

Victorian taskforce on violence in nursing

Final report

November 2005

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Letter from the chair

Hon Bronwyn Pike MP
Minister for Health
555 Collins Street
Melbourne Victoria 3000

Dear Minister,

It is my pleasure to submit for your consideration the Report of the Victorian Taskforce on Violence in Nursing.

Health care professionals are frequently exposed to occupational violence and bullying. Australian and international research indicates that nurses, who are often the first point of contact with the public in our health system, experience high levels of occupational violence, particularly nurses involved in direct clinical care. Occupational violence and aggression is directed towards nurses from clients, clients' relatives and visitors. Nurses are also exposed to bullying within the workplace from other health professionals, supervisors and from their nursing peers.

This problem is not unique to Victoria and studies have shown that it is a problem experienced by nurses and health professionals across Australia and the world.

Nurses are a highly valued and vital component of the health workforce and the consequences of occupational violence are significant. In addition to the obvious physical, emotional and psychological consequences for the nurse, the broader impact on health services are considerable.

The Victorian Taskforce on Violence in Nursing was asked to identify and review existing systems, procedures and policies in place in Victorian health services and to recommend strategies to reduce the incidence of violence. The taskforce members have extensive and diverse knowledge and experience in the Victorian health sector, and have made an extremely valuable contribution to the development of strategies to address the problem.

The taskforce found that a significant barrier to addressing nurse violence is a lack of clear and consistent definitions and underreporting. Themes emerged during the work of the taskforce that were common to the understanding and approach to addressing the problem of violence, aggression and bullying. Themes included the impact of organisational culture and the importance of education and training.

Victorian health services do have in place a range of strategies and policies to address occupational violence against nurses. However, in aiming to create a safer work culture and environment for nurses the committee has put forward recommendations aimed to improve the strategy and to address the problem in a more consistent and coordinated manner.



Maxine Morand MP

Chair Victorian Taskforce on Violence in Nursing

Taskforce membership and terms of reference

Taskforce Chair Maxine Morand MP – Member for Mount Waverley

The membership of the taskforce comprised the following representatives:

Ms Oonagh Barron, Project Officer representing **WorkSafe Victoria**

Ms Jennifer Bennie, Program Coordinator, Goulburn Valley TAFE, representing the **VET sector – Providers of Certificate IV in Nursing**

Ms Maxine Brockfield, Director of Nursing, Kyabram and District Health Services, representing the **Directors of Nursing – Rural Health**

Ms Bobbie Carroll, Executive Nurse/Midwife – Policy and Planning, Women’s and Children’s Health, representing the **Directors of Nursing – Metropolitan Health**

Ms June Dyson, Director of Nursing Services, Aged and Sub-Acute Care Bendigo, representing the **Director of Nursing – Sub Acute Health**

Ms Lisa Fitzpatrick, Secretary ANF (Victorian Branch), representing **Australian Nursing Federation (Victorian Branch)**

Mr John Forster, Psychiatric Liaison Nurse, Mental Health Clinical Service Unit and Nursing Services, Austin Health, representing **division 3 registered nurses**

Ms Robyn Gillis, Director for Public Sector and Community Services representing **WorkSafe Victoria** (to 21 May 2004)

Ms Denise Guppy, Professional Officer HACSU, representing **Health and Community Services Union**

Ms Mandy Heather, Director of Nursing, Bundoora Extended Care Centre, representing the **Royal College of Nursing Australia**

Professor Olga Kanitsaki, Professor and Head of School of Nursing, RMIT, representing the **Victorian Deans of Nursing**

Ms Maryann Lindsay, Industrial Officer HSUA, representing **Health Services Union**

Mr Iain McKinnon, Nurse Manager, Fairfield House Continuing Care, The Alfred, representing **division 1 registered nurses**

Ms Louise Milne-Roch, Chief Executive Officer, Nurses Board of Victoria, representing the **Nurses Board of Victoria**

Ms Jeanette Sdrinis, Co-ordinator, Occupational Health and Safety Unit, ANF (Victorian Branch), representing **Australian Nursing Federation (Victorian Branch)**

Mrs Patricia Sherwell, Kooweerup Regional Health Service, representing **division 2 registered nurses**

Sen Serg David Short, Community Consultation and Crime Prevention, representing **Victoria Police**

Mr Chris Steinfort, Human Resources Manager, Affinity Health (from 25 September 2004) representing the **private sector**

Ms Nicole Waldron, Operations Manager/Director of Nursing, Private Hospital, La Trobe Medical Centre (to 25 June 2004) representing **Directors of Nursing – private sector**

Ms Marnie Williams, A/Director for Public Sector and Community Services (from 25 June 2004) representing **WorkSafe Victoria**

Ms Christina Wilson, Human Resource Director, Peter MacCallum Cancer Institute, representing **Human Resource Directors in health services**

Representatives from the Department of Human Services

Ms Maree Cameron, Manager Quality Improvement Unit, **Rural and Regional Health and Aged Care, Department of Human Services**

Ms Elizabeth Crowe, Project Officer/Secretariat, (to 21 May 2004) representing the **Nurse Policy Branch, Department of Human Services**

Ms Trish Dito, Project Officer/Secretariat, Nurse Policy Branch, (from 25 June 2004) representing the **Nurse Policy Branch, Department of Human Services**

Ms Miranda Fraser-Adams, Manager, Nurse Policy Branch, representing the **Nurse Policy Branch, Department of Human Services**

Dr Margaret Grigg, Senior Nurse Advisor (from 17 September 2004), representing the **Mental Health Branch, Department of Human Services**

Mr Steven McConchie, Senior Project Officer, Office of Chief Clinical Adviser, representing **Metropolitan Health and Aged Care, Department of Human Services**

Mr Greg Miller, A/Senior Nurse Adviser (to 6 August 2004), representing the **Mental Health Branch, Department of Human Services**

Ms Belinda Moyes, Principal Nurse Adviser, Director, Nurse Policy Branch, (to 5 March 2004), representing the **Nurse Policy Branch, Department of Human Services**

Ms Deborah Sykes Project Officer/Secretariat, Nurse Policy Branch, (from July 2005) representing the **Nurse Policy Branch, Department of Human Services**

Ms Kim Sykes, Principal Nurse Adviser, Director, Nurse Policy Branch (from 16 April 2004), representing the **Nurse Policy Branch, Department of Human Services**

Terms of reference

Aim

In line with the recommendations of the Nurse Recruitment and Retention Committee Final Report (May 2001), the taskforce will establish mechanisms that promote:

- (i) consistent reporting
- (ii) measurement
- (iii) monitoring and evaluating
- (iv) prevention and reduction of workplace violence.

Objectives

1. To define what constitutes workplace violence in nursing.
2. To review current approaches to the prevention and management of workplace violence in health care facilities:
 - i. directed at nurses by patients, visitors and others
 - ii. directed at nurses by co-workers.
3. To develop strategies that promote a reduction of, and consistent reporting of incidents of workplace violence in nursing and determine whether a coordinated approach would be of value.
4. To provide written reports to the Minister for Health.

Executive summary and recommendations

Health care professionals who are involved in direct clinical care and who are in frequent contact with the public are confronted with incidents of occupational violence and bullying. Among health care professionals, nurses are particularly exposed to occupational violence and bullying. Nurses have been identified as the occupational group most at risk of violence in the workplace in Australia (Mayhew 2000). Recent Australian research indicates that as many as 95 per cent of nurse respondents had experienced repeated episodes of verbal aggression in the year prior to the study, with 80 per cent reporting multiple episodes of physical aggression from patients (O'Connell et al. 2000).

Research consistently indicates that nurses under-report incidents of violence (Erickson & Williams-Evans 2000; Fry et al. 2002; Poster 1996). There are indications that nurses who are frequently exposed to violence are less likely to report the incident as they believe it is just part of the job, and the way an incident or near incident is reported itself differs across hospitals. There is a lack of consistent definition and measurement of violence and bullying against nurses, which contributes to a lack of understanding of the nature and prevalence of the problem.

The Minister for Health, the Hon Bronwyn Pike MP, established a taskforce in early 2004 to provide strategic advice to the Victorian Government regarding occupational violence and bullying against nurses. The Victorian Taskforce on Violence and Bullying was chaired by Maxine Morand, Member for Mount Waverley, who is a former nurse and research scientist.

Members of the taskforce possess in-depth knowledge and experience of the Victorian health sector, particularly concerning nursing matters. Representatives were brought together from division 1, 2 and 3 registered nurses, the Australian Nursing Federation (Vic Branch), Health Services Union, Health and Community Services Union, Victoria Police, Victorian Deans of Nursing, the Vocational Education and Training sector, human resource directors in health services, Nurses Board of Victoria, Royal College of Nursing Australia, Directors of Nursing, and WorkSafe Victoria.

The taskforce was asked to define occupational violence and bullying against nurses, develop approaches to the prevention and management of occupational violence and consider factors that impact on the provision and management of a safe environment for nurses, other health professionals and clients. The taskforce aims included developing strategies that promote a reduction and consistent reporting of incidents of occupational violence in nursing and to consider a coordinated approach to addressing these issues.

In order to fully examine key issues and recommend specific strategies to address occupational violence and bullying against nurses, the committee determined that four subcommittees should be convened. The four subcommittees reviewed and further refined the different aspects, definitions and potential strategies to approaching their specific area. They covered the areas of violence and aggression, bullying, education, and reporting tools. Each subcommittee undertook specific analysis and discussion to identify strategies.

The taskforce highlighted a number of themes as being crucial to preventing and managing violence and bullying in the nursing workplace. These themes were common to each of the areas analysed and are reflected in the recommendations.

Informing the taskforce

The Victorian Government initiated a comprehensive strategy to begin to address the issues of occupational violence and bullying in nursing. In 2002, the Department of Human Services provided funds to engage the University of Melbourne to undertake a research project, *Occupational violence in nursing: an analysis of the phenomenon of patient aggression and code grey/black in four Victorian hospitals*. The results of this project provide an insight into the prevalence and severity of violence within the Victorian health care sector.

A literature review was undertaken by the Nurse Policy Branch, Department of Human Services into violence and bullying in nursing; and through existing research, examine types, causes and systemic approaches for managing and preventing occupational violence and bullying.

The taskforce, through the Department of Human Services, conducted a survey of public health care facilities to ascertain the mechanisms currently in place for the reporting, prevention and management of incidents of occupational violence and bullying in nursing. The survey also provided information about support that is available for nurses following such incidents.

Themes

Organisational culture

Culture permeates every facet of organisations. Organisational culture is derived from implicit and explicit messages about what is considered to be acceptable behaviour in the workplace. Exposure to violence may have been seen as a fact of life by some nurses and therefore could have contributed to significant under-reporting of violent incidents. The message that violence is unacceptable and should not be tolerated should be a key part of policy statements adopted by organisations and advocated by senior management and throughout organisations. A positive culture needs to be supported by workplace policies, procedures, systems and processes to prevent or manage violent incidents. The emphasis should be on prompt, effective clinical management and compassionate care of the patient, while at the same time protecting the safety of staff and others. In addition, developing a person-centred workplace culture based on dignity, respect, anti-discrimination, equal opportunity and cooperation is an integral part of any strategy aimed at reducing bullying and violence in the workplace.

Preventing and managing occupational violence

Under occupational health and safety laws, all health care facilities are required to have in place strategies to proactively prevent and manage occupational violence. An occupational health and safety risk management framework, consistent with occupational health and safety legislation, WorkSafe guidelines and contemporary knowledge, will assist health care facilities to achieve legislative compliance.

Education

All levels of staff must be educated about how to prevent, manage and report violence in the workplace. They must be aware that violence and aggression is not acceptable. Education should be actively and openly supported by senior management and should be part of the induction program for all new staff. Education is only effective if it is part of a broader organisational approach.

Public awareness

As nurses work in many diverse settings and are exposed to a large cross-section of the community, it is important that the general public is educated about expectations of behaviour, including potential consequences of violent or abusive behaviour, while engaging with the various health settings. Consumers need to be informed about what is acceptable and unacceptable behaviour before they access a health care facility or come into contact with nurses.

Resources

Implementing strategies and actions to prevent and manage violence and aggression against nurses and other health workers will require a commitment of resources – money and time – across a range of areas. For strategies to be effective, those involved in the provision of health services, including the Department of Human Services and individual health care facilities, will need to commit resources to support strategies to prevent and manage violence and bullying in the workplace.

Definitions

The lack of consistent definitions of occupational violence has significant implications for identifying the nature and extent of work-related violence in the health care sector. The taskforce was clear that the health sector needs uniform definitions of occupational violence in order to adequately assess and address the issue. Classifying the various types of violence and developing a definition of occupational violence and aggression are important factors to promote consistency of application across the industry. Key themes emerged, including the need to incorporate the range of violent behaviours experienced by nurses, including verbal aggression and psychological abuse.

The taskforce identified a lack of consensus regarding what constitutes bullying in the workplace. However, the taskforce was very clear that bullying is a part of occupational violence. Unlike physical violence, which may be a one-off event, bullying is repeated and often escalates over time.

Organisational plan of action

The taskforce proposed that a well-developed plan of action endorsed by senior management is required in order to achieve a cultural shift within an organisation, from one that accepts violence and bullying as 'part of the job' to one that does not tolerate violence or bullying behaviours. To be effective, risk management needs to be incorporated into the culture of the organisation and become part of the overall philosophy, practices and business plans.

The taskforce found that a readily accessible, simple to implement reporting procedure will encourage reporting, as will prompt, sensitive and appropriate follow-up by all managers. In addition, any policy must be endorsed by the organisation, distributed throughout the workforce and displayed where employees can read it. Managers have an important role in assisting staff to manage and recover from an incident of violence and aggression.

This report and its strategies are aimed at supporting health facilities across the public and private sectors to provide a safe workplace where violence and bullying is not accepted. The taskforce has confidence that all health care facilities can adopt the recommendations of this report to provide a safer workplace for nurses and all health care workers.

Recommendations

Occupational violence and aggression

Recommendation 1

The Department of Human Services and health care facilities adopt a uniform definition of occupational violence consistent with the definition and classifications developed by the Taskforce on Violence and Aggression Subcommittee in this report.

Recommendation 2

That the Department of Human Services and health care facilities adopt a policy statement that has key messages including:

- violence against nurses is unacceptable and must be proactively addressed
- there is not a culture of tolerance of violence in the workplace
- encouraging a culture of reporting amongst nurses.

Recommendation 3

That the Department of Human Services develops a framework for the prevention and management of occupational violence and aggression for adoption in Victorian health care settings and that this work be informed by:

- NSW Health, *Zero tolerance to violence in the NSW health workplace – policy framework guidelines* (2003)
- Department of Human Services, *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services* (2004).

Recommendation 4

That the Department of Human Services will:

- establish a hierarchy of response guidelines for a uniform system of sanctions in response to violence and aggression against nurses. The response should include warning systems, contracts of acceptable behaviour, and the enforcement of sanctions/consequences.
- develop guidelines that include the duty of care and legal responsibilities of all parties. Case study examples should be provided to highlight the issues to be considered in determining strategies and responses to occupational violence and aggression against nurses in the workplace.

Recommendation 5

That the Department of Human Services develops education and awareness programs for the community, police and the judiciary, to promote a greater understanding of occupational violence in nursing.

Recommendation 6

That the Department of Human Services requests the Department of Justice to consider the issues of occupational violence in nursing and consider legislative mechanisms and strategies that will improve the safety of nurses and other health care workers.

Recommendation 7

That the Department of Human Services consider the development of statewide guidelines with respect to weapons and dangerous articles within the health care setting. This may include introducing legislation or guidelines in health services that relate to the search and removal of weapons and/or dangerous articles, the storage, disposal or return of such articles, and to allow police to receive and hold such property, regardless of whether it is to be used as evidence in relation to a crime or that charges are to be laid. This matter should be considered together with other legislative issues referred to the Department of Justice.

Recommendation 8

That the Victorian Government and health services develop, pilot and implement a public awareness campaign that:

- promotes an expectation of behaviour and consequences for unacceptable violence and aggression
- clearly states the message that violence towards nurses is unacceptable.

Recommendation 9

That the Department of Human Services, in consultation with health services, adapts for broad use: *The industry occupational health and safety interim standards for preventing and managing of occupational violence and aggression in Victorian mental health services* (Department of Human Services 2004) for post-incident management.

Recommendation 10

That the Department of Human Services introduces into Victorian health services, standardised Code Grey (violence and aggression emergency) and Code Black response (armed threat).

Recommendation 11

All health organisations will:

- establish an aggression management reference group which will be responsible for developing policies and procedures around the management of aggressive incidents, primarily through a clinically led aggression management team
- ensure that all clinical areas undertake a risk assessment and give consideration to a number of strategies, including the development of guidelines to address the needs of each different setting and reviewing the need for appropriately trained security personnel
- establish, in all high-risk departments, security measures that include a response by staff who are trained in the prevention and management of violence and aggression during hours of operation
- consider how to address the broader issues of physical restraint and seclusion within non-designated mental health areas
- develop guidelines for emergency responses during operating hours in smaller health facilities or for those nurses working in community, rural and remote settings.

Recommendation 12

That the Victorian Government considers procedures for reporting to police, laying charges and prosecutions, including the potential for legislation for nurses similar to that developed for ambulance officers. (A Memorandum of Understanding, similar to that adopted between NSW Health and NSW Police, is a useful reference.)

Recommendation 13

The Department of Human Services and health services commit resources to support:

- the implementation of strategies to prevent and manage violence and aggression against nurses and other health workers
- strategies developed in areas that include design, personnel, equipment, publications and training
- the evaluation of the strategies following their implementation
- preliminary analysis of the data set and strategies 12 months after implementation and a comprehensive evaluation of the same after three years.

Recommendation 14

The principles of affecting behaviour through environmental design and management should be applied to all future building development and refurbishment.

Education

Recommendation 15

Health services develop a clear statement of expected behaviour, outlining acceptable and unacceptable behaviour, for both staff and consumers.

Recommendation 16

The Department of Human Services develops guidelines to ensure a minimum standard of education is provided to all nurses.

