices and escalation processes – to ensure that risk management translates into real preventative action rather than becoming a procedural exercise.

RECOMMENDATIONS

1. **Development of specific WHS Regulation and Code of Practice on Management of Occupational Violence.**
2. **Robust violence risk assessment tools with guidance on appropriate risk controls developed and rolled out across the sector.**
3. **Staff trained in how to use them.**
4. **Resources allocated to allow necessary controls identified to be implemented.**

Key theme 2: Sufficient and capable staffing

Many workplaces do not have adequate numbers of suitably qualified staff to manage the risks of occupational violence (an example of this is the need for nurses with mental health training). Decisions on numbers of nursing, midwifery and care staff focus on clinical patient needs and fail to consider the need to keep the people providing the care safe.

Patients with a known history of violence are frequently transferred to smaller hospitals, when they no longer need the higher levels of clinical care provided in larger facilities, with no consideration of whether the smaller hospitals have capacity to manage the violence risk. In rural areas, these facilities have limited numbers of nursing staff, (especially on night shift), often have no security, and may be 90kms from the nearest 24/7 police station.

When decisions are made to provide an inpatient "special" (one to one supervision), this resourcing is almost always taken from existing staffing numbers – meaning there are no additional staff on the unit to assist in managing the risk and that the rest of the staff have more patients than usual and therefore have less capacity to assist. Further, decision making about what type of worker is appropriate to allocate to this work is often based on budget rather than on skill set or consideration of risk (this will often be an assistant in nursing (AiN), often an AiN undergraduate student nurse with limited clinical experience), when an experienced mental health nurse or a security officer might be the safest option depending on the patient presentation.

RECOMMENDATIONS

1. **Staffing decisions must consider staff safety in addition to patient care needs.**
2. **When violence risk necessitates inpatient specials, these must be additional staff, not taken from existing numbers.**
3. **Patient placement decisions must consider staff safety as well as patient acuity.**
4. **Workers must be provided with relevant high-quality training prior to working in high-risk areas, with refresher training at regular intervals and regular documented "code black" drills.**

Key theme 3: Timely incident response

A timely and effective response to incidents of occupational violence is a legal and safety imperative yet remains one of the most inconsistent aspects of current risk management practice.

WHS Regulation 43 requires duty holders to prepare, maintain and implement emergency plans but does not provide clear guidance on what constitutes an "emergency". The SafeWork Australia factsheet on emergency plans mentions "armed confrontations" as an example of the type of emergency that should be covered by these plans, and the SafeWork NSW website is broader, talking about "violence".

Emergency plans must provide for: an effective response to the emergency; medical treatment and assistance, effective communication, testing of procedures; and information, training and instruction for relevant workers. At a regulatory level, this provision must be clarified and strengthened to make it clear that occupational violence is an "emergency" to which these requirements apply.

At the organisational level, health services must have comprehensive organisation wide policies and procedures that reflect all of these elements, which must then be translated into facility specific procedures that clearly set out how these systems operate in practice at each site, taking into account local layout, service profile, staffing model and risk profile.

Critically, the right to a timely and effective response must apply to ALL health workers, regardless of the size, remoteness or model of the workplace. It is unacceptable that some regional or community-based workers are effectively told to isolate themselves and wait for external emergency services who may be two hours away.

Systems must include purpose designed and fit for purpose equipment to reliably summon assistance, along with clearly defined response arrangements that ensure that trained personnel are available to attend, intervene, and provide immediate support.

Support must not end with stopping the incident but must include immediate post incident support to affected workers. Workers who receive timely and meaningful support from their employer after a violent incident – including acknowledgement, practical assistance and access to appropriate care – experience better psychological recovery while those who feel unsupported are more likely to experience prolonged distress and adverse mental health outcomes.

RECOMMENDATIONS

1. **Regulatory clarification of WHS Regulation 43.**
2. **Mandatory requirement for all health workplaces to have effective emergency plans for occupational violence.**
3. **Workers must have access to equipment to summon assistance (not only emergency department and mental health staff, as the research demonstrates they are not the only workers at risk of exposure).**
4. **Timely and effective duress response from trained responders must be available across all locations.**
5. **Timely access to medical and psychological support for workers.**
6. **Ongoing appropriate management support for workers exposed to violence, including, regular trauma informed welfare checks, release from duties, ensuring workers can get home safely, debriefing, and consultation around risk management.**

Key theme 4: Systems supporting the safety and dignity of both patients and healthcare workers

Our current healthcare system prioritises patient safety (and patient preference) over the safety of the workers caring for them. This is unacceptable, we must be able to focus on both patients and workers. Our nurses, midwives and carers cannot provide safe patient care when their own health and safety is so seriously compromised.

This will require work at multiple levels within our healthcare system.

At a macro level we need to see cooperation between regulatory agencies responsible for patient/resident safety and those responsible for worker safety. This would allow for better use of limited regulatory resources and assist in preventing the prioritisation of patient/resident safety over worker safety, when both need focused attention, e.g. this might look like ensuring WHS measures are included in the aged care standards and subject to review by the Aged Care Quality and Safety Commission as well as by SafeWork NSW.