Recommendation 17

Health services:

- provide education and training for nurses to prevent and manage occupational violence and bullying. The education and training will be consistent with DHS guidelines and address the key elements identified by the Education Subcommittee, including prevention and management of occupational violence and bullying
- provide nurses, including part-time and casual bank nurses and other health care employees, with education and training as part of the orientation process to a new organisation
- ensure all nurses in the workplace undertake continuing education and training programs that address occupational violence and bullying at least on an annual basis
- provide additional specific training to staff working in identified high risk areas
- maintain a database of all nurses who have completed education, and develop systems to ensure the adequate education of casually employed nurses in relation to occupational violence and bullying and that these systems meet the requirements of the *Occupational Health and Safety Act 2004*.

Recommendation 18

Providers of agency nurses ensure nurses receive education and training in the prevention and management of occupational violence and bullying prior to undertaking casual employment with any health care facility. This education is to include all key elements identified as a minimum educational and training requirement.

Recommendation 19

Health services develop specific education programs for all managers, covering:

- the impact of occupational violence and bullying on the workforce
- the organisation's expectations of the managers, inclusive of policy and procedures for prevention and management of incidents
- the importance of supporting staff to report incidents
- the obligations of the manager
- techniques and available support mechanisms for staff and managers.

Recommendation 20

That the Minister for Health requests:

- the Nurses Board of Victoria to require, through accreditation processes, nursing courses leading to registration to include OH&S principles, particularly those that address occupational violence and bullying
- the Australian Nursing and Midwifery Council to consider the development of competency standards pertaining to OH&S principles and require the inclusion of OH&S components of occupational violence and bullying.

Recommendation 21

Higher education providers and health services create a mechanism for monitoring and evaluating the prevalence of bullying and violence experienced by students in the workplace during clinical placements.

Bullying

Recommendation 22

That the Department of Human Services and health services accept an agreed definition of bullying that is aligned with the WorkSafe definition and use it consistently.

Recommendation 23

That health services establish consistent management strategies that include:

- clear organisational policy with 'safe' reporting to an objective, senior, listener
- timely and consistent response from management
- support for realistic outcomes.

Recommendation 24

That health services establish management education strategies that:

- explore and articulate mechanisms to assist organisations to manage situations where, despite investigation, no clear resolution to bullying is obvious and/or possible
- emphasise positive behaviours in the workplace
- raise nurses' awareness of the differences between bullying behaviours and legitimate business practices, for example, legitimate and reasonable performance management and organisational change
- minimise ambiguity so that bullies and victims are aware of the subtleties and trivialities that comprise bullying in nursing.

Recommendation 25

That the Department of Human Services develops and disseminates a statewide 'tool kit' containing bullying prevention strategies (adapted from *WorkSafe Victoria Guidance Note 2003*) that:

- includes examples of policies, procedures and suggestions for culture change
- ensures consistency in the approach to managing bullying
- provides a useful resource that contributes to quality improvement processes
- includes readily accessible policies, procedures, case studies and customised pamphlets for nurses
- uses innovative ways to convey messages about bullying behaviours that are relevant to nursing.

Recommendation 26

That the Department of Human Services:

- promotes management of bullying in accordance with the WorkSafe Victoria *Bullying and Violence at Work Guidance Note* (February 2003)
- further researches nursing culture to identify key factors that may trigger bullying behaviour by nurses, thereby enabling a more targeted approach to prevention
- considers sponsorship of innovative strategies to prevent bullying and disseminate ideas and outcomes to health services.

Reporting tools

Recommendation 27

That the Department of Human Services:

- develops a statewide minimum data set that includes key critical fields, with reference to the critical fields identified by the Reporting Tools Subcommittee
- develops guidelines to assist health services to understand the significance of data collection related to violence and bullying and to collect critical field information
- pilots the data set across a sample of Victorian health services prior to implementation.

Recommendation 28

All health services submit a minimum data set to the Department of Human Services on a biannual basis.

Recommendation 29

That the Department of Human Services makes aggregated local data results available to health services and WorkSafe Victoria to compare local prevalence and nature of events and create statewide benchmarking.

Part 1. The context

Introduction

An emerging global trend in the health care industry is the increasing incidence of occupational violence and bullying within the workplace.

Health care professionals who are involved in direct clinical care and who are in frequent contact with the public are increasingly confronted with incidents of occupational violence and bullying. Among health care professionals, nurses are particularly exposed to occupational violence and bullying. This may be due to a number of factors, including nurses are often the first point of contact with the public, such as the triage nurse in the emergency department; and they often have more contact with inpatients and the public than most other health care workers.

Some recent Australian research indicates that as many 95 per cent of nurse respondents had experienced repeated episodes of verbal aggression in the year prior to the study, with 80 per cent reporting multiple episodes of physical aggression from patients (O'Connell et al. 2000).

Evidence shows that a nurse's sense of wellbeing can affect the quality of care given to patients. In addition, there may be a direct link between episodes of violence towards nurses and absenteeism, poor recruitment and retention. Both the tangible effects of occupational violence and the intangible effects, such as motivation and commitment, loyalty to enterprise, creativity, working climate, openness to innovation, knowledge building and learning, and emotional and social consequences, result in significant financial implications for health services. Not only is there increased nurse sickness and absence, but evidence suggests that decreased staff effectiveness also has an economic consequence.

The financial implications are potentially significant for the industry and the government, and include the impact on workers compensation and insurance premium costs for health care agencies, and the administrative costs associated with managing injuries, rehabilitation and return to work. Other legal and financial implications relate to potential prosecutions under the Occupational Health and Safety Act, and the impact on the reputation of the health care agency. Recent changes to the Occupational Health and Safety Act mean that individual senior officers of organisations and employees may now also be prosecuted, imprisoned and/or fined.

The Department of Human Services values health care workers and strongly denounces occupational violence and bullying. The Victorian Government is committed to preventing and reducing occupational violence and bullying and this taskforce has been established to recommend a range of proactive interventions to assist in providing a safe environment for nurses, other health professionals and clients.

Definitions

The taskforce found that one of the most significant problems with understanding and preventing occupational violence is the lack of consistent definitions. Without consistent definitions, the true nature, extent and impact of work-related violence and bullying is not fully understood within the health care sector. A consistent theme in the literature is that where there is a lack of agreed definition, there is an inability to accurately measure the success of intervention.

The taskforce subcommittees devoted considerable time to defining behaviours and recommends the following definitions for adoption across the state.

Violence

Occupational violence and aggression is defined as any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of, their employment (adapted *WorkSafe Guidance Note Feb 2003*).

Within this definition:

- **'threat'** means a statement or behaviour that causes a person to believe they are in danger of being physically attacked; it may involve an actual or implied threat to safety, health or wellbeing
- **'physical attack'** means the direct or indirect application of force by a person to the body of, or clothing or equipment worn by, another person, where that application creates a risk to health and safety.

Neither intent nor ability to carry out the threat is relevant, the key issue is that the behaviour creates a risk to health and safety.

Examples of violence

Examples of occupational violence and aggression include, but are not limited to, verbal, physical or psychological abuse, punching, scratching, biting, grabbing, pushing, threats, attack with a weapon, throwing objects/furniture, sexual harassment or assault, and any form of indecent physical contact.

Classification

To assist with prevention approaches, occupational violence and aggression can be separated into three basic classifications:

- **client-initiated violence** – where a client¹ or a client’s family member/friend/guardian can be the source of the violence
- **internal violence** – where someone who works under the direction of an organisation is the source of the behaviour, for example, employee-to-employee, contractor to employee, supervisor to employee
- **external violence** – where violence is perpetrated by persons with no legitimate relationship to the organisation, for example, robbery.

Bullying

WorkSafe Victoria uses the following definition:

Workplace bullying is defined as **repeated, unreasonable behaviour** directed toward an employee or group of employees, that creates **a risk to health and safety** (*Prevention of bullying and violence at work Guidance Note 2003, p. 6*).

Within this definition:

- **‘unreasonable behaviour’** means behaviour that a reasonable person, having regard to all the circumstances, would expect to victimise, humiliate, undermine or threaten
- **‘behaviour’** includes actions of individuals or of a group, and may involve using a system of work as a means of victimising, humiliating, undermining or threatening
- **‘risk to health and safety’** includes risk to mental or physical health of the employee.

There is a lack of consensus regarding what constitutes workplace bullying. Most definitions share three elements:

1. Bullying is defined in terms of **its effect on the recipient** not the intention of the bully, thus it is subject to variations in personal perception. In respect to this element, the bullying actions and practices are clearly unwanted by the victim.
2. There must be **a negative effect** on the victim, which creates a risk to their health and safety. The bullying acts clearly cause the victim to feel harassed, humiliated, offended or distressed and/or interfere with their job performance and/or make an unpleasant working environment. In other words, there is a risk to the mental and/or physical health or wellbeing of the employee as a result of the bullying.
3. The bullying behaviour **must be repeated** or occurring as part of a pattern of behaviour. A one-off incident of verbal abuse or harassment is not considered to be bullying, especially if the victim’s performance was not affected.

Examples of bullying

Bullying behaviours include, but are not limited to:

- verbal abuse, physical attacks, social isolation, excluding or isolating employees, psychological harassment, intimidation, devaluation of one’s work and efforts, teasing, insulting, ridiculing, assigning meaningless tasks unrelated to the job, giving employees impossible assignments, deliberately changing work rosters to inconvenience particular employees, and deliberately withholding information that is vital for effective work performance
- practical jokes, being sworn at, being insulted, being excessively supervised, being constantly criticised, being put down in public, spreading rumours, being overloaded with work or not given enough work to do, not getting the information needed to do a job, personal effects or work equipment being damaged, and being threatened with termination.

¹ Client includes people who: have a commercial relationship with an organisation; are in the care or custody of an organisation; must legally submit to inspection by an organisation; use or are seeking to use the services of an organisation.

Code Grey and Code Black events

Many Victorian health care agencies have instituted a system for identifying and responding to violent or threatening events.

- Code Grey events are threatening events, where there is potential for violence or escalation.
- Code Black events are serious events of violence.

In 2003, the University of Melbourne undertook a study that explored occupational violence in nursing by examining events in which nurses activate a hospital-wide security response to potential or actual violence (Code Black/Code Grey events). One of its findings was that there was considerable variability in defining responses to violent behaviour across the four participating organisations.

The research proposed that uniform collection of hospital-wide security responses that accurately describe the event in terms of both its clinical and security features would be of benefit.

Minimum information collected in respect to code responses should include:

- response type
- date
- time called
- time called down
- location
- age of aggressor
- gender of aggressor
- type of aggressor (client of the service or other)
- number and appointment level of response team members
- a description of the type of behaviour demonstrated by the aggressor that resulted in the activation of the team
- other factors which contributed to the behaviour/incident.

Taskforce subcommittees

Four subcommittees were convened by the taskforce to examine key issues and recommend strategies to eliminate and/or manage occupational violence and bullying. The four subcommittees were:

- Violence and aggression
- Education
- Bullying
- Reporting tools

Each subcommittee investigated current procedures, definitions and management issues in relation to occupational violence and bullying against nurses. The aims of the subcommittees were to establish mechanisms that promote monitoring and evaluation of strategies to prevent and reduce bullying in the workplace.

Violence and Aggression Subcommittee

Key objectives included:

- classifying the various types of violence and aggression, as defined in the WorkSafe Guidance Note 2003, experienced by nurses in the workplace
- recommending strategies to prevent and manage the various types of workplace violence and aggression
- recommending guidelines for organisations to use with respect to:
 - policy development
 - implementation
 - risk management/monitoring systems
- recommending strategies to increase awareness of undergraduate students and registered nurses of issues associated with occupational violence.

Members of the violence and aggression subcommittee:

Name	Area of representation
Mr John Forster (Chair)	Division 3 registered nurse
Ms Oonagh Barron	WorkSafe Victoria
Ms Trish Dito	Nurse Policy Branch, Department of Human Services
Ms Denise Guppy	Health and Community Services Union (HACSU)
Mr Steven McConchie	Metropolitan Health, Department of Human Services
Mr Iain McKinnon	Division 1 registered nurse
Ms Jeanette Sdrinis	Australian Nursing Federation (Vic Branch)
Sen Sgt David Short	Victoria Police

Education Subcommittee

Key objectives included developing and implementing a framework for use by health services and education providers that:

- recommends educational strategies to prevent occupational violence and bullying in the workplace
- recommends educational strategies to reduce the impact of violence and bullying in the workplace
- recommends educational strategies to ensure consistent reporting of incidents or potential incidents of occupational violence and bullying
- recommends strategies to increase awareness amongst undergraduate nursing students and registered nurses concerning occupational violence and bullying.

Members of the education subcommittee:

Name	Area of representation
Ms Louise Milne-Roch (Chair)	Nurses Board Victoria
Dr Margaret Grigg	Mental Health Branch, Department of Human Services
Ms Lisa Fitzpatrick	Australian Nursing Federation, (Vic Branch)
Ms Trish Dito	Nurse Policy Branch, Department of Human Services
Professor Olga Kanitsaki	Victorian Deans of Nursing and Midwifery
Ms Jennifer Bennie	Vocational education and training (VET) sector
Mr John Forster	Division 3 registered nurse

Bullying Subcommittee

Key objectives included:

- classifying the various types of bullying, as defined in the Worksafe Guidance Note, experienced by nurses in the workplace
- recommending strategies to prevent and manage bullying in the workplace
- recommending guidelines for use by organisations with respect to:
 - policy development
 - implementation
 - risk management/monitoring systems
- recommending strategies to increase awareness of undergraduate nursing students and registered nurses of issues associated with bullying.

Members of the bullying subcommittee:

Name	Area of representation
Ms Bobbie Carroll (Chair)	Director of Nursing, Metro Health
Ms Maxine Brockfield	Director of Nursing, Rural Health
Ms June Dyson	Director of Nursing, Aged and Sub-Acute Care
Ms Christina Wilson	Health Services Human Resource Directors
Ms Maryanne Lindsay	Health Services Union of Australia (HSUA)
Ms Miranda Adams	Nurse Policy Branch, Department of Human Services
Ms Trish Dito	Nurse Policy Branch, Department of Human Services

Reporting Tools Subcommittee

Key objectives included a reporting framework for use by health services and education providers that:

- facilitates consistent statewide reporting of incidents and potential incidents of occupational violence and bullying as defined in the Worksafe Guidance Note
- facilitates standardised data collection and analysis of incidents of occupational violence and bullying
- provides a mechanism to monitor the impact of strategies to prevent incidents of occupational violence and bullying.

Members of the reporting tools subcommittee:

Name	Area of representation
Ms Mandy Heather (Chair)	Royal College of Nursing Australia
Ms Jeanette Sdrinis	Australian Nursing Federation (Vic Branch)
Ms Maree Cameron	Rural and Regional Health and Aged Care, Department of Human Services
Ms Kim Sykes	Nurse Policy Branch, Department of Human Services
Ms Patricia Sherwell	Division 2 registered nurse
Mr Chris Steinfort	Private Sector – Health Services
Mr Andrew Oates	Nurse Policy Branch, Department of Human Services
Ms Trish Dito	Nurse Policy Branch, Department of Human Services

Taskforce report

This final report of the taskforce provides a background to the issue of violence and aggression in the workforce through the literature review, research and survey findings. It outlines the work undertaken by the taskforce and presents an analysis of key issues and recommended strategies and actions to prevent and manage violence and aggression in the nursing workplace.

This report and its recommendations have been prepared for the Minister for Health, the Hon Bronwyn Pike MP, for consideration and to inform health services in the development and implementation of strategies at a local level.

Victorian legislative framework

Strategies to prevent and manage occupational violence and aggression need to reflect and comply with relevant legislation and standards that relate to the health care sector specifically and to the workplace generally.

Employers and employees have responsibilities under legislation, including responsibilities relating to each other as well as responsibilities to their clients and patients.

The most relevant Acts related to the regulation of the health and safety of Victorian nurses are the *Occupational Health and Safety Act* and the *Accident Compensation Act*.

Occupational health and safety legislation

The Victorian *Occupational Health and Safety Act 2004* is the main legislation which deals with health, safety and welfare in the workplace. The objects of the Act are:

- to secure the health, safety and welfare of employees and other persons at work
- to eliminate, at the source, risks to the health, safety or welfare of employees and other persons at work
- to ensure that the health and safety of members of the public is not placed at risk by the conduct of undertakings by employers and self-employed persons
- to provide for the involvement of employees, employers, and organisations representing those persons, in the formulation and implementation of health, safety and welfare standards.

The principles of health and safety protection set out in the Act are:

- employees, other persons at work and members of the public be given the highest level of protection against risks to their health and safety that is reasonably practicable in the circumstances
- persons who control or manage matters that give rise or may give rise to risks to health or safety are responsible for eliminating or reducing those risks so far as is reasonably practicable
- employers and self-employed persons should be proactive and take all reasonably practicable measures to ensure health and safety at workplaces and in the conduct of undertakings
- employers and employees should exchange information and ideas about risks to health and safety and measures that can be taken to eliminate or reduce those risks
- employees are entitled, and should be encouraged, to be represented in relation to health and safety issues.

The Act requires employers to, so far as is reasonably practicable, provide and maintain for employees a working environment that is safe and without risks to health.

Accident compensation legislation

The *Accident Compensation Act 1985* is the legislation which deals with Victoria's WorkCover compensation system.

The objects of this Act are:

- to reduce the incidence of accidents and diseases in the workplace
- to make provision for the effective occupational rehabilitation of injured workers and their early return to work
- to increase the provision of suitable employment to workers who are injured to enable their early return to work
- to provide adequate and just compensation to injured workers
- to ensure workers compensation costs are contained so as to minimise the burden on Victorian businesses
- to establish incentives that are conducive to efficiency and discourage abuse
- to enhance flexibility in the system and allow adaptation to the particular needs of disparate work situations
- to establish and maintain a fully-funded scheme
- in this context, to improve the health and safety of persons at work and reduce the social and economic costs to the Victorian community of accident compensation.

WorkCover compensation is a statutory, no-fault, compulsory insurance scheme. Employers, where required, must take out a WorkCover insurance policy to insure themselves against compensation claims for workplace injuries and diseases. The scheme seeks to insure employers against the impact of economic loss caused through injury to workers.

The benefit to workers is that the scheme is a 'no fault' scheme where the injured employee does not have to prove injury arose out of the negligence of one party or another. All workers (as defined by the statute) are able to access the system if they meet the appropriate criteria, and have access to the benefits as described in the *Accident Compensation Act 1985*.

Employees are entitled to WorkCover benefits if they suffer a work-related injury or disease. If an employee is unable to perform their normal duties because of a work-related injury, the employee may be entitled to weekly benefits. Weekly benefits are based on an employee's rate of pay for the number of hours normally worked per week. WorkCover will pay the reasonable costs of medical and like services an employee may require due to work-related injury or disease. Only services specifically provided for in the Act, or approved by WorkCover under the Act, can be paid.

The Accident Compensation Act requires employers to have:

- an occupational rehabilitation program
- an individual return to work plan for injured workers
- a risk management program.

Part 2. Research

Literature review

The Department of Human Services, Nurse Policy Branch undertook an extensive literature review in June 2003. This literature review was used to inform the subcommittees of the Victorian Taskforce on Violence in Nursing.

Research in Australia and other countries indicates that nurses experience high levels of occupational violence. This violence is directed toward them from patients, patients' relatives and visitors, doctors, supervisors and from their nursing peers (Gray-Toft & Anderson 1981; Holden 1985; Lipscombe & Love 1992; O'Connell et al. 2000; Farrell 1999; Lam 2002).

Nurses have always known that their workplaces are dangerous but most seem to accept violence 'as part of the job' (Fry et al. 2002; Lyneham 2002; Poster 1996). Recent Australian research indicates, however, that this already serious problem is worsening. A study by O'Connell et al. (2000), for example, found that 95 per cent of nurse respondents had experienced repeated episodes of verbal aggression in the year prior to the study, with 80 per cent reporting multiple episodes of physical aggression during the same period. Usually, high rates of occupational violence such as these are associated with nurses who work in emergency departments (Lyneham 2002) and psychiatric settings (Fry et al. 2002; Owen et al. 1998); however, the nurses in this study were recruited from medical/surgical and aged care wards.

Another cross-sectional survey of nurses from Australian hospitals by Lam (2002) found that 62.1 per cent of respondents had been exposed to at least one incident of patient aggression within the four weeks prior to the survey. In addition to these exceptionally high levels of occupational violence, some nurses report that they are being exposed to violence on a weekly or daily basis (ANF 2002; Farrell 1999; Lyneham 2000; O'Connell et al. 2000). These and other studies (ANF 2002; Di Martino 2002) confirm that Australian nurses are particularly at risk of occupational violence and this risk exists independent of the setting in which they work.

The experiences of Australian nurses in regard to occupational violence reflect those of their overseas colleagues. Increasingly, international and cross-cultural studies are indicating that violence in the health care workplace is a global phenomenon (Di Martino 2002; Nolan et al. 2001; Poster 1996). According to the World Health Organisation (2002a), violence in the health care workplace crosses borders, cultures, work settings and occupational groups and is now an epidemic in all societies, including the developing world.

Nurses, however, tend to be more at risk of occupational violence than most other groups of health care workers. In the USA, for example, more violent acts were committed against nurses in the workplace between 1993 and 1999 than any other occupational group except for police officers (Bureau of Justice 2001). Similarly, in the UK, the *2000 British Crime Survey* (HOHSE 2001) found that nurses were in the highest risk category for assaults (second only to security and protective services) and for threats (fifth after public transport workers, security and protective services, other health care professionals and retail sale workers). This report also found that nurses are up to four times more likely to experience work-related violence and aggression than other workers.

There are a number of compelling reasons why managers, administrators, OH&S experts and the nursing profession would want to seek solutions to the problem of work-related violence in nursing. Firstly, nurses can be seriously injured or even killed as a result of being attacked at work. In recent times, nurses have been killed while on duty in the USA (Gilmore-Hall 2001), Gaza (McGreal 2003) and Pakistan (Asghar 2002). Secondly, nurses can experience significant psychological distress and depression as a result of the violence they experience in the workplace (Lam 2003; Whittington & Wykes 1992 & 1996). Other symptoms, such as fear, anger, headaches, sleeplessness and flashbacks are also commonly reported (Denton et al. 2000; Fry et al. 2002; Lyneham 2000; Mahoney 1991; O'Connell et al. 2000). Violence can also adversely affect a nurse's ability to interact with colleagues and patients, thus affecting the quality of care she or he provides (Arnetz & Arnetz 2001). Furthermore, there may be a direct link between episodes of violence towards nurses and absenteeism, poor recruitment and retention rates, and burnout (Denton et al. 2000; Di Martino 2002; Jackson et al. 2002).

Violent incidents in the workplace also have significant financial consequences for health care organisations. These may arise from increased sickness and absence, legal action brought by employees, or indirectly through decreased staff effectiveness (Di Martino 2002; Paterson, Leadbetter & Bowie 1999). Di Martino (2002) also calls attention to the negative impact of violence on intangible factors, such as company image, motivation and commitment, loyalty to enterprise, creativity, working climate, openness to innovation, knowledge building and learning.

Although there is some evidence that European countries are beginning to tackle the high levels of violence in the health care workplace (NAO 2003; NHS 2002a; EASHW 2002c; EASHW 2002d), there is no evidence in the published literature that this problem is being addressed in Australia. However, NSW Health, Australian Nursing Federation (Victorian Branch), and the Department of Human Services interim industry standards for mental health services, are just some who have developed policies and resources to prevent and manage occupational violence against nurses and other health care workers. While credible OH&S publications provide detailed information on preventing and controlling occupational violence in the health care sector (CAL/OSHA 1998; Mayhew & Chappell 2001b & 2001c; NIOSH 2002; OSHA 1998), and more nurses and nursing organisations have made recommendations in regard to occupational violence (ANA 2002; Beech 2001; Brown 2001; Dimond 2002; Distasio 2002; Gilmore-Hall 2001; Green 2000; ICN 2000 & 2001; ILO et al. 2002; Keely 2002; Sunderland 2001), there is little reporting on health care organisations or professionals who have implemented successful anti-violence programs. In other words, analysis of best practice is conspicuously absent in the literature.

This literature review provides a synthesis of the literature relating to occupational violence in nursing. It explores the nature and extent of occupational violence in nursing, in Australia and other countries, and examines methodological issues associated with collecting data on violence in nursing. The literature review offers an overview of the physical, emotional, biophysiological, cognitive and social impacts of occupational violence on nurses. The antecedents or circumstances that mediate occupational violence in nursing are outlined as well as the major findings and recommendations in regard to preventing and managing both client-initiated/relative violence and bullying in nursing.

Definitions and typologies of occupational violence

One of the most significant problems with understanding and preventing occupational violence is the lack of consistent definition (Leather 2002; Rippon 2000; Wykes 1994). Some OH&S organisations and researchers restrict their working definitions of occupational violence only to incidents that involve actual or attempted physical assault (NIOSH 2002; VWA 2003; Wright, Gray, Parkes & Gournay 2002). This means that other types of behaviour that may be considered by some people to be 'violent', such as bullying, verbal abuse and sexual harassment, are defined as separate phenomena or are not defined at all. At the other end of the scale are those who use definitions that are so broad that they do not distinguish between the different types of occupational violence (Arnetz, Arnetz & Petterson 1996; Nolan et al. 1999). Some researchers do not use a definition of violence or occupational violence in their research; they allow their subjects to define violence or describe acts of violence from their own personal perspective (Lyneham 2000). As demonstrated throughout this review, the lack of consistent definition of occupational violence has significant implications for identifying the nature and extent of work-related violence in the health care sector.

Another factor that obscures the research and discussion on occupational violence is the interchangeability of the terms 'violence' and 'aggression'. Some authors focus on aggression only while others attempt to clarify the differences between violence and aggression (Rippon, 2000). For the purpose of this review, the term 'aggression' is only used when an author or organisation makes a specific reference to it.

This review uses the following definition of occupational violence, that is, occupational violence includes:

incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health (ILO et al. 2002, p.3).

This definition implies that violence is more than acts of physical violence, such as homicide, assault and robbery. According to Perrone (1999), there are also subtle and insidious aspects which are far more prevalent and, therefore, constitute a greater threat to wellbeing. These other forms of violence include verbal abuse, bullying (or mobbing), harassment (especially sexual and racial harassment) and threats (ILO et al. 2002). The harm that may arise from these forms of violence should not be underestimated. According to Perrone (1999):

Such abuses are often systemic in nature and are ingrained in the very cultural fabric of certain enterprises. Their very pervasiveness makes these practices difficult to identify and hence address. Moreover, since the consequences of these forms of violence may not be immediate or tangible, they are often regarded as relatively innocuous, socially acceptable, and even good fun. Despite such perceptions, the consequences are just as real [as physical violence] and the potential for longer-term harm should not be underestimated (p.13).

Several authors have developed useful typologies to distinguish between the different forms and causes of occupational violence. Perrone's (1999) typology of occupational violence, for example, is outlined in Appendix B. This typology demonstrates that occupational violence ranges widely between the two extremes of homicide and passive aggression.

Another widely adopted typology is that proposed by the California Occupational Safety and Health Administration (CAL/OSHA 1998) (see Table 1).

Table 1: Typology of occupational violence (CAL/OSHA, 1998)

Type I: External violence	Where the assailant has no legitimate relationship to the workplace and the main object of the attack is cash or some other valuable commodity.
Type II: Client-initiated violence	Involves some form of assault by a person who is either the recipient or the object of a service provided by the affected workplace or the victim.
Type III: Internal violence	Where an assault is perpetrated by another employee, a supervisor, or an acquaintance of work

Mayhew and Chappell (2001a) point out a fourth 'systemic' type of violence that arises out of wider social and economic developments. This occurs when, due to economic pressures, organisations are required to restructure, downsize, reduce staff or increase performance. These changes contribute to a workplace culture that tolerates threatening behaviours. This form of violence has also been identified by a number of authors (Green 2000; ILO et al. 2002; Sunderland 2001).

Having acknowledged the difficulties associated with defining occupational violence, it is equally important to consider and define the various types of violence and violent behaviours that may occur in the workplace.

Physical violence

The ILO et al. (2002, p. 4) define physical violence as:

the use of physical force against another person or group that results in physical, sexual or psychological harm. It includes amongst others beating, slapping, stabbing, shooting, pushing, biting and pinching.

Typically, definitions of physical violence (in the context of occupational violence) are defined without consideration of the attacker's intent (Worksafe Victoria 2003). Thus, if a nurse is punched by a male patient with an acquired brain injury, the patient's act is still an act of physical violence even though he may not have made a conscious decision to do this.

Psychological violence

In the workplace, psychological violence is more common than physical violence (Di Martino 2002). The term 'psychological violence' (also referred to as emotional violence) encompasses all violent activities that are not classified as acts of physical violence. These include verbal abuse, neglect, omission, deprivation, bullying, mobbing, harassment, threats and intimidation. It is not uncommon for psychological violence and physical violence to occur concurrently (ILO et al. 2002).

ILO et al. (2002, p. 4) have defined psychological violence as:

the intentional use of power, including the threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, moral or social development. It includes verbal abuse, bullying/mobbing, harassment and threats.

Economic violence

Several authors refer to violent acts of an economic nature (Astrom et al. 2002; WHO 2002b). The WHO (2002b, p. 6) classifies economic violence as a type of collective violence which includes:

attacks by larger groups motivated by economic gain – such as attacks carried out with the purpose of disrupting economic activity, denying access to essential services, or creating economic division and fragmentation.

Although not commonplace, there is potential for this type of violence to occur. In addition, the literature indicates that both patient/outsider violence and internal violence may increasingly be linked to economic reforms in the health care sector (Flannery et al. 1997; Green 2000; ILO et al. 2002; Sunderland 2001).

The consequences of occupational violence

Whether or not a violent incident affects the health and wellbeing of a victim depends on the individual and the support they receive post-incident. A person's response to violence in the workplace will be mediated by their personality type, their learned mechanisms of responding and coping (both conscious and unconscious), and by the cultural and professional expectations under which they function (ICN 2000). The literature indicates, however, that a significant proportion of nurses will experience physical, emotional, biophysiological, cognitive or social problems as a result of work-related violence.

Physical consequences

The physical consequences of work-related violence include injuries to the head, facial areas, legs, chest and genitals and range from scratches, cuts, swellings, gouges, bites bruises, aches, pains, strains, concussion and fractures (ANF 2002; Fry et al. 2002). Long-term physical consequences of assault include chronic pain and changes in functional status (Findorff-Dennis et al. 1999). As mentioned, death is also an outcome of work-related violence. It should be noted that few assaults result in physical injury (Arnetz & Arnetz 2001; Wright et al. 2002; Whittington 1994), however, even assaults that do not cause physical harm may still result in severe psychological distress for the victim (Whittington 1994).

Emotional consequences

Nurses also experience an array of emotional responses following violent incidents. These include fear, anger, shock, disbelief, anxiety, worry, frustration, distress, hurt, helplessness, powerlessness, loss of control, loss of confidence, increased irritability, depression, sadness, confusion, embarrassment, guilt, annoyance (with self for not anticipating the incident), loss of self-esteem, emotional exhaustion and insecurity (Arnetz & Arnetz 2001; Atawneh et al. 2003; Denton et al. 2000; Einarsen et al. 1998; Findorff-Dennis et al. 1999; Fisher 2002; Fry et al. 2002; Lyneham 2000; Mahoney 1991; O'Connell et al. 2000). Of these, the most frequently reported emotional symptoms are fear, worry, anxiety, depression and anger.

While researchers have conducted a basic audit of nurses' emotional responses to occupational violence, others have examined these responses in more depth. Lam (2002), for example, investigated the effects of aggression on the psychological health of 314 nursing staff from NSW hospitals. He found that nearly 40 per cent of nurses who had experienced an aggressive patient in the four weeks prior to the survey could be classified as psychologically distressed. In addition, while 19.7 per cent of the subjects were mildly depressed, 8 per cent were moderately depressed and 1.6 per cent were severely depressed. Lam found that the odds of psychological distress for high exposure nurses was more than twice that of nurses with low exposure, and the odds of depression was more than 1.5 times. Whittington and Wykes (1992) found that psychiatric nurses developed a short-term anxiety reaction following assaults, even from assaults of a minor nature.

In addition, some of the nurse subjects reported symptoms that were consistent with a diagnosis of post-traumatic stress disorder. In a later study, Whittington and Wykes (1998) compared the effects of occupational violence on a group of UK psychiatric nurses who had been assaulted in the previous month with a control group who had not been assaulted in the previous month. They found that while most assaults were of a minor nature, two participants met the criteria for a diagnosis of post-traumatic stress disorder. Assaulted staff reported poorer mental health and anger control than control staff. The authors also found that psychological distress was higher following assaults resulting in physical injury. Staff who were repeatedly assaulted reported either significantly higher or significantly lower distress than those assaulted once.

Biophysiological consequences

Health care workers exposed to episodes of occupational violence may also experience biophysiological consequences. These include muscle tension, headaches, difficulty falling asleep, sleeplessness, change in appetite, lethargy, decreased sexual activity, and nausea and vomiting (Atawneh et al. 2003; Denton et al. 2000; Mahoney 1991). Of these, the most frequently reported symptoms appear to be sleep disturbances and headaches. *Cognitive* sequelae to violent incidents include flashbacks, nightmares and preoccupation with risks and safety (Atawneh et al. 2003; Fry et al. 2002).

Social consequences

The social consequences of occupational violence can be substantial. At the personal level, nurses' relationships with their children and spouses/partners may change as a result of being exposed to occupational violence (Mahoney 1991). This is referred to as the 'ripple' effect of work-related violence (Mayhew & Chappell 2001c). Nurses report taking sick leave

(O’Connell et al. 2000; RCN 2003) and using alcohol or drugs following episodes of occupational violence (O’Connell et al. 2000). Occupational violence has also been found to adversely affect nurses’ relationships with their patients. Staff who have been abused or assaulted tend to have negative attitudes towards their patients, which may compromise the quality of care that is given (Arnetz & Arnetz 2001) and play a role in precipitating future episodes of violence (Wright et al. 2002).

Nurses also report their job performance is adversely affected by experiences of violence (Mahoney 1991). At the organisational level, occupational violence in the health care sector has been associated with:

- decreased job satisfaction (Denton et al. 2000; Einarsen et al. 1998; Nolan et al. 1999; RCN 2003; Whittington et al. 1996)
- reduced workplace morale (Lipscomb & Love 1992; Lyneham 2000)
- increased requests for transfers to other areas (Mahoney 1991)
- absenteeism (Kivimaki et al. 2000; Lipscomb & Love 1992)
- loss of staff and increased rates of turnover (Lipscomb & Love 1992; Nabb 2000; O’Connell et al. 2000; RCN 2003)
- burnout (Einarsen et al. 1998; Lyneham 2000; O’Connell et al. 2000).

Economic consequences

It is highly likely that occupational violence amongst nurses has significant financial implications for health care organisations. These may arise from increased sickness and absence, legal action brought by employees or, more indirectly, through decreased staff effectiveness (Di Martino 2002; Paterson, Leadbetter & Bowie 1999). Di Martino (2002) also highlights the negative impact of violence on intangible factors, such as company image, motivation and commitment, loyalty to enterprise, creativity, working climate, openness to innovation, knowledge building and learning.

There appears to be a dearth of studies that have estimated the economic cost of occupational violence in the Australian health care sector. There is, however, research that has examined the economic impact of work-related assaults in various American industries, including the health care industry. McGovern et al. (2000) collected data on all incidents of physical assault that resulted in indemnity payments from the Minnesota Department of Labour and Industry Workers’ Compensation system in 1992. The researchers collected data on medical expenses, lost wages, legal fees, insurance, administrative expenses, lost fringe benefits and household production losses associated with all cases. They then estimated the present value of past losses from 1992 through to 1995 for all cases, and the future losses for cases still open in 1996. The total costs for 344 non-fatal work-related assaults were estimated at approximately \$US5.9 million (1996 dollars). The study does not take into account the costs associated with unreported incidents of physical assault or the costs associated with other types of occupational violence, such as verbal abuse, threats, sexual harassment and bullying.