Executive level

Without a clear commitment from senior executives to prioritising the elimination or minimisation of violence we won't see the resources allocated to violence prevention that are required.

The increased focus on patient safety including focus on clinical governance, development of standards, accreditation processes and the collection and use of data such as patient safety metrics, e.g. wait times for surgeries, hospital acquired infections, and use of seclusion and restraint have created accountability and led to organisational focus on improvements in these areas, including in budgeting.

A similar approach, including appropriate lead and lag indicators, must be developed and included in all service agreements with local health districts and with funding arrangements in other parts of the industry.

Incident data should be publicly reported, not hidden. This commitment has been made by NSW Health on several occasions to parliamentary inquiries but has not been followed through on. The NSW Department of Education data on violence in schools is published twice a year, and includes the date, school region and description of incident. This must be replicated for NSW Health.

Management level

All managers with responsibility for making decisions relevant to the management of occupational violence – whether:

- undertaking risk assessments,
- determining controls for management of risk,
- reviewing reported incidents or
- supporting staff following an incident

must receive mandatory training to ensure that they understand WHS obligations and have the skills and knowledge to competently undertake this work and have suitable accountabilities.

They must be provided with access to an appropriate budget to implement necessary controls and clear escalation pathways where required controls are outside their delegated authority to approve.

RECOMMENDATIONS

1. **Improvement of industry standards to include systems to minimise occupational violence, and enhanced cooperation between regulatory agencies.**
2. **Introduction of new governance arrangements and accountabilities for senior leaders in relation to violence prevention to be built into service agreements and funding arrangements across the sector.**
3. **Publication of incident reports in NSW public hospitals (similar to incident reporting in NSW government schools) to increase transparency.**
4. **Mandatory training for managers and supervisors with responsibilities around the management of occupational violence.**

Key theme 5: Incident reporting and learning

Members consistently tell us the incident reporting systems used in their sector are time consuming, fail to adequately identify harm and are not fit for purpose. This is particularly so for workers in the NSW public health system.

When reporting systems are time consuming and people see no safety improvements when they report, they stop reporting. Underreporting is particularly rife in areas where workers have regular exposure to violence.

The current harm score system in NSW Health is broken. It fails to appropriately reflect harm arising from the cumulative exposure to violence or to adequately consider psychological harm. On top of this, even within the existing inadequate rating system, injuries are regularly rated at a lower harm score than they should be, and there is no prompt to review the harm score if the injury ends up more serious than initially apparent.

We urgently need a proper review of and changes to how workers report incidents, the measures used to determine harm scores and how workers are consulted and supported following incident reports.

By comparison to NSW Health, the Department of Education has a number of alternative reporting pathways for workers including online, a paper-based form or over the phone. The benefit of reporting over the phone is that there are specially trained workers who know how to complete an incident report, who can prompt for additional information where required as well as offer direct referral to support services and/or the police.

Most incident reviews in the sector are undertaken by line managers who haven't had any risk management training. Even though issues are common across the industry there are no processes to ensure that lessons learned are shared and enhancements to systems implemented more broadly across the sector.

Another way to share lessons learned is through SafeWork NSW incident information releases informing a person conducting a business or undertaking (PCBU) about serious workplace incidents to help prevent similar occurrences. These can be used by PCBUs to help review risk management approaches and safe systems of work. Unlike other high-risk industries, SafeWork NSW does not publish regular incident information releases for health, (there is only one dated 2021 relating to patient lifters). Compare this with 104 for construction, 33 for agriculture, 15 for manufacturing, and 23 in transport.

RECOMMENDATIONS

1. **Introduction of user-friendly incident reporting systems and processes.**
2. **Review of harm scores to more appropriately reflect harm including psychological harm arising from cumulative exposures.**
3. **Training for all people with responsibilities relating to incident reporting.**
4. **Development of systems to enable better sharing of insights.**
5. **SafeWork NSW to prioritise incident information releases in health as it does in other high-risk industries.**

Key theme 6: Management of patients with a high propensity for violence

There are some patients with a high propensity for violence. These patients are often very well-known and may have regular lengthy admissions to hospital or be residents in residential settings such as aged care or disability. They may require care and be extremely dangerous to those providing the care. It is unacceptable to expect our nurses, midwives and carers to sacrifice themselves to provide this care.

Patients with a high propensity for violence must be flagged and have clearly documented management plans that can be immediately implemented on presentation

Patients with a high propensity for violence need care in specialised environments, that are physically designed for staff safety and have high staff patient ratios, and well trained and well supported staff.