A study commissioned by the ILO attempted to calculate the overall cost of violence and stress to society. The authors estimate that work-related stress and violence account for approximately 30 per cent of the overall costs of ill-health and accidents in the UK (Hoel, Sparks & Cooper 2001). The costs to society are related to medical costs and possible hospitalisation, benefits and welfare costs in connection with premature retirement, as well as potential loss of productive workers. On the basis of figures from a number of countries, the authors estimate that, in total, stress and violence at work may account for 1-3.5 per cent of Gross Domestic Product (GDP) (Hoel et al. 2001).

Antecedents to occupational violence in nursing

Occupational violence occurs in all work environments; however, some sectors are particularly exposed to violence, such as the health services sector and related social services (Cooper & Swanson 2002). Historically, the blame for much of the violence in the health care sector has been directed at patients, but they are only one contributing element (Leather 2002). A range of situational factors, including those related to patients, need to be considered if effective violence prevention strategies are to be implemented in the health care sector. Leather (2002) recommends that a social interactionist perspective be adopted when considering the nature and impact of occupational violence. When this perspective is applied to the workplace, ‘aggression and violence are seen as a possible outcome of negative interpersonal interactions, which are, in turn, embedded in the broader social and organisational context in which they occur’ (p. 13). This means that any factor that might influence the nature of the exchange between the parties involved should be considered. Such factors include the characteristics of the individuals involved, the nature and motive for the interaction, and the environment and socio-cultural context in which the interaction takes place (Leather 2002).

Characteristics of perpetrators

Patients who act violently towards nurses and other health care workers tend to have similar characteristics. These include a prior record of violent behaviours, a history of drug and alcohol abuse, mental health disorders, poor coping skills and social skills, and currently under significant stress (Di Martino 2002; Leather 2002; Mahoney 1991). Of these risk factors, the best predictor of violence is previous violent behaviour (CAL/OSHA 1998; Lindow & McGeorge 2000). In regard to patients with mental health conditions, those with organic brain disorders, schizophrenia and bipolar disorders and personality disorders, are more likely to assault employees (Blair as cited in Brickhouse 1997; Whittington et al. 1996). Whittington et al. (1996) also found that patients who are recovering from unconsciousness, for example, post-operatively or following self-poisoning, hypoxia during infections and acute brain trauma, are also more likely to assault health care staff. Male patients are the main instigators of violence against health care workers (Fry et al. 2002; Mahoney 1991; Saverimuttu & Lowe 2000). It has consistently been found in psychiatric settings that a comparatively small group of inpatients are disproportionately involved in violence (Brickhouse 1997). Many studies also report nurses being assaulted and abused by patients' relatives (Farrell 1999; Nolan et al. 2001; RCN 2003) but none appear to discuss personality-related factors that predispose relatives to doing this.

Characteristics of victims

Findings are inconsistent in relation to identifying those health care workers who are most at risk of work-related violence. While some studies show that health care workers with the least experience (such as students and first year graduates) appear to be at greater risk of violence (Astrom et al. 2002; Carmel & Hunter 1993; Grenade & Macdonald 1995; Lipscomb & Love 1992; Whittington et al. 1996), other studies, Whittington and Wykes (1994a) for example, found that inexperienced nurses had a relatively low risk of being assaulted. The Fry et al. (2002) study of Australian community mental health workers found workplace aggression to be highly correlated with the length of time in mental health. In spite of these mixed findings, it is clear that inexperienced nurses, particularly student nurses, frequently encounter client-initiated violence in the workplace (Fisher 2002; Grenade & Macdonald 1995).

Health care workers who spend more face-to-face time with patients and their relatives are also more likely to be assaulted, threatened or verbally abused (Astrom et al. 2002; Nolan et al. 1999; Whittington et al. 1996). Whittington et al. (1996), for example, found that providing direct patient care and treatments was a major precursor to staff being assaulted. This includes actual 'hands-on' delivery of treatment as well as verbal statements by the employee relating to the delivery of care (for example, questioning, persuading or arguing with the patient). Physical contact with a patient, such as that associated with dressing or moving a patient, taking blood glucose or giving an injection, was found to be an important trigger for aggression (Whittington et al. 1996).

As a consequence, nurses appear to be particularly at risk of encountering violence from patients (Leather 2002). Nurses spend more time with patients than other health care workers and are more intimately involved in care provision, especially in acute phases of illness. Therefore, there are more opportunities for patients to vent their aggression on nurses (Nolan et al. 1999).

Increasingly, researchers are finding that health care workers' ineffective communication styles or lack of awareness about factors that precipitate violence in patients are contributing to incidents of occupational violence. Whittington and Whykes (1996), for example, found that 86 per cent of 63 assaults by psychiatric patients on nurses were preceded by the assaulted nurse having delivered an aversive stimulus, for example, demanding something of a patient, refusing a request by the patient, or needing to physically touch the patient in some way. Bensley et al. (as cited in Leather 2002) report that restricting patients' smoking and access to the outdoors is recognised by patients and staff as an antecedent of violent and aggressive interactions. Encouraging or discouraging the movement of patients has also been found to be a precursor of patient-initiated violence against health care staff (Whittington et al. 1996). Other studies have found the 'limit-setting' style of nursing staff to be a forerunner to client violence, particularly in psychiatric settings (Lancee et al. 1995; Lowe, Wellman & Taylor 2003). Astrom et al. (2002) argue that younger staff are more at risk of violence from (elderly) patients because they have more negative attitudes towards older people and this translates into inappropriate verbal or non-verbal communication and actions.

Situational factors

A range of environmental factors have been identified as precursors to patient-initiated violence against health care staff. Historically, it has been argued that staff working in certain areas of health care, such as accident departments, psychiatric facilities and aged care settings, are more at risk of being assaulted or abused than staff working in other areas (ICN 2000). Researchers who focus on these ‘at risk’ areas invariably find high levels of occupational violence (Astrom et al. 2002; Dalphond et al. 2000; Fry et al. 2002; Lyneham 2000; Mahoney 1991). It is becoming more evident, however, that these high levels of occupational violence are no longer confined to commonly acknowledged high risk areas. Studies of nursing populations in Australia (Di Martino 2002; Holden 1985; O’Connell et al. 2000; Lam 2002) and other countries (Arnetz & Arnetz 1996; Carroll & Morin 1998; Di Martino 2002; RCN 2002; Whittington et al. 1996) confirm that general ward settings can be just as dangerous for nurses as traditional high risk areas. Studies of nurses who work in community health settings in Australia (Fry et al. 2002) and other countries (Denton et al. 2000; Fazzone et al. 2000) indicate that these nurses also encounter high levels of occupational violence. Remote area nurses in Australia also experience high levels of physical and psychological violence (Fisher et al. 1996; NHMRC 2002). It is reasonable to conclude, therefore, that client-initiated violence against nurses is endemic to all health care settings. Increasingly, the literature on occupational violence in the health care sector is recognising the pervasiveness of this problem (ICN 2000; Jackson et al. 2002; Leather 2002).

Researchers, commentators and organisations have proposed that changes to the way health care organisations are currently managed and funded may also contribute to the rising levels of work-related violence in the health care sector (Curbow 2002; Elliot 1997; Erickson & Williams-Evans 2000; Green 2000; ICN 2001; Leather 2002; Nabb 2000; Smith-Pitmann & McKoy 1999). There is a greater emphasis on more cost-effective models of care (such as managed care) and, as a result, the number of hospital beds and average length of stay are decreasing (Curbow 2002). Understaffing, for example, has been found by some researchers to be a contributing factor to occupational violence in health care settings. Lanza et al. (1994) found an inverse relationship between assault frequency and number of staff. Low staffing levels are perceived to compromise worker safety on wards, particularly at night (Lindow & McGeorge 2000) and have been found to contribute towards visitor anger (Nabb 2000).

Another situational factor that may contribute to nurses’ experiences of violence is the time of day they work. While some studies have found that those who work in the evening and at night are more at risk of patient-initiated violence (Arnetz, Arnetz & Petterson 1996; Mahoney 1991), other studies have found daytime staff to be more at risk (Astrom et al. 2002; Carmel & Hunter 1993; Frey et al. 2002). Findings, albeit inconsistent, indicate that occupational violence is setting-specific and that any assessment of risk should be based on the needs of the unit, ward or setting in question.

Other situational factors that mediate violent incidents in health care settings include poorly thought out and unsafe ward designs (Lyneham 2000; Nabb 2000); ad hoc discharge planning (Nabb 2000); substandard working conditions (Di Martino 2002); increased staff workload (Nabb 2000); reduced hospital security (Erickson & Williams-Evans 2000; Levin et al. 1998); increased waiting times for patients and relatives and delays in receiving treatment (Di Martino 2002; Levin et al. 1998; Lyneham 2000; NIOSH 2002; Whittington et al. 1996); and lack of staff training in preventing and managing occupational violence (Lyneham 2000; Mahoney 1991).

Bullying

A number of organisations and researchers view bullying as a component of occupational violence (Di Martino 2002; ILO et al. 2002), although others view it as a different phenomenon (Barron 1998). While there is a lack of consensus regarding workplace bullying (EASHW 2002b; Quine 1999; Raynor, Sheehan & Baker 1999), most definitions of bullying share three elements:

- Bullying is defined in terms of its effect on the recipient not the intention of the bully, thus it is subject to variations in personal perception (Quine 1999). In respect to this, the bullying actions and practices are clearly unwanted by the victim (Einarsen 1999).
- There must be a negative effect on the victim (Quine 1999). The bullying acts must clearly cause the victim to feel harassed, humiliated, offended or distressed, interfere with job performance and/or make an unpleasant working environment (Einarsen 1999; Malcom 2001; Quine 1999; Raynor & Hoel 1997; Raynor, Hoel & Cooper 2002). In other words, there is a risk to the mental or physical health or wellbeing of the employee as a result of the bullying (EASHW 2002b).

- The bullying behaviour must be persistent (Einarsen 1999; Mayhew & Chappell 2001c; Quine 1999; Raynor & Hoel 1997; Raynor et al. 2002). A one-off incident of verbal abuse or harassment would not be considered to be bullying, especially if the victim's performance was not affected.

Some authors have argued that bullying is also characterised by an unequal or asymmetrical power relationship between the perpetrator and their victim (Raynor & Hoel 1997; Raynor et al. 2002). Bullying often involves a misuse or abuse of power and occurs in circumstances where the victim or target can experience difficulties in defending themselves (EASHW 2002b).

Another factor that complicates the development of a clear understanding of workplace bullying is that the term 'bullying' is not an internationally accepted term. In the European Union and Australia, 'bullying' commonly refers to low-level violence, whereas in the US, 'harassment', 'mistreatment' or 'emotional abuse' are preferred (Mayhew & Chappell 2001c). In Germany and Scandinavian countries, bullying is also referred to as 'mobbing', a term that refers to being bullied by a group as opposed to being bullied by an individual (Raynor & Hoel 1997). In some publications, however, mobbing and bullying are used interchangeably (Zapf 1999). In Australia, New Zealand and the UK, bullying in nursing is also referred to as 'horizontal violence' (Duffy 1995; Farrell 2001; Freshwater 2000; McKenna et al. 2003).

Workplace bullying is sometimes also referred to as 'internal violence'. As discussed, internal violence occurs 'where an assault is perpetrated by another employee, a supervisor, or an acquaintance of work' (CAL/OSHA 1998) (see Table 1). 'Internal violence' is a generic term that includes all of the various types of violence that occur between people who work together. In other words, it is not a term burdened with the emotional or contextual meanings associated with alternate terms, such as bullying, harassment, mobbing and horizontal violence.

The problematic nature of defining bullying is highlighted by the experiences of the Queensland Government Workplace Bullying Taskforce (QGWB 2002). The QGWB decided to replace the term 'workplace bullying' with the term 'workforce harassment' on the basis that 'harassment' was already recognised as prohibited conduct when it is 'sexual harassment' under the *Anti-Discrimination Act 1991*. It was also considered that harassment would be an easier concept for industry to understand and to identify as unacceptable behaviour, with a greater potential for education and raising awareness in the workplace.

A variety of bullying behaviours have been described in the literature. These include verbal abuse, physical attacks, social isolation, excluding or isolating employees, psychological harassment, intimidation, devaluation of one's work and efforts, teasing, insulting, ridiculing, assigning meaningless tasks unrelated to the job, giving employees impossible assignments, deliberately changing work rosters to inconvenience particular employees and deliberately withholding information that is vital for effective work performance (Einarsen 1999; EASHW 2002b; Worksafe Victoria 2003).

Some authors have developed systems that classify the various types of bullying behaviours. Rayner and Hoel (1997), for example, grouped bullying behaviours into the following categories:

- threat to professional status (for example, belittling opinion, public professional humiliation, accusation regarding lack of effort)
- threat to personal standing (for example, name-calling, insults, intimidation, devaluing with reference to age)
- isolation (for example, preventing access to opportunities, physical or social isolation, withholding of information)
- overwork (for example, undue pressure, impossible deadlines, unnecessary deadlines)
- destabilisation (for example, failure to give credit when due, meaningless tasks, removal of responsibility, repeated reminders of blunders, setting up to fail).
- The following definitions of bullying have been extracted from the literature on occupational violence. Each definition represents a different perspective on bullying.

According to Worksafe Victoria (2003, p.6) and EASHW (2002b, p.1), workplace bullying is:

Repeated, unreasonable behaviour directed toward an employee, or group of employees, that creates a risk to health and safety. Within this definition: "unreasonable behaviour" means behaviour that a reasonable person, having regard to all the circumstances, would expect to victimise, humiliate, undermine or threaten; "behaviour" includes actions of individuals or of a group, and may involve a system of work as a means of victimising, humiliating, undermining or threatening; and "risk to health and safety" includes risk to mental or physical health of the employee.

In this context, a ‘reasonable person having regard to all the circumstances’ means a hypothetical person who has observed the situation (WorkSafe Victoria 2003, p. 6). In contrast, other authors encourage the view that bullying should be defined by the recipient of the unwelcoming behaviour. For example:

Bullying is defined as a situation where one or more persons persistently over a period of time, perceive themselves to be on the receiving end of negative actions from one or several others in a situation where the one at the receiving end has difficulties defending himself against these actions (Einarsen 2001, p.1).

Other definitions of bullying do not rely on the observations of a hypothetical person or the perceptions of the victim. For example, the ILO et al. (2002, p. 4) define bullying as:

repeated and over time offensive behaviour through vindictive, cruel or malicious attempts to humiliate or undermine an individual or groups of employees.

In contrast, this definition makes no mention of who judges the bullying behaviour to be offensive behaviour.

Harassment

Like bullying, there appears to be a lack of consensus regarding what constitutes harassment in the workplace. Some OH&S publications and researchers do not include harassment in their definitions of occupational violence or aggression (Lam 2002; Lindow & McGeorge 2000; Nolan et al. 1999; NIOSH 2002; Worksafe Victoria 2003). In some publications, the terms ‘harassment’ and ‘bullying’ are used interchangeably (QGWBT 2003; WorkCover New South Wales 2003). Others consider sexual harassment to be a type of occupational violence but do not discuss other forms of harassment, such as those of a racial or religious nature (ICN 2000; Jackson et al. 2002; O’Connor et al. 2001). Fortunately, some organisations have produced comprehensive definitions of harassment that describe multiple grounds for harassment, not just those of a sexual nature. The National Occupational Health and Safety Commission (NOHSC, 2003, p. 1), for example, defines harassment as:

Any form of behaviour that is not wanted and humiliates you (puts you down), or offends you, or intimidates you. Throughout Australia, it is against the law for you to be harassed because of sex; pregnancy; race (including such things as colour, nationality, ethnic descent and background); marital status; or disability (including physical, intellectual and psychiatric disability; and actual, perceived, past, present or future disability).

An integral component of harassment is unwanted behaviour directed towards a person because of a particular characteristic, for example, the person’s gender, race or disability. Every Australian state and territory has a law that protects people against discrimination and harassment. In Victoria, the relevant Act that covers discrimination and harassment is the *Equal Opportunity Act 1995*. Federal anti-discrimination laws also protect Australians against these types of behaviours.

Antecedents to bullying in nursing

Characteristics of perpetrators

In general, the study of workplace bullies is a new area of research, so data is very limited (Raynor, Hoel & Cooper 2002). It is particularly difficult to find research that describes the characteristics of perpetrators who engage in bullying and harassing behaviours. Demographically, however, both Australian and overseas studies indicate line managers, doctors and nursing peers to be the main perpetrators of violence against nurses (Farrell 1999; Holden 1985; O’Connell et al. 2000; Quine 1999; RCN 2003). Peers and subordinates can also be bullies.

In the RCN (2003) study of 6,000 UK nurses, for example, 41 per cent of respondents said their immediate supervisor or manager was the main person responsible; a further third said a nursing colleague was the main source. Another UK study of 1,100 employees from a National Health Service (NHS) community trust found that the most common bully was a senior manager or line manager (54 per cent), followed by someone of the same level of seniority as the victim (34 per cent) and someone less senior (12 per cent) (Quine 1999). Studies of bullying conducted in other industries, however, confirm managers as being foremost amongst the perpetrators of such behaviour (Rayner 1997; Rayner 1998).

In regard to sexual harassment of nurses, the major perpetrators are male physicians, co-workers or immediate supervisors (Finnis & Robins 1994; Grieco 1987; Kaye et al. 1994; Madison 1997). Male patients also harass nurses on a frequent basis (Grieco 1987; Finnis & Robins 1994; Finnis, Robbins & Bender 1993; Lobell 1999). This literature does not provide useful data on the physical or psychological characteristics of health care workers and patients who harass nurses.

Characteristics of victims

There is little data on the characteristics of nurses who are the targets of bullies, and most experts advise caution when interpreting studies. Findings such as those described below are more likely to be a consequence, rather than a cause, of bullying (Zapf 2001; Mayhew & Chappell 2001b). That is, workers emotionally withdraw from others in the workplace because they have been bullied or harassed (Mayhew & Chappell 2000b). Victims of bullying at work have been described as overachievers with an unrealistic view of their own abilities and resources, and whose work tasks are highly rigid (Brodsky as cited in Einarsen 1999; Zapf as cited in Einarsen 1999), oversensitive, suspicious and angry (Gandolfo 1995), low in self-esteem and self-confidence (Vartia 2001), less independent and extroverted, less stable and more conscientious than non-victims (Coyne, Seigne and Randall 2000) and having high levels of neuroticism (Zapf 2001).

When victims of bullying have been asked why they think they have been bullied, many attributed blame to the bully. Seigne (as cited in Einarsen 1999) interviewed victims of bullying and found that all of them blamed the difficult personality of the bully for their experiences. About half of the respondents felt this was combined with a change in the job situation putting the alleged bully into a position of power. Two out of every three victims also felt that the bully was envious of them, in particular of their qualifications. A Finnish study found that 68 per cent saw envy as an important reason for why they were bullied, followed by a weak superior (42 per cent) and competition for tasks or advancement (38 per cent) or the superior's approval (34 per cent) (Vartia 1996 as cited in Einarsen 1999). In another study (Einarsen 1999), envy was also the most common factor mentioned by victims. Poor leadership was perceived to be a contributing factor and respondents also felt that their own lack of coping resources and self-efficacy contributed to the problem.

Situational factors

The situational factors underpinning workplace bullying in general are multifaceted and more research is necessary before conclusive viewpoints of bullying can be developed (Raynor et al. 2002).

Situational factors may include poor leadership, lack of career pathways, inadequate processes for resolving conflict, job roles and responsibilities that are difficult to appraise, competition for job security and career advancement, intense time pressures (coupled with little time for conflict resolution), role ambiguity and role conflict, workplaces with rigid hierarchies and very structured systems, and workplaces with entrenched attitudes and traditions (Raynor et al. 2002; Richards & Freeman 2002; Zapf 2001).

Einarsen and his colleagues (1998) proposed three situational factors that contribute to bullying amongst assistant nurses:

- systematic aggression, which exists within female peer groups and within female subordinate/superior relationships
- heavy physical and emotional workloads, which contribute to negative attitudes towards other people, and reduce the individual's ability to handle interpersonal relationships
- increased level of burnout, which may impair an individual's job performance and make them the target of aggressive behaviour, particularly from their nurse managers.

Another situational factor that has contributed to bullying in nursing has been the introduction of individual workplace agreements. Some studies conducted by nursing unions have found that the bullying behaviours of managers and supervisors escalate when it comes time for individual workplace agreements to be negotiated and signed (Blake 2001; Giles 1998). According to these authors, health care managers are becoming more aggressive with negotiating workplace agreements because they are under pressure to reduce labour costs (Curbow 2002; Green 2000; ILO et al. 2002; Sunderland 2001).

The RCN (2002) study of UK nurses reports that full-time staff and staff who work long shifts were more likely to have been bullied than part-time staff; that agency staff were bullied more than permanent staff; black and Asian nurses were bullied and harassed more than their white colleagues; and nurses with disabilities were bullied and harassed more than nurses without disabilities. Respondents also reported that personality clashes were a common cause of bullying and harassment in nursing.

It is contended that nurses are exposed to bullying and harassment because they ‘collude’ with the structures and processes that perpetuate and maintain a culture of violence (Jackson et al. 2002). Farrell (1999) suggests that interpersonal conflict is perpetuated in Australian nursing because nurses accept it as part of the job. Nurses tolerate abuse from doctors because they see that doctors work long hours and are faced with excessive responsibilities. They accept aggression from other nurses because they are not in a position to withdraw from interactions with ‘difficult’ colleagues.

A study of horizontal violence amongst graduate nurses in New Zealand found that over 50 per cent of incidents were not reported (McKenna et al. 2003). Nurses may not report incidents of bullying and horizontal violence because they have come to accept that violence is part of the job (Di Martino 2002; Erikson & Williams-Evans 2000; Jackson et al. 2002; Malcolm 2001) and because employers often don’t deal with nurses’ complaints effectively and fairly (RCN 2002; Quine 1999).

Various theoretical perspectives have been proposed to explain the bullying and aggression that takes place in nursing. Roberts (1983), who first used the term ‘horizontal violence’ to describe nurse-on-nurse conflict, claims that nurses have all the characteristics of an oppressed group, that is, that they exhibit self-hatred and dislike for each other and they lack cohesion and are divisive. She suggests that nurses have internalised the values of physicians and the medical model to the extent that they are dominated by a system that doesn’t value nursing (Roberts 2003). This argument has been supported, and expanded upon, by others (Dishwater 2000; Duffy 1995; Farrell 2001; Hastie 2002). There are, however, few studies that have investigated the extent of horizontal violence in nursing (Farrell 1999; McKenna et al. 2003).

Farrell (2001) suggests that while oppressed group behaviour may be useful in providing a macro-level explanation for poor staffing relations in nursing, this view may be but one consideration in understanding horizontal violence. Farrell proposed a multilevel conceptual framework to account for poor staff relationships in nursing. At the macro-perspective, the interpersonal conflict that occurs in nursing can be explained by oppression and feminist theories. From this perspective, incidents of work-related violence between nursing co-workers occurs in relation to where nursing sits with medicine and other perceived dominant groups (for example, hospital managers) (Farrell 2001). As a result of this unequal access to power and rewards, nurses feel alienated and removed from decisions of control and autonomy over their working conditions.

The fear of reprisal or because of the fruitlessness of previous attempts to effect change, [nursing] staff frustration is manifested or displaced as conflict within their own ranks (Farrell 2001).

From the meso-level perspective, the interpersonal conflict is a result of disenfranchising workplace practices, many of which are controlled by nurses themselves (Farrell 2001). Farrell proposes that nurses’ obsession with task/time imperatives, their inability to counter generational and hierarchical abuse, their ineffective management responses to staff conflict, and the lack of good nursing role models, promotes conflict and divisiveness in the profession.

The micro-level perspective emphasises the interactional nature of staff conflict, that is, that individuals actively mediate interactions with other people and attach their own meanings and interpretations to these interactions. According to Farrell (2001), poor staff relations in nursing can be partly explained by the tendency that people have to view their own negative behaviour as a result of factors beyond their control and attribute them to personal dispositions of others. ‘Our attributions tend to condition us to believe that when we fight for our rights we are being assertive, while another’s similar behaviour is viewed as aggressive’ (Farrell 2001, p. 31). Farrell argues that nurses consider workplace relationships to be less important than meeting task/time imperatives.

Research report on occupational violence in four Victorian hospitals

In late 2003, the University of Melbourne was funded by the Department of Human Services to commence a research project titled 'Occupational Violence in Nursing: An Analysis of the Phenomenon of Patient Aggression and Code Grey/Black in Four Victorian Hospitals'. Principal researchers were Dr Marie Gerdtz, Dr Phil Maude and Associate Professor Nick Santamaria.

The research results have been used to inform the Violence and Aggression Subcommittee of the taskforce and provide a more comprehensive insight into the prevalence and severity of violence and aggression in Victorian health care facilities.

The following section is an excerpt from the report *Occupational violence in nursing: an analysis of the phenomenon of code grey/black events in four Victorian hospitals* (Department of Human Services 2005).

Introduction

There has been little substantive research undertaken in Australian health care settings to ascertain the prevalence of occupational violence and aggression. The Victorian Government provided funds to conduct research in Victorian health care settings to determine the prevalence and severity of occupational violence and aggression in Victorian health facilities, particularly towards nurses.

This study explored occupational violence in nursing by examining events in which nurses activate a hospital-wide security response to potential or actual violence (Code Grey/Code Black events). It described the prevalence and impact of Code Black and Code Grey events in three Melbourne metropolitan health care agencies and one regional centre; identified organisational factors, patient characteristics and specific patient groups that are more susceptible to being involved in violent incidents within the workplace; and identified best practice and suggested organisational and nursing interventions to improve the management of patient violence directed towards nurses and other health care staff.

The study addressed the following research questions:

- What is best practice when training for the de-escalation of aggression, the management of Code Black and Code Grey events, and debriefing of nurses following a Code Black or Code Grey event?
- What is the prevalence of occupational violence across three major metropolitan and one regional health care agency?
- How does patient aggression manifest and how is it perceived and managed by nurses?
- Do reported incidents of patient aggression accurately reflect actual levels of patient aggression?
- What demographic, patient and organisational factors influence the frequency of Code Grey and Code Black events?

Research methodology

The study used a mixed method design combining key stakeholder and clinician interviews with prospective audits of incidents of actual or potential episodes of aggressive behaviour where an internal hospital-wide security response was activated.

To guide project implementation and provide expertise and local knowledge to support the research team, a multidisciplinary advisory committee was established. The role of the advisory committee was to:

- assist in the development and validation of data collection tools
- review the development and implementation of best practice guidelines
- assist in the facilitation of the process of data collection.

The advisory committee comprised members who were employees or contracted to one of the four participating hospitals and who have expertise in the area under investigation.

Findings

The major findings of the report were in relation to operational issues and the considerable variability in defining responses to violent behaviour that was evident across the four participating organisations; the prevalence of potential or actual aggressive events; and the influences that were found to be associated with incidents, most notably the significant associations that were identified between code type and clinical area.

The current research indicates that nurses are able to, at least in retrospect, identify warning signs for aggressive behaviour.

In accord with previous work, this study found that gender (male) is a key predictor of aggressive behaviour in hospitals (Eastley & Mian 1993; Harris & Rice 1997). Also consistent with previous research, is that violent and aggressive episodes involve an aggressor who has a history of violent behaviour (Chou Lu & Mao 2002; Harris & Rice 1997).

This result highlights the volatile nature of patient aggression. Despite behavioural warnings, patient aggression appears to rapidly escalate to a level that requires organised and definitive action.

Given this information, it is reasonable to assume that at least a proportion of violent events may be amenable to preventative intervention. Further research is required to more closely explore the situational factors contributing to the escalation and de-escalation of such behaviours within the clinical environment. Valid and consistent demographic, clinical and situational data is required.

The research illustrated the higher risk areas of violence and aggression. There were 2,662 potential or aggressive incidents reported in this study across all four sites, and the majority (53.6%) occurred in emergency departments, while fewer occurred in wards (30.8%) and psychiatric settings (12.1%).

A further study was undertaken to elicit more specific detail in respect to episodes of patient violence in relation to nurses. In this phase, data was collected by nurses working in each of the organisations involved in the study, and involved performing an audit of episodes of violence that resulted in a hospital-wide security response. A total of 264 episodes of violence were recoded using the nursing audit and this number represents 9.9% of all violent events that occurred in the four hospitals included in the study over the six-month period.

The results obtained using the nursing audit were consistent with the percentage breakdown of incidents in the earlier study. Most of these occurred in emergency departments (68.2%) while fewer occurred in the ward (20.8%) and psychiatric units (6.1%).

Of those people who were physically abused as a result of the violent episode in the nurse audit, most were nurses (57.6%) while fewer were patients and relatives (15.2%), security staff (15.2%), medical staff (6%), domestic staff (3%) or police (3%).

In 46.6% of the incidents in the nurse audit, nurses noted warning signs for aggressive behaviour. These warning signs included a range of clinical signs of which the majority were agitated, restless and irritable behaviour. In 43.4% of the episodes of aggression, nurses stated they thought the aggressor appeared to be under the influence of alcohol or drugs. Again, this result accords with previous work that has demonstrated that the use of alcohol and drugs are important factors contributing to aggressive behaviour (Doyle 1996).

Most of the violent episodes in the nurse audit involved:

- verbal abuse (51.9%)
- threats to staff or another person (47%)
- physical abuse of nurses (57.6%), patients and relatives (15%), security staff (15%), medical staff (6%), domestic staff (6%) or police (3%).

An interesting result of the study related to the issue of verbal communication. Notably, in this study, the majority of aggressors possessed sufficient levels of English to communicate adequately to staff.

This study has highlighted the need for further research into patient violence.

Considerations

A set of key considerations arising from the literature, the current study data and discussions within the taskforce is outlined below.

A clear statement of expected behaviour

All persons entering an acute health care facility should receive clear information outlining what is acceptable behaviour. Specifically, this information should contain a statement that violence, including verbal abuse and threats made toward others, will not be tolerated.

A notable dimension that emerged from the literature and in discussions with key stakeholders relates to the philosophical tension between the occupational safety 'zero tolerance approach' to the management of occupational violence in nursing and client or consumer focused models of aggression management, where violence is conceptualised as a barrier to achieving a therapeutic interaction. This tension requires further debate. However, a statement of expected behaviour is necessary, and is rudimentary in communicating to staff, visitors and clients of the service that violent behaviour is not acceptable.

Standardisation of codes grey/black across the acute care sector

Standard categories and definitions for team responses to violence should be considered for implementation across the acute care sector. As part of this process, consideration should be given to the ways in which clinicians conceptualise and manage violent behaviour in practice. This is because the lack of uniformity in definitions and instruments used to quantify the scope of occupational violence severely limits the development of a true understanding of the extent of occupational violence in nursing. This information is required if policy is to reflect how violence and aggression actually manifest in practice.

Uniform collection of core demographic and clinical data

Uniform collection of hospital-wide security responses that accurately describe the event in terms of both its clinical and security features would be of benefit.

Minimum information collected in respect to code responses should include:

- response type
- date
- time called
- time called down
- location
- age of aggressor
- gender of aggressor
- type of aggressor (client of the service or other)
- number and appointment level of response team members
- a description of the type of behaviour demonstrated by the aggressor that resulted in the activation of the team.

Multidisciplinary code grey/black committees

In each acute care facility, management should consider the establishment and maintenance of workplace committees, comprising members of clinical staff (nursing and medical), security, OH&S and management, to oversee policy development, reporting, monitoring and training of staff in relation to code grey/black events.

Policy, procedures and all aspects of code grey/black management must clearly articulate the multidisciplinary relationship between clinical and security staff in the management of code grey/black events, emphasising that responses are clinically driven.

Aggression management training for clinical and security staff

All clinical and security staff (including nurses, medical staff and security staff) require aggression management training during orientation to a new acute health facility. Students and casual staff also require training in violence management and code grey/black events.

The researchers suggested that all acute care agencies should maintain a centralised record of staff who have completed code grey/black training.

Evaluation of training

To contain the growing problem of occupational violence in nursing, evaluation of existing violence management programs that appraises cost, sustainability, skill and knowledge retention and effectiveness is essential.

Conclusion

The findings of this study are a valuable first step in understanding occupational violence in nursing. Code grey/black events are complex in nature, unpredictable in their course and potentially damaging to patients, staff and their families. Their multifactorial causation and multidisciplinary response places clinicians, clinical agencies and government in a position that requires immediate responses to complex and poorly understood situations. This research provides information to assist the development of effective and safe responses to this difficult yet important aspect of clinical practice and violence in the workplace.

Part 3. Subcommittee reports

Key themes from the subcommittees

A number of important themes are highlighted in the literature review, surveys and in the analysis and recommendations of the subcommittees. These themes are described here as they are critical in informing successful action in preventing and managing violence and aggression in the workplace.

Organisational culture

Culture permeates every facet of organisations. As such, culture must be incorporated into the development and implementation of all strategies aimed at preventing the occurrence and minimising the impact of violence and aggression towards nurses. This applies to all strategies and recommendations referred to in this document.

Exposure to violence has been seen as a fact of life by nurses. Key messages have been that nurses have to 'be available'; that they should provide care at all costs or risk being seen as negligent or not fulfilling a duty of care. Nurses have seen violence and aggression as being 'all in a day's work' and subsequently have conceptualised it as a work-related risk, tolerating it as part of being a nurse. It is estimated that, at best, one in five work-related incidents of violence and aggression are reported, therefore, around 80% of incidents remain unrecorded (Mayhew & Chappell 2001).

Organisational culture must be considered when examining the incidence of occupational violence and bullying. Developing a person-centred workplace culture based on dignity, respect, anti-discrimination, equal opportunity and cooperation is an integral part of any strategy aimed at reducing violence in the workplace.

In order to support a positive culture that encourages reporting, senior executives of health care facilities should be visible in their commitment to the implementation and support of violence and aggression minimisation strategies. Encouragement and support for appropriate staff action and response should be provided at all levels of the organisation including feedback on the outcome of these responses. Roles, responsibilities and accountability should be incorporated into policies and procedures to prevent and manage occupational violence and should be supported through the allocation of adequate authority and resources.

Every individual needs to advocate that violence in the workplace is unacceptable. Senior management needs to ensure that policies, procedures, systems and processes are in place to prevent or manage violent incidents. Training staff to understand and deal with occupational violence and bullying requires ongoing education and support, which should commence at orientation to the organisation and be updated on a periodic basis. Managers must model that violence and aggression is unacceptable; their actions and communications must consistently reflect this.

Key principles of positive culture include:

- senior executives are visible in their commitment to the implementation and support of violence and aggression minimisation strategies
- it is made clear that appropriate action will be taken to prevent and manage occupational violence and aggression and to protect staff, patients and visitors from the effects of violent and aggressive incidents
- all members of the health service community are aware of and accept responsibility for maintaining a safe workplace
- encouragement and support for appropriate staff action and response is provided by all levels of the organisation, including feedback on the outcomes of these responses
- appropriate responses to acts of violence and aggression are consistently enforced
- managers are held accountable for exercising their responsibilities in relation to preventing and managing violence. This accountability must be supported through the allocation of adequate authority and resources.

Organisational culture is derived from implicit and explicit messages about what is considered to be acceptable behaviour in the workplace. These messages demonstrate to staff what is valued, what is important and what they are expected to do to be accepted and rewarded. Nurses internalise these messages, adapt their behaviour and reinforce the culture by sending these messages to other colleagues. Subsequently, to achieve a cultural shift within an organisation from one that accepts violence and bullying as 'part of the job' to one that does not tolerate such behaviours requires a well developed plan of action endorsed by senior management.

Education

Occupational violence and bullying can be prevented or significantly decreased if proactive measures are taken to ensure the workforce understands the factors and behaviours that influence violence and bullying. An important component of reducing the incidence of violence in the workplace is implementing an educational program that is accessible to all staff.

Education and training programs should include core content, to ensure a consistent level of understanding, as well as content specific to individual health care facilities to ensure that training needs for that environment are met.