RECOMMENDATIONS

1. **Specialty environments for high-risk patient cohorts:** more mental haealth intensive care beds (in every LHD); more specialty units like the PANDA (Psychiatric, Alcohol and Non-Prescription Drug Assessment) at St Vincent's hospital to divert intoxicated people from emergency departments; more specialty dementia services for residential aged care.
2. **Better support for NDIS providers to prevent breakdowns in care arrangements, and secondary NDIS accommodation of last resort available for when care arrangements break down.**
3. **Security staff in forensic environments.**
4. **Hospitals designed to have appropriate bed spaces in every hospital to manage high risk inpatients.**
5. **Information sharing between agencies.** Better systems for sharing information about occupational violence risk between hospitals and other relevant agencies including residential aged care providers and NDIS providers, community health, patient transport, ambulance and police. With the privatisation of disability care and dismantling of ADAC, effective systems for handover of relevant information, and joint development of management plans have been lost.
6. **File flagging of patients with a history of violence along with documented risk management plans ready for future presentations.**
7. **Specialty environments for patients with high propensity for violence.** Over recent years, there have been significant changes to legislation, policy and clinical practice around the use of "restrictive practices". While the intent of these changes is admirable, unfortunately the reality is that restrictive practices are implemented to ensure the safety of workers providing care to high-risk patients. Reducing the ability to use restrictive practices has not been accompanied by other improved risk controls (such as increased staffing levels or more secure physical environments) reducing capacity to manage risk. There has been no review to determine the impact of these changes on the safety of workers caring for high-risk patients.

Key theme 7: Health facility design

We are seeing an emphasis on hospital design that preferences the patient experience over the safety of workers – for example the construction of open nurses' stations in high-risk settings such as acute mental health.

For hospitals, the Australasian Health Facility Guidelines need to be amended to prioritise the safety of workers, importantly the guidelines must require enclosed nurses' stations in high-risk wards/units.

In residential care environments the desire for a home-like environment cannot take precedence over worker safety, residential care environments are workplaces as well as homes and workers have a right to a safe workplace.

There is a need to significantly improve consultation on facility renovations or new facilities, especially at the early stages of project planning with workers and their representatives. Consulting after something has already been built results in dangerous workplaces or large delays in opening and additional expense in rectifying mistakes.

RECOMMENDATIONS

1. **Review of hospital and residential care design standards to ensure staff safety is a key priority, including enclosed nurses' stations in high-risk environments.**
2. **Consultation with workers and their representatives early in the design phase and continuing.**

> We are facing increasing violence and aggression, we receive training to manage but simultaneously are being told to not use any restrictive practices e.g. restraint & seclusion, feeling we will be criticised if we do & thus disempowered. Nurses with 20+ years' experience feel walking on eggshells as seclusion & restraint data now public & minimising this seems all the hospital cares about, over and above staff mental & physical care, or trauma and impact of care on other patients, from not assertively managing incidents. **Registered Nurse, NSW Health**

Key theme 8: System wide consultation and coordination

SafeWork NSW has been coordinating a committee looking into occupational violence in hospitals for several years. While this committee has done some admirable work, unfortunately this has largely not seen significant changes in industry practice, and rates of violence have continued to increase.

A statewide plan for addressing occupational violence in health must be developed and signed off by the relevant Ministers, and a taskforce established with oversight for the implementation of the plan, and regular report back on progress against the plan to Ministers.

There must be more centralised coordination around violence prevention in the public sector from the Ministry of Health as leaving each Local Health District to determine how to address these matters is not working, with a committee involving all health unions and regular report back to relevant Ministers.

At a facility level, each facility should have an occupational violence prevention plan specific to their site and focused on pro-active measures to eliminate risk of harm from violence. These plans should be developed and overseen by committees that include workers and their representatives, who must be provided with all relevant information about incidents to assist with their work.

RECOMMENDATIONS

1. **Statewide plan signed off by all relevant Ministers.**
2. **Statewide inter-agency violence prevention taskforce with NSWNMA to oversee implementation of recommendations.**
3. **More centralised coordination in the public sector.**
4. **Facility level occupational violence prevention plans and committees with worker representation.**

Key theme 9: Broader public attitudes towards healthcare workers

Broader community attitudes towards healthcare workers play a significant role in shaping the frequency and severity of occupational violence. Normalisation of aggression, heightened frustration with health systems, and a lack of understanding of the pressures facing staff all contribute to an environment where abusive behaviour is more readily directed at workers.

A coordinated, evidence based public awareness campaign is needed to reset expectations about respectful behaviour in healthcare settings, reinforce that violence and aggression towards healthcare workers is unacceptable, and highlight the human impact on the workforce and patient care. This campaign should be developed in genuine partnership with relevant unions and frontline workers to ensure messaging reflects real world risks, promotes shared responsibility, and supports broader prevention strategies within workplaces.

Additionally, where aggression is not linked to an underlying clinical condition such as a cognitive impairment, there must be genuine consequences for perpetrators of violence, including charges laid and withdrawal of services. While these options exist in policy in the public sector, they are rarely implemented.

RECOMMENDATIONS

1. **Public awareness campaign.**
2. **Consequences for perpetrators.**

Occupational Violence: has no place in my workplace

Report into the experiences of nurses and midwives in NSW

NSW Nurses and Midwives' Association
Australian Nursing and Midwifery Federation NSW Branch

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The NSW Nurses and Midwives' Association acknowledges the Gadigal of the Eora Nation, the traditional custodians of this land and we pay our respects to the Elders both past and present.