Key principles that underpin education aimed at prevention include:

- education programs should reflect a whole of organisation approach to occupational violence and bullying and include senior management in the development and delivery of programs
- education should be supported by appropriate policies, procedures and monitoring systems
- a participative approach ensures that employees are actively consulted and involved in the development, implementation and evaluation of education programs
- education programs should include a means for evaluating the effectiveness of training to ensure that it is responsive to the needs of the organisation, staff and consumers over time.

The specific content of educational programs needs to reflect the organisational context and the needs of the employee. Key elements for training programs include organisational culture, legislative framework, safety measures, policy, reporting, staff support and public awareness.

Occupational violence and bullying programs should be included in staff orientation processes. Private providers of agency nurses also need to provide minimum standards of education for the nurses they employ.

Continuing education programs should be offered regularly to ensure that nurses continue to manage occupational violence and incidents of bullying in an effective and efficient manner.

There is consensus that education is only effective if it is part of a broader organisational approach. Periodic review of reports of incidents, evaluation of educational and induction programs and measurement of behavioural change in the workplace will provide data to indicate whether the strategies have been effective. All managers will require training that assists them to:

- understand the adverse impacts of occupational violence and bullying on employees, patients and the workplace
- develop skills to prevent occupational violence and bullying within the health care setting
- understand their obligations as an employer to provide a safe workplace for employees and clients
- understand and manage their own behaviours, including the capacity to shape behaviour of others through role modelling, setting clear standards and effectively managing incidents.

OH&S principles, particularly an introduction to occupational violence and bullying management principles and coping strategies, should be an integral part of nurses' undergraduate preparation for entry into practice. OH&S content should also be undertaken by students before clinical placements and reinforced once they enter the nursing workforce.

Public awareness

It is important that the general public is educated about expected behaviours and potential consequences of their behaviour while engaging with health services.

Media campaigns to raise public awareness about occupational violence and bullying and to inform potential consumers of health care that such behaviour will not be tolerated have been used nationally and internationally. The campaigns inform consumers about what is acceptable and unacceptable behaviour before they access a health care facility or come into contact with nurses. This should be considered as a strategy in Victoria.

A successful public awareness campaign should:

- be part of a broader strategy to address violence against nurses
- include messages directed at employers, nurses, other health service employees and members of the general public
- ensure that information reaches consumers before they attend a health facility or come into contact with nurses
- have clear and easily understood messages that are widely disseminated (UK examples included advertising in public places such as train stations, pubs, clubs and libraries).

Resources

The adoption and implementation of the strategies and recommendations outlined in this report will require the allocation of resources.

Resources that may be required include:

- time – for example, releasing staff for training or involvement in consultative arrangements
- funding – such as providing for publications, equipment, the design and delivery of training packages, public awareness campaigns
- personnel – for example, employing staff with expertise, employing security staff.

Assessing the type and level of resources required to implement recommendations should be integrated into planning processes.

Violence and aggression

The aim of the Violence and Aggression Subcommittee was to establish mechanisms that promote monitoring and evaluation of strategies to prevent and reduce occupational violence.

Key objectives included:

- classifying the various types of violence and aggression, as defined in the WorkSafe Guidance Note 2003, experienced by nurses in the workplace
- recommending strategies to prevent and manage the various types of occupational violence and aggression
- recommending guidelines for organisations to use with respect to:
 - policy development
 - implementation
 - risk management/monitoring systems
- recommending strategies to increase awareness of undergraduate students and registered nurses of issues associated with occupational violence.

In tackling its key objectives, the subcommittee investigated diverse issues, including understanding violence and aggression, workplace culture, risk management, the effect of sanctions, environmental factors, legislative and strategic frameworks.

Definitions

To understand the nature and extent of occupational violence, and its prevention, it is important to have clear and accepted definitions.

Occupational violence and aggression is defined as any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of, their employment (adapted from WorkSafe Guidance Note, Feb 2003).

Within this definition:

- **'threat'** means a statement or behaviour that causes a person to believe they are in danger of being physically attacked, and may involve an actual or implied threat to safety, health or wellbeing
- **'physical attack'** means the direct or indirect application of force by a person to the body of, or clothing or equipment worn by, another person, where that application creates a risk to health and safety.

Note: Within this definition, neither intent nor ability to carry out the threat is relevant, the key issue is that the behaviour creates a risk to health or safety.

Examples

Examples of occupational violence and aggression include, but are not limited to, verbal, physical or psychological abuse, punching, scratching, biting, grabbing, pushing, threats, attack with a weapon, throwing objects/furniture, sexual harassment or assault and any form of indecent physical contact.

Classification

Classification of occupational violence and aggression into the three following basic classifications is helpful when developing prevention strategies:

- **client-initiated violence** – covers situations where a client² or a client's family member/friend/guardian can be the source of the violence
- **internal violence** – covers situations where someone who works under the direction of an organisation is the source of the behaviour, for example, employee-to-employee, contractor to employee, supervisor to employee
- **external violence** – covers situations where violence is perpetrated by persons with no legitimate relationship to the organisation, for example, robbery.

² Client includes people who: have a commercial relationship with an organisation; are in the care or custody of an organisation; must legally submit to inspection by an organisation; use or are seeking to use the services of an organisation.

Recommendation 1

The Department of Human Services and health care facilities adopt a uniform definition of occupational violence consistent with the definition and classifications developed by the Taskforce on Violence and Aggression Subcommittee in this report.

Culture

Violence and aggression exist, in part, as a result of cultural factors. Therefore, culture must be incorporated into all strategies aimed at minimising or preventing the occurrence and impact of violence and aggression towards nurses.

There is a culture that nurses have to ‘be available’ and provide care at all costs or risk being seen as negligent or not fulfilling a duty of care. It is reported that nurses accept violence and aggression as being ‘all in a day’s work’ and subsequently have conceptualised it as a work-related risk, tolerating it as part of being a nurse (Mayhew & Chappell 2001).

It is estimated that, at best, one in five work-related incidents of violence and aggression are reported, therefore, around 80% of incidents remain unrecorded (Mayhew & Chappell 2001). In the health care sector, staff don’t report incidents because:

- they believe some incidents are not important enough to be reported
- they perceive violent incidents to be ‘part of the job’
- they did not incur an injury or feel adversely threatened
- it was not considered serious enough because they think that incident reports are not taken seriously
- they don’t believe that anything can be achieved or changed by reporting violent incidents (Erikson et al. 1995; Fry et al. 2002; Lyneham 2000; Poster 1996).

Studies conducted by the International Council of Nurses and Erickson & Williams-Evans (2000) found that the more the nurses were subjected to assaults, the less likely they were to report them. This phenomenon is referred to as ‘habituation’: ‘a process whereby persons who may initially experience negative emotional responses while observing aggression, may respond less emotionally after repeated exposure’.

In a study of 270 nurses in Tasmania, Farrell & Bobrowski (2003) state:

Nurses indicate that abuse has the potential to affect their productivity at work and may even cause them to make errors. Over 1 in 10 nurses (11%) indicated that they had left a nursing position sometime during their careers because of verbal or physical abuse, and 2% of respondents indicated that they had left the nursing profession altogether specifically because of verbal or physical abuse.

Culture is often created from messages about how people are expected to behave in an organisation. These messages demonstrate to staff what is valued, what is important and what they need to do to fit in, be accepted and be rewarded. Nurses pick up messages, adapt their behaviour and, in doing so, reinforce the culture by sending the message themselves. Subsequently, to manage a culture that accepts violence and aggression as ‘part of the job’ requires management of these messages.

Staff observe managers at all levels in the organisation. Their actions frequently send strong messages about ‘what is expected around here’. The taskforce believes that to establish a successful violence and aggression program, each individual must advocate that violence is unacceptable and measures must be in place to prevent or address violence. This must be conveyed to nurses in the workplace by the behaviour of managers and systems in the hospital setting.

Key principles of positive culture include that:

- senior executives are visible in their commitment to the implementation and support of violence and aggression minimisation strategies

- it is made clear that appropriate action will be taken to prevent and manage occupational violence and aggression and to protect staff, patients and visitors from the effects of violent and aggressive incidents

all members of the health service community are aware of and accept responsibility for maintaining a safe workplace

- encouragement and support for appropriate staff action and response is provided by all levels of the organisation, including feedback on the outcomes of these responses
- appropriate responses to acts of violence and aggression are consistently enforced
- managers are held accountable for exercising their responsibilities in relation to preventing and managing violence. This accountability must be supported through the allocation of adequate authority and resources.

Strategy framework

The strategy framework for preventing and managing occupational violence and aggression should be informed by existing knowledge and literature.

Existing resources and models have been considered by the taskforce and adapted as necessary to meet the needs of the Victorian health care context and legislative environment.

Where required, additional information has been included in the strategies identified in this report. References for the development of strategies include:

- NSW Health, *Zero tolerance response to violence in the NSW health workplace – policy and framework guidelines*
- WorkSafe Victoria, *Guidance note for the prevention of bullying and violence at work*
- WorkSafe Victoria, *PSCS Inspector Guide – occupational violence prevention*
- ANF (Vic Branch), *Zero tolerance policy and interim guidelines and Toolkit*
- ILO/WHO/ICNPSI, *Position statement on abuse and violence against nursing personnel*
- Department of Human Services, *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria’s mental health services*
- California Occupational Safety and Health Administration (CAL/OSHA)
- Chappell and Mayhew study 2003

The Violence and Aggression Subcommittee recommends strategies be adapted from these references for the development of a Victorian occupational violence policy guideline framework.

The purpose and scope of strategies is:

- to convey to Victorian nurses that bullying in the workplace is unacceptable and that the Department of Human Services is committed to prevention (refer to strategies developed by the Bullying Subcommittee)
- to convey to Victorian health care employers, nurses and public that violence and aggression towards nurses is unacceptable and that the Department of Human Services is committed to its prevention
- to convey to Victorian health care employers and nurses their responsibility in the prevention and management of occupational violence and aggression
- to comply with OH&S legislation and other relevant legislation and standards.

These strategies are applicable to all Victorian nurses in all health sectors.

The features of these strategies include:

- health services use a multifaceted approach. A ‘zero tolerance’ approach or comparative philosophy is a primary feature of successful strategies to prevent occupational violence and aggression (Mayhew & Chappell 2003)
- the promotion of policies and programs that support risk reduction strategies and the prevention of occupational violence and aggression in health services, which are endorsed by the chief executive officer and executive management
- strategies incorporate principles and risk management systems adapted from current research and practice

- strategies and approaches are clear that no punitive action is to be taken against consumers whose violent behaviour is the direct result of a medical condition
- strategies are developed to prevent and reduce violence and aggression from clients who are competent and can be held responsible for their actions, and from clients who lack intent or the capacity to understand their actions (Mayhew & Chappell 2003)
- key strategies are developed in the context of a model of primary, secondary and tertiary prevention. Within this model:
 - primary prevention aims to prevent and reduce the risk of violence
 - secondary prevention is based on early intervention that protects nurses and consumers and includes the method and procedure for managing an incident of violence when it occurs
 - tertiary prevention is a post-incident approach that aims to reduce or prevent the negative consequences of violence and aggression.

Recommendation 2

That the Department of Human Services and health care facilities adopt a policy statement that has key messages including:

- violence against nurses is unacceptable and must be proactively addressed
- there is not a culture of tolerance of violence in the workplace
- encouraging a culture of reporting amongst nurses.

Strategies and guidelines for preventing and managing violence and aggression in the health care setting will be adapted primarily from:

- NSW Health, *Zero tolerance response to violence in the NSW health workplace – policy and framework guidelines* (2003)
- Department of Human Services, *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria’s mental health services* (2004)

The framework should also incorporate guidelines for risk assessment, including factors such as physical environment, security, staffing, and tools to identify the risk of violent or aggressive behaviour of clients. Information from risk assessment tools should inform actions that prevent and manage risk. Protocols/systems for communicating risk between referring agencies, and within organisations, for example patient flagging and alert systems, should also be developed and incorporated into the guidelines.

Recommendation 3

That the Department of Human Services develops a framework for the prevention and management of occupational violence and aggression for adoption in Victorian health care settings and that this work be informed by:

- NSW Health, *Zero tolerance to violence in the NSW health workplace – policy framework guidelines* (2003)
- Department of Human Services, *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria’s mental health services* (2004).

Risk management

Risk management is an interactive process consisting of clearly defined steps that support improved decision making by contributing a greater insight into risks and their impact. It provides a framework for establishing the context, identification, analysis, evaluation, treatment, monitoring and communication of risk. To be effective, risk management needs to be incorporated into the culture of the organisation and become part of the overall philosophy, practices and business plans, rather than be viewed as a separate program.

Risk management involves hazard identification, risk assessment, risk control, developing policies and procedures, consultation, training, audit review and evaluation, and all these areas are included in the *Occupational Health and Safety Act 2004*.

A risk management approach will assist organisations to minimise the negative consequences of an event, which may include loss, injury or disadvantage, including financial cost. Cost may be defined as the cost of activities, both direct and indirect, involving negative impact, including money, time, labour, disruption, goodwill, and political and intangible loss (AS/NZS 4630:2004).

OH&S legislative framework and principles

Under the Victorian *Occupational Health and Safety Act 2004*, employers are required to provide and maintain, so far as is reasonably practicable, a working environment that is safe and without risks to health, including the psychological health and welfare of employees.

Under the legislation, this duty includes the provision of:

- a safe physical environment
- safe systems of work
- adequate facilities for the welfare of employees
- information, instruction, training and supervision to enable employees to perform their work in a safe manner, without risks to health.

Employees also have duties under the legislation. This includes a duty to take reasonable care for their own health and safety, and to cooperate with their employer with respect to any action taken to comply with workplace health and safety policies and procedures.

The Act contains penalties, including increased fines and imprisonment, which may be imposed on bodies corporate as well as senior officers of organisations, for contraventions of the Act. All employees may also face fines and imprisonment for conduct that recklessly endangers life or places another person at risk of serious injury. Occupational violence and aggression can place staff and others at risk of death or serious injury, and employers and employees must be aware of the new penalties that may be imposed under the Act.

The Act also contains duties on building designers to ensure, so far as is reasonably practicable, that buildings and structures are designed to be safe and without risks to the health of the persons using them. Under the OH&S Act, hazards must be eliminated at the source, wherever practicable. The most effective means of eliminating hazards is to 'design them out' before a building is built or renovations or refurbishments undertaken.

The new duties on designers under the Act (effective from 1 July 2006) establish that issues such as physical security of buildings and surrounds, and designing the environment, furniture and fittings to promote deterrence, must now be addressed in the design of health care buildings.

Principles of the OH&S Act will help inform the development of strategies to address violence and aggression against nurses. Some of these are:

- Employers have a duty to ensure the health and safety of employees, as well as patients/residents/clients, visitors and others.
- A proactive approach should be employed to effectively prevent and manage risks of occupational violence and aggression.

- A hierarchy of controls must be applied in controlling risks associated with occupational violence and aggression. This describes a preferred ranking of controls, requiring in the first instance, elimination of the hazard at the source so far as is reasonably practicable. If this is not possible, controls to reduce the risk so far as is reasonably practicable must be implemented.
- A comprehensive risk management approach, based on a multifaceted, whole of service approach, is the most effective approach to prevent and manage occupational violence and aggression and will assist employers to comply with the legislation.
- Employers have a duty to consult employees and their representatives, including OH&S representatives, in the development and implementation of the risk management process, policies and procedures.

An example of how the risk management process can be applied to a broad range of health care settings is provided by the *Zero tolerance response to violence in the NSW Health workplace – policy and framework guidelines* (NSW Health 2003). This provides the basis for a standardised approach that organisations can tailor to their local needs. Adapting and implementing these guidelines will assist organisations to achieve legislative compliance, and protect nurses and other health care workers from violence and aggression.

Strategies

1. Sanctions

The taskforce considers the development of a hierarchy of consequences, including sanctions, to be a key component of a preventative and proactive management approach to occupational violence and aggression. When applied in an appropriate manner and in appropriate circumstances, sanctions can act as an effective deterrent and send a strong message that violent and aggressive behaviour is unacceptable and will not be tolerated.

In determining sanctions and their application, it is relevant to consider the source/nature of the behaviour. It is not the intent that inappropriate action is taken against those whose violence arises directly from a medical condition. In these cases, the emphasis should be on prompt, effective clinical management and compassionate care of the patient, while at the same time protecting the safety of staff and others who may be affected by the behaviour (NSW Health, 2003).

However, it is also noted that there has been a tendency by nurses to ‘explain away’ violent or aggressive behaviour by clients affected by a medical condition, with the absence ‘of malicious intent by the perpetrator mitigating staff interpretations of an aggressive incident’ (Mayhew & Chappell 2003). This has contributed to a ‘culture of silence’, which is perpetuated by both the failure of nurses to assert their legal rights after they become the victim of a violent episode, and a lack of support systems at the institutional level (Forrester 2002).

Australian research by Mayhew and Chappell (2003) established that the majority of perpetrators of violence and aggression experienced no negative consequences following their inappropriate behaviour. Few perpetrators are prosecuted following violent acts and perpetrators of violence against nurses and medical officers are least likely to experience any negative consequences. For those perpetrators who receive a sanction, this is usually a verbal warning from a nurse unit manager or security officer. The taskforce considers that the current system, where few aggressors have any form of sanction imposed, is deficient.

Mayhew and Chappell (2003) recommend that clear strategies be devised for aggressive clients who are in need of medical care. An example of a system of sanctions is the UK NHS card system, where clients who behave inappropriately are issued with yellow warning cards. If the behaviour continues after a number of warnings, clients are issued with a red card, which withholds treatment (mental health clients are exempted from the system).

Some Victorian hospitals use a similar system, issuing written warnings in a letter, followed by the imposition of ‘contracts of acceptable behaviour’. This hierarchy of responses ranges from managed visits; limiting the number of times when clients or visitors can access the service; a requirement to report to security when entering the hospital; security escorts while accessing the service; and/or refusal of service (except for treatment of life threatening conditions) for serious repeat offenders.

The premise underlying this recommendation is that certainty of sanction is a greater deterrent of unacceptable behaviour than the severity of punishment. Research supports this notion, proposing that violent and aggressive behaviour is contained when clear and direct sanction has been enforced on relatives/visitors who perpetrate violence against health care staff. This has included exclusion, restriction of visiting rights and prosecution of the perpetrators (Mayhew & Chappell 2003).

The concept of sanction should be supported by the development of codes of conduct and visitor guidance materials. It is critical that facilities not only have protocols and procedures around sanction, but that they are enforced and consistently applied.

Recommendation 4

That the Department of Human Services will:

- establish a hierarchy of response guidelines for a uniform system of sanctions in response to violence and aggression against nurses. The response should include warning systems, contracts of acceptable behaviour, and the enforcement of sanctions/consequences.
- develop guidelines that include the duty of care and legal responsibilities of all parties. Case study examples should be provided to highlight the issues to be considered in determining strategies and responses to occupational violence and aggression against nurses in the workplace.

It is also critical that nurses have confidence in the justice system and in their own employer to support them to report attempted or actual assaults to police and, where appropriate, to request that charges be laid. In NSW, a written Memorandum of Understanding between NSW Health and NSW Police underpins police response and support for health care workers when reporting violent incidents, including laying charges and pursuing prosecutions where appropriate.

A presentation was given to the taskforce from a clinical nurse who had experienced an assault during a home visit to a patient suffering from mental illness. The taskforce heard that while assault is a criminal offence and may be prosecuted under the Victorian *Crimes Act 1958*, nurses can experience a lack of response when they report matters to police; action is rarely taken and prosecutions are rarely pursued (ANF 2002). The taskforce heard that this is due to a number of factors, including reluctance by police to pursue charges against patients with a medical condition due to the belief that such prosecutions will not succeed. It was also submitted that police resources at the local level influence the response.

Some nurses also report a lack of support from their own employing institutions to pursue charges, particularly against patients. This is often evidenced by the absence of any formal protocol or procedure to provide information and to assist staff with this process.

Behaviour that does not incur a sanction may put at risk not only nursing staff, but other staff, patients and members of the public. Whether a prosecution will succeed or not is a legal issue, and nurses should be supported by their organisation to report violent assaults or threats to the police.

The courts, using the legal tests and criteria which apply under the *Crimes Act 1958*, should make the issue of mental competence or impairment objectively. It is noted that prosecution may not be appropriate in all circumstances. Subsequently, consideration should be given to increasing the options available to police, for example, a cautioning system or the provision of awareness courses for offenders, similar to those developed in young offender programs.

Education and awareness programs for the judiciary and the community should also be considered. These programs provide messages that lead to changes in attitudes, particularly those that view assaults against nurses differently to assaults in a non-health care context.

Recommendation 5

That the Department of Human Services develops education and awareness programs for the community, police and the judiciary, to promote a greater understanding of occupational violence in nursing.

The taskforce believes that changes to legislation, similar to those made by the Victorian Government in 2004 in relation to ambulance officers (Minister for Health 2004), may be of benefit. These amendments included changes to the *Ambulance Services Act 1986* and the *Summary Offences Act 1966*, which provided paramedics with the same type of protection from attack as police officers. Under the new laws, it is now an offence to assault, resist, obstruct, hinder or delay operational ambulance personnel in the course of providing treatment to a patient. New penalties for any person who attacks or harasses a paramedic include fines of up to \$6,000 and/or six months imprisonment.

In addition to a nurse's duty of care to their patients, they also have a right to safety at work. The safety of employees under OH&S legislation must be given consideration when staff have been placed in a situation that has a risk of violence and aggression.

Ultimately, a balance must be achieved between the duty of care owed by nurses and facilities to their clients and the duty of care of health care employers to ensure the safety of nurses under OH&S legislation. However, awareness and actions that support staff safety are imperative for changing current practice.

Many Victorian health services, particularly major hospitals, have developed policies with respect to the seizure of any prohibited, controlled weapons and dangerous articles. However, the legislative framework is not clear regarding the position of hospital staff in relation to searching clients who may be suspected of possessing such articles. It should also be acknowledged that the attempted removal of any property can escalate violence.

To ensure that a safe and secure environment is maintained through the provision of mechanisms that promote safety, a coordinated approach to the search and seizure of any weapons is required. The key considerations are search and seizure, storage, disposal or return of any weapons and dangerous articles.

Recommendation 6

That the Department of Human Services requests the Department of Justice to consider the issues of occupational violence in nursing and consider legislative mechanisms and strategies that will improve the safety of nurses and other health care workers.

Recommendation 7

That the Department of Human Services considers the development of statewide guidelines with respect to weapons and dangerous articles within the health care setting. This may include introducing legislation or guidelines in health services that relate to the search and removal of weapons and/or dangerous articles, the storage, disposal or return of such articles, and to allow police to receive and hold such property, regardless of whether it is to be used as evidence in relation to a crime or that charges are to be laid. This matter should be considered together with other legislative issues referred to the Department of Justice.

2. Public awareness campaign

A public awareness campaign should be developed and implemented to support the strategies developed by the Taskforce on Violence and Bullying in Nursing.

The taskforce believes that public awareness campaigns underpin strategies to address violence against health workers.

In 1998, the UK NHS coordinated a campaign to convey a public message that violence against NHS staff was unacceptable and the government was determined to reduce and eliminate this culture of violence. It also conveyed to staff that violence and intimidation was unacceptable and would be addressed. The campaign conveyed a range of positive and negative messages using various media, all emphasising that any level of violence is unacceptable (www.nhs.uk/zerotolerance).

Other UK examples include:

- Ambulance services in London and Wales launched 'No Excuse Campaigns' with the message that an ambulance officer was assaulted every day in London and that it was unacceptable behaviour. The aim was to reduce the number of violent incidents against ambulance officers (www.unison.org.uk).

- The NHS Scotland 1999 zero tolerance campaign encouraged staff to report violence and informed the public that they should not stand by and let it happen (www.wales.nhs.uk/sites).

Public messages must reach consumers before they attend a health facility or come into contact with nurses, as often the perpetrators are in an impaired state when they commit the assault.

The Victorian experience of public awareness campaigns includes the recent drug awareness media campaign and the campaign undertaken by the Transport Accident Commission to reduce injuries and fatalities from road accidents. The media campaign to encourage nurses back into the health system is an example of the successful use of multimedia to support an important government initiative resonating with Victorian nurses.

Recommendation 8

That Victorian Government and health services develop, pilot and implement a public awareness campaign that:

- promotes an expectation of behaviour and consequences for unacceptable violence and aggression
- clearly states the message that violence towards nurses is unacceptable.

A successful public awareness campaign should be part of a broad strategy aimed at minimising violence and bullying against nurses. It should:

- include messages directed at employers, nurses, other health services employees and members of the general public
- ensure that information must reach consumers before they attend a health facility or come into contact with nurses
- have clear and easily understood messages that are widely disseminated (UK examples included advertising in public places such as train stations, pubs, clubs and libraries).

The Department of Human Services should develop and pilot the effectiveness of proposed messages before they are more broadly introduced, and should evaluate the effectiveness of a public awareness campaign.

3. Post-incident management

Occupational violence and aggression may cause an individual to experience physical, behavioural, cognitive and emotional reactions. This may occur as a direct result of violence and aggression and/or indirectly as a witness to an incident of violence and aggression.

Post-incident management procedures require managers and nurses to understand stress and emotional reactions and how best to manage responses to incidents of violence and aggression.

Managers have an important role in assisting staff to manage and recover from an incident of violence and aggression. An individual's response is usually related to both the incident itself and the perception of how they have been 'looked after' by the health organisation. This feature is represented by the actions taken by the manager.

It is the manager's role to create a climate for recovery within the workplace. This includes activities such as organising defusing, debriefing and/or counselling for nurses and follow-up in the immediate period post-incident. The manager is also responsible for establishing an operational review of the incident, which aims to determine an immediate risk assessment and actions to prevent the recurrence of further episodes of violence and aggression.

Employees also have a role in post-incident management, including the responsibility to report violent or aggressive incidents, to assist the provision of care and support.

Recommendation 9

That the Department of Human Services, in consultation with health services, adapts for broad use: *The industry occupational health and safety interim standards for preventing and managing of occupational violence and aggression in Victorian mental health services* (Department of Human Services 2004) for post-incident management.

The post-incident framework includes management strategies adapted from these guidelines and includes guidelines and education for awareness of post-incident management support for nurses and managers.

4. Aggression management teams

Every organisation should use a range of systems and structures to minimise the risk of aggression and maintain a safe and therapeutic environment for patients, their visitors and staff.

Actual or potentially aggressive behaviour in relation to patients and their family should primarily be seen as a clinical matter and, therefore, is best managed by clinical staff trained and skilled in de-escalation techniques.

The local staff response, where appropriate, should remain the initial response to an aggressive incident as a means to encourage safe treatment and care of patients and their visitors. If assessment of the incident indicates that it cannot be safely and effectively managed at a local level, then either a Code Grey or Code Black should be called.

More focused training of clinical staff in emergency departments and psychiatry is recommended, due to the prevalence of aggressive incidents in these areas.

One component of a clinically led aggression management response is the Code Grey – Aggression Management Team (AMT). This team should be developed in association with security services (where applicable) and other key hospital personnel appropriately trained to manage such incidents.

The AMT focus is to assist the local team to provide ongoing and appropriate care and treatment for patients, and optimise staff safety. In the case of visitors, similar principles are adopted, although security/police may have a more active role in eviction from the clinical area or hospital if this is required.

AMT members may be drawn from any area of the health service and undertake this role as part of their normal duties. Adequate training for the role is critical and AMT members should be trained to assess the incident and coordinate the appropriate responses to best resolve the incident in the least restrictive and safest manner. The AMT will assist the local staff response with the management of an aggressive incident. The senior clinician should have responsibility for escalating a Code Grey to a Code Black, and to engage the support of other personnel (for example, a psychiatrist or police), if required. Where applicable and according to the needs of the organisation, security services should form part of the AMT or be accessible to the service. The effectiveness of the AMT can be enhanced by having clear policies and associated guidelines in place regarding the use of restraint and/or seclusion but, in any event, should be a temporary or last-resort action.

The appropriate number and skill of members of the AMT may depend on the size of the organisation and number of staff, hours of operation, geographical location and the types of clients that the service supports. For instance, a large public hospital with an emergency department that operates 24 hours per day, seven days per week will have different requirements of an AMT to a maternal and child health service operating only on weekdays. Staff skill and availability of security personnel for the AMT should be determined according to individual workplace situations and requirements. A team should be available to respond to aggressive incidents for the entire duration that any facility is open to the public.

An effective way to manage and coordinate the AMT function is through an aggression management reference group. Such a group may have the following objectives:

- to facilitate the aggression management program and its continued development and implementation
- to further enhance a clinically led AMT as part of a process to effectively manage aggressive behaviour
- to ensure that security services (where applicable) are integrated into planning, operations, reporting and evaluation in a manner consistent with obligations

- to integrate training programs
- to develop and review protocols and procedures that are integrated into existing management systems
- to monitor trends through auditing, data collection and evaluation
- to recommend changes to existing systems through review of the current program and serious incidents.

The regulation, definition, application and clinical practice of mechanical restraint is consistent across health organisations, where it occurs. For example, in mental health services mechanical restraint is highly regulated by the Mental Health Act and guidelines issued by the Chief Psychiatrist. Further, it is considered an intervention of last resort. In addition, the Standards and Guidelines for Residential Aged Care state that resident behavioural management should be in accordance with contemporary practice, and do not advocate restraint except to protect the resident or others from injury as a last resort. It is apparent that restraint is and needs to continue to be context-dependant and the preparation of staff working in all health settings in their understanding of the context and application of physical restraint requires education and training at all levels. More detailed guidelines and education are required to assist all health settings in their understanding and application of physical and chemical restraint of clients.

Similarly, seclusion is poorly understood in most acute health settings. The *Mental Health Act 2003* provides clear legislative requirements for staff to implement seclusion in the mental health setting, however, there are no clear guidelines for seclusion of clients in the acute setting. Guidelines are needed to assist staff in their response to violence and aggression.

Recommendation 10

That the Department of Human Services introduces into Victorian health services, a standardised Code Grey (violence and aggression emergency) and Code Black response (armed threat).

Recommendation 11

All health organisations will:

- establish an aggression management reference group which will be responsible for developing policies and procedures around the management of aggressive incidents, primarily through a clinically led aggression management team
- ensure that all clinical areas undertake a risk assessment and give consideration to a number of strategies, including the development of guidelines to address the needs of each different setting and reviewing the need for appropriately trained security personnel
- establish, in all high-risk departments, security measures that include a response by staff who are trained in the prevention and management of violence and aggression during hours of operation
- consider how to address the broader issues of physical restraint and seclusion within non-designated mental health areas
- develop guidelines for emergency responses during operating hours in smaller health facilities or for those nurses working in community, rural and remote settings.

Recommendation 12

That the Victorian Government considers procedures for reporting to police, laying charges and prosecutions, including the potential for legislation for nurses similar to that developed for ambulance officers. (A Memorandum of Understanding, similar to that adopted between NSW Health and NSW Police, is a useful reference.)

Resources

The adoption and implementation of the strategies and recommendations outlined in this report will require the allocation of resources.

Resources that may be required include:

- time – for example, release of staff for training or involvement in consultative arrangements
- money – for example, funding publications, equipment, the design and delivery of training packages, public awareness campaigns
- personnel – for example, employing staff with expertise, employing security staff.

NSW Health provides a reference for the allocation of resources. It has allocated significant funding to support and implement the strategies developed by the NSW Taskforce on the Prevention and Management of Violence in the Health Workforce.

Assessing exactly what resources are needed should be integrated into planning processes.

Recommendation 13

The Department of Human Services commit resources to support:

- the implementation of strategies to prevent and manage violence and aggression against nurses and other health workers
- strategies developed in areas that include design, personnel, equipment, publications and training
- the evaluation of the strategies following their implementation
- preliminary analysis of the data set and strategies 12 months after implementation and a comprehensive evaluation of the same after three years.

Environment

The physical environment of public spaces and buildings can have a strong influence on behaviour.

A presentation to the subcommittee from Senior Sergeant David Short demonstrated several frameworks that draw on the principle of affecting behaviour through environmental design. Two of these frameworks are *Crime Prevention Through Environment Design (CPTED)* and *Safer by Design* (which draws on the CPTED principles). These are systematic processes of creating features within our built environments that influence social behaviour in a positive way (NHS 1997). The benefits are achieved by reducing undesirable behaviours and increasing the sense of wellbeing.

These frameworks are used in shopping centres, residential zones and parkland. Although created with crime prevention in mind, the frameworks could be applied to health services to improve the safety of the environment through designing for a reduction in violent and aggressive events.

Key principles of CPTED that are applicable to the health care setting are:

- Territorial reinforcement: people assume and express feelings of ownership and possibly pay more attention to an area or note potential intruders or acts of violence.
- Access control: physical and symbolic barriers control access. Clearly identifying staff-only areas with physical or symbolic barriers makes it more difficult to reach potential victims or targets.
- Natural surveillance: as people often feel safe where they can be seen and interact with others, natural surveillance can be achieved by creating sightlines between public and private space.
- Space management: there is a belief that a well-maintained facility may reduce criminal activity, whereas a run down, empty, graffiti covered building may attract criminal activity and offenders (NHS 1997).

Control strategies that are components of the key principles include:

- clear communication strategies to provide information and signs
- service delays are minimised
- activity or noise levels are minimised
- adequate lighting in waiting areas, entrances and car parks
- consistent, clear and concise signage that caters to the needs of clients who may be culturally and linguistically diverse
- fixtures are secured wherever possible, with sharp corners and edges eliminated
- staff identification is worn at all times
- access to buildings is restricted, staff only access points are clearly signposted and access is reduced in times of reduced staffing, such as after hours in smaller health services
- legal implications with regards to weapons are specified
- computerised access control systems for locks and for recording of audit trails
- security/reception areas are protected through design
- closed circuit television (CCTV) monitoring clearly states whether monitors are staffed by security or not
- CCTV monitor is reversed, where the public watches themselves
- waiting rooms are comfortable, spacious, provide reading material, access to phones, water dispensers, and so on.

To be effective, CPTED requires:

- cooperation from all staff
- Chief Executive Officer and senior management endorsement and support
- an understanding of the impact of environmental design and its benefits, which should be included in education and training programs.

Before recommending or implementing any such strategy, it is important that contextual considerations and site risk are properly identified, measured and assessed by appropriately trained personnel, such as OH&S representatives and risk managers. This particularly applies to health services that vary in their size, purpose, location and resources.

It is important to establish a balance between creating a safe environment for all and delivering care to the clients. Risk assessment and risk management are imperative in reducing environmental risks.

Security resources have been identified as a component for promoting a safe environment in some health care settings. The need for security officers will depend on a range of factors, including the size and needs of the health care setting and other locally implemented safe environment strategies, and should be considered by all health organisations as part of their risk assessment and management framework.

Recommendation 14

The principles of affecting behaviour through environmental design and management should be applied to all future building development and refurbishment.

Education

The aim of the Education Subcommittee was to establish mechanisms that promote monitoring and evaluation of strategies to prevent and reduce occupational violence.

A key objective was to develop and implement a framework for use by health services and education providers that recommends educational strategies to:

- prevent occupational violence and bullying in the workplace
- reduce the impact of violence and bullying in the workplace
- ensure consistent reporting of incidents or potential incidents of occupational violence and bullying
- increase awareness amongst undergraduate nursing students and registered nurses concerning occupational violence and bullying.

The taskforce believes that occupational violence and bullying can be prevented or significantly decreased if proactive measures are taken to ensure the workforce understands the factors and behaviours that shape and influence violence and bullying in the workplace. An important component of reducing the incidence of violence in the workplace is implementing an appropriate educational program that is accessible to all staff.

The educational program is an integral part of a broader risk management approach that includes environmental, administrative and behavioural strategies. Education and training should be a major focus for the control of risks.

Organisational culture

Organisational culture is a critical element to consider when examining the incidence of occupational violence and bullying. It is also a critical component of education and training programs aimed at preventing violence and bullying.

Education and training programs should acknowledge the role of organisational culture in supporting or preventing occupational violence and bullying. Education should reinforce the values of the organisation, emphasise positive staff behaviours and identify negative behaviours, identify appropriate behaviour to other workers and respectful treatment of clients in difficult situations, and address issues such as sensitivity to multicultural diversity.

The taskforce believes that every individual needs to advocate that violence in the workplace is unacceptable. Senior management need to ensure that policies, procedures, systems and processes are in place to prevent or manage violent incidents. Training all staff to understand and deal with occupational violence and bullying requires ongoing education and support that should commence at orientation and be updated on a periodic basis.

Behaviour

Individual behaviour (and sometimes group behaviour) has been identified as a potential catalyst of violence. Education and training should include strategies to assist individuals to recognise how their own behaviour and attitudes may contribute to violence in the workplace. On occasions, it will be necessary to counsel staff who exhibit such behaviours.

Staff may be confronted with the range of behaviours exhibited across the broader community, including verbal abuse, threatening behaviour and assault. Staff may also experience unacceptable treatment from colleagues. Nurses will be better equipped and empowered to deal with violence and bullying if they are supported and educated to do so.

Consumers have certain expectations about access to quality public health services. When they face delays and lack of communication, the consumer, who is already experiencing a stressful and emotional situation, may become aggressive. Many people feel disempowered in an unfamiliar environment such as a hospital emergency department.

To promote a workplace free of violence, the roles of all staff in the management and prevention of violence and bullying need to be explicit. Organisations should also clearly state what is acceptable and unacceptable behaviour for staff and consumers.

Recommendation 15

Health services develop a clear statement of expected behaviour, outlining acceptable and unacceptable behaviour, for both staff and consumers.

Language and definition

A significant problem in developing education programs aimed at violence prevention and management is the lack of consistent definitions. The taskforce believes it is important that there are agreed definitions of bullying and violence and that the language used by management and staff is consistent.

Consistency of language and terminology used in statewide education and training programs and reporting mechanisms would assist with:

- long term benchmarking of like services
- identifying high risk areas
- identifying and sharing best practice.

Staff education

Occupational violence and bullying programs should be included in staff orientation processes. All new employees, including casual bank and part-time nursing staff, should undertake compulsory training for the prevention and management of occupational violence and bullying. Private providers of agency nurses also need to provide education for nurses engaged by them.

Education to improve the reporting of violence and bullying incidents is also important. This may include statistical data regarding the prevalence of occupational violence and bullying within the health sector and local organisation, as well as addressing how reporting of incidents will benefit staff. Such reporting can inform the development of strategies to reduce the likelihood of similar incidents and improve responses to incidents. Most importantly, employees have an obligation to their colleagues, the organisation and the general public to report potential or actual incidents and make suggestions for reducing risk of violence and bullying and improving work conditions (ILO, ICN, WHO, PSI, Geneva 2002).

Education program content

Education and training programs on occupational violence and bullying should incorporate:

- core content to ensure a consistent level of understanding amongst nursing staff employed in the health care sector
- content that individual health care facilities identify to ensure specific training needs are met for their local environment. For example, contextualised content may be influenced by factors such as size and location of the organisation, available resources and risk levels.

The benefits of education and training relating to occupational violence and bullying include:

- increased staff skills and confidence in managing violence and bullying
- promoting a feeling of safety amongst staff
- reduced fear, anxiety, negative attitudes and possibly burnout
- early recognition of subtle bullying behaviour
- a potential decrease in the number of incidents of aggression and violence
- a potential decrease in the number of injuries to staff and clients, the level of aggression and type of injury
- a decrease in the number of days missed from work and the overall costs associated with service delivery.

Key principles that underpin education aimed at prevention include:

- education programs should reflect a whole of organisation approach to occupational violence and bullying and include senior management in the development and delivery of programs. This includes ensuring that education is supported by appropriate policies, procedures and monitoring systems
- a participative approach ensures that employees are actively consulted and involved in the development, implementation and evaluation of education programs
- the program should include a means for evaluating the effectiveness of training to ensure that it is responsive to the needs of the organisation, staff and consumers over time.

A fundamental stage in developing a statewide education and training program is to identify the characteristics that shape and influence violent and bullying behaviours. This may be informed by the literature review and, more importantly, by an analysis of incidents at the local level.

Other key aspects to consider in developing a successful education program are:

- consistency in content
- teaching/learning approaches
- accessibility for staff.

The specific content of educational programs needs to reflect the organisational context and the needs of the employee.

The following educational content is recommended for a program aimed at nurses to address and manage occupational violence and bullying in the workplace while protecting themselves when facing such incidents.

Organisational culture

- Values of the organisation
- How to emphasise positive staff behaviours and identify negative behaviours
- Appropriate behaviour to other workers
- Respectful treatment of clients in difficult situations
- Sensitivity to multicultural diversity

Legislative framework

- Employee rights and obligations
- Legal implications, for example, *Occupational Health and Safety Act 2004*, risk assessment and management framework, risk assessment for potential violence and aggression, and other compliance Acts

Safety measures

- Risk assessment for potential violence and aggression
- An overview of the risks associated with occupational violence and bullying
- Behaviours that are an antecedent to bullying and violence
- Identification of causes and early recognition of violent and/or aggressive behaviour
- Preventing and/or defusing potential and actual volatile situations
- Clearly defined personal safety techniques, including counter-restraint and take-down techniques
- The safe use of safety devices, such as alarms and restraint
- Emergency response procedures

Policy/safety

- Organisational policies and procedures
- Strategies to assist staff in recognising bullying behaviours
- Strategies for dealing with aggressive or violent behaviours

Reporting

- Reporting mechanisms and the importance of reporting

Staff support

- Post-incident support processes and how to access follow up

Public awareness

- Client expectations
- What is acceptable and unacceptable behaviour

Recommendation 16

The Department of Human Services develops guidelines to ensure a minimum standard of education is provided to all nurses.

Recommendation 17

Health services:

- provide education for nurses to prevent and manage occupational violence and bullying. The education and training will be consistent with DHS guidelines and address the key elements identified by the education subcommittee, including prevention and management of occupational violence and bullying
- provide nurses, including part-time and casual bank nurses and other health care employees, with education and training as part of the orientation process to a new organisation
- ensure all nurses in the workplace undertake continuing education programs that address occupational violence and bullying at least on an annual basis
- provide additional specific training to staff working in identified high risk areas
- maintain a database of all nurses who have completed education, and develop systems to ensure the adequate education of casually employed nurses in relation to occupational violence and bullying and that these systems meet the requirements of the *Occupational Health and Safety Act 2004*.

Recommendation 18

Providers of agency nurses ensure nurses are provided with education and training in the prevention and management of occupational violence and bullying prior to undertaking casual employment with any health care facility. This education is to include all key elements identified as a minimum educational and training requirement.

Continuing education

Continuing education programs should be offered regularly to ensure that nurses continue to manage occupational violence and incidents of bullying in an effective and efficient manner. There is little evidence to indicate how frequently refresher training should be provided; general recommendations appear to be every one to two years.

Safety training for nurses and other health care workers should be ongoing (Levin et al. 1998; O'Connell et al. 2000) especially for staff who are assessed at being at high risk of violence (Nolan et al. 1999). A range of indicators can be used to provide feedback on the effectiveness of training, including:

- monitoring incidents, that is, reporting and periodic review of reports of incidents
- evaluating educational/induction programs and changes in behaviour in the workplace; these are reliable indicators of the effectiveness of educational programs, policies and procedures
- ongoing reassessment of workplace culture, systems, procedures and policies to effectively respond to occupational violence and bullying—organisational survey will also contribute to a reduction in incidences (ILO, ICN, WHO, PSI, Geneva 2002).

Environment

The work environment also contributes to the occurrence of occupational violence and bullying. For example, some speciality areas pose a higher risk of occupational violence than others, including emergency departments, drug and alcohol clinics, mental health units, maternity services, intensive and coronary care units, rural health settings and outpatient and visitor waiting areas. Staff working in these high risk areas need additional and locally-specific education on an annual basis to prevent and manage occupational violence and bullying.

There is consensus that education is only effective if it is part of a broader organisational approach. The taskforce believes that all managers, medical staff and team leaders of health services play an important role in establishing the health care environment. As such, managers of services in which nurses work can have an influence on the prevalence, reporting and management of violence and bullying of nurses in the workplace.

All managers require training that assists them to:

- understand the adverse impacts of occupational violence and bullying on employees, patients and the workplace
- develop skills to prevent occupational violence and bullying within the health care setting
- understand their obligations to provide a safe workplace for employees and clients
- understand and manage their own behaviours, including the capacity to shape behaviour of others through role modelling, setting clear standards and effectively managing incidents.

Recommendation 19

Health services develop specific education programs for all managers, covering:

- the impact of occupational violence and bullying on the workforce
- the organisation's expectations of the managers, inclusive of policy and procedures for prevention and management of incidents
- the importance of supporting staff to report incidents
- the obligations of the manager
- techniques and available support mechanisms for staff and managers.

Undergraduate education

There is evidence to suggest that inexperienced nurses, particularly students, are at a greater risk of being the victims of client-initiated violence and bullying (Little 1999). Also, there is an identified lack of consistency in undergraduate nursing curricula concerning the preparation of students to cope with occupational violence and bullying.

Fisher's (2002) Australian study reinforces the need for clinical staff and educators to provide appropriate support for students who experience or observe a violent or aggressive incident. This will provide opportunities to learn to resolve and deal with such critical incidents effectively. Furthermore, nurse educators need to ensure that strategies to deal with occupational violence and bullying are included in undergraduate curricula (Lam 2002; O'Connell et al. 2000) and conducted before undergraduate students embark on their first clinical placement. Another consideration in the undergraduate curricula is the inclusion of organisational culture and understanding how each individual can contribute to a positive culture through behaviours and upholding the organisation's values.

It is the taskforce's view that an integral part of a nurse's undergraduate preparation for entry into practice is the inclusion of OH&S principles, particularly an introduction of occupational violence and bullying, management principles and coping strategies. It is also argued that OH&S content should be undertaken by students before clinical placements and reinforced once they enter the nursing workforce.

Recommendation 20

That the Minister for Health requests:

- the Nurses Board of Victoria to require, through accreditation processes, nursing courses leading to registration to include OH&S principles, particularly those that address occupational violence and bullying
- the Australian Nursing and Midwifery Council to consider the development of competency standards pertaining to OH&S principles and require the inclusion of OH&S components of occupational violence and bullying.

Recommendation 21

Higher education providers and health services create a mechanism for monitoring and evaluating the prevalence of bullying and violence experienced by students in the workplace during clinical placements.

Public awareness

The general public also needs to be educated about the expectations of behaviours and the potential consequences of their own behaviour while engaging with the various health settings.

Media campaigns to raise public awareness about occupational violence and bullying and inform potential consumers of health care that such behaviour will not be tolerated have been used nationally and internationally. This should be considered as a strategy in Victoria. These programs convey to the community their rights and responsibilities. Examples are provided by NHS-coordinated 'Zero Tolerance' campaign (1998) and the Welsh Ambulance Service NHS 'Trust No excuse' campaign.

The aim is to inform consumers about what is acceptable and unacceptable behaviour before they access a health care facility or come into contact with nurses.

The majority of campaigns used positive and negative messages and a range of media, all emphasising that any level of aggression or violence is unacceptable.

Monitoring and evaluation

With the introduction of comprehensive education programs across the state, it is likely there will be an increase in the number of incidents reported for bullying, violence and aggression. This does not necessarily mean an overall increase in the number of incidents or their severity, but rather a better understanding and compliance with reporting. The NHS believed that there had been significant under-reporting of violence directed at staff. Following implementation of its Zero Tolerance campaign, the number of incidents reported rose from 65,000 in 1998–99 to 95,501 in 2002 (NHS 2002a, 2002b; NAO 2003). After this initial increase, the incidence of violence and bullying is expected to decrease as a result of the systematic implementation of recommendations and strategies.

Bullying

The aims of the Bullying Subcommittee were to establish mechanisms that promote monitoring and evaluation of strategies to prevent and reduce bullying in the workplace.

Key objectives included:

- classifying the various types of bullying, as defined in the WorkSafe Guidance Note, experienced by nurses in the workplace
- recommending strategies to prevent and manage bullying in the workplace
- recommending guidelines for use by organisations with respect to:
 - policy development
 - implementation
 - risk management
 - monitoring systems
- recommending strategies to increase awareness of undergraduate nursing students and registered nurses of issues associated with bullying.

The Bullying Subcommittee explored the understanding and experience of workplace bullying in Australia and in other countries as well as existing and recommended strategies to prevent and manage bullying.

This report includes a range of issues and factors that should be considered in the development and implementation of strategies and actions to understand, prevent and manage bullying.

Definitions and types of bullying

Workplace bullying is sometimes referred to as ‘internal violence’, where another employee, supervisor or an acquaintance of work, perpetrates an assault.

There is a dearth of substantive Australian data pertaining to the extent and severity of internal occupational violence in the health care industry, as well as a lack of consensus regarding the meaning and use of the term ‘bullying’. Debate continues as to whether bullying should be defined as one of the many forms of internal violence or whether it is distinct in its own right.

There is a view that forms of internal violence are perpetuated along a continuum of severity, ranging from ridicule to verbal abuse, threats and physical assaults. The key difference between internal and other forms of occupational violence is that the perpetrators and victims know one another and may have daily contact.

Bullying can occur whenever people work together. Bullying is not always intentional. Sometimes people are not even aware that their behaviour is causing harm to others. Bullying usually occurs over a period of time. It is a repeated pattern of behaviour that can be made up of different types of incidents.

In Australia, there has been little substantive research of bullying in health workplaces. However, a descriptive study of 270 Tasmanian nurses found that 30% were subjected on a daily basis or near-daily basis to aggression from nurse managers and colleagues, which resulted in significant levels of distress (Farrell 1999).

Definition

WorkSafe Victoria’s *Prevention of bullying and violence at work Guidance Note* (2003) offers the following definitions:

- Workplace bullying is defined as **repeated, unreasonable behaviour** directed toward an employee or group of employees that creates **a risk to health and safety** (p.6).
- ‘**Unreasonable behaviour**’ means behaviour that a reasonable person, having regard to all the circumstances, would expect to victimise, humiliate, undermine or threaten.
- ‘**Behaviour**’ includes actions of individuals or of a group, and may involve using a system of work as a means of victimising, humiliating, undermining or threatening.
- ‘**Risk to health and safety**’ includes risk to mental or physical health of the employee.

There is a lack of consensus regarding what constitutes workplace bullying. Most definitions share three elements:

1. Bullying is defined in terms of **its effect on the recipient** not the intention of the bully, thus it is subject to variations in personal perception. In respect to this, the bullying actions and practices are clearly unwanted by the victim.
2. There must be **a negative effect** on the victim. The bullying acts clearly cause the victim to feel harassed, humiliated, offended or distressed and/or interfere with their job performance and/or make an unpleasant working environment. In other words, there is a risk to the mental and/or physical health or wellbeing of the employee as a result of the bullying.
3. The bullying behaviour **must be persistent**. A one-off incident of verbal abuse or harassment is not considered to be bullying, especially if the victim's performance was not affected.

The following examples of bullying behaviour reflect the intent of the listed definitions. Bullying behaviours include, but are not limited to:

- verbal abuse, physical attacks, social isolation, excluding or isolating employees, psychological harassment, intimidation, devaluation of one's work and efforts, teasing, insulting, ridiculing, assigning meaningless tasks unrelated to the job, giving employees impossible assignments, deliberately changing work rosters to inconvenience particular employees and deliberately withholding information that is vital for effective work performance
- practical jokes, being sworn at, insulting a colleague, being excessively supervised, being constantly criticised, being put down in public, rumours being spread about you, being overloaded with work or not given enough work to do, not getting the information you need to do your job, your personal effects or work equipment being damaged, and being threatened with termination.

Rayner and Hoel (1997) group bullying behaviours into the following categories:

- a threat to professional status, for example, belittling opinion, public professional humiliation, accusation regarding lack of effort
- a threat to personal standing, for instance, name calling, insults, intimidation, devaluing with reference to age
- isolation, for example, preventing access to opportunities, physical or social isolation, withholding of information
- overwork, for example, undue pressure, impossible deadlines, unnecessary deadlines
- destabilisation, for example, failure to give credit when due, meaningless tasks, removal of responsibility, repeated reminders of blunders, setting up to fail.

It is important to have a clear and accepted definition in order to understand and consider bullying in an objective manner, to evaluate strategies, and to prevent bullying.

Sources of bullying

Bullying usually derives from a source within the workplace, for example:

- an employee may bully another employee
- an employer may bully an employee or group of employees
- a group of employees may bully an individual or another group of employees
- clients and customers may also bully employees.

What is not workplace bullying

Distinguishing between 'poor management' that contributes to a violent culture and inappropriate coercive behaviour is often difficult. It is important to distinguish between legitimate supervisory activities and inappropriate behaviours that are motivated by non-professional factors.

Employers have a right to direct and control the ways in which work is carried out in the workplace. Situations where an employee has a grievance about legitimate and reasonable performance management processes, disciplinary action and a fair and equitable allocation of work do not qualify as workplace bullying.

The definition of bullying within the WorkSafe Guidance Note (2003) is clear and unambiguous, that is, the behaviour is repeated and unreasonable.

Recommendation 22

That the Department of Human Services and health services accept an agreed definition of bullying that is aligned with the WorkSafe definition and use it consistently.

Organisational culture

Management style and organisational culture should be considered when examining the incidence of occupational violence and bullying.

Management style

A quasi-military hierarchy with a rigid management style, marked supervisor/employee divisions, and a highly competitive business environment enhances the probability of bullying. Additional risk factors include management toleration of bullying, cultures where horseplay and practical jokes are normalised, job insecurity, workers with a strong sense of entitlement who feel cheated, and disciplinary suspensions (Mayhew 2001d; Mullen 1997; Randall 1997:50-53; Myers 1996:3; WCBBC 1995:8; Wiltowski 1995).

Developing a human-centred workplace culture based on dignity, respect, anti-discrimination, equal opportunity and cooperation is an integral component of any strategy aimed at reducing violence in the workplace. To implement this culture, it is necessary for the organisation and its staff to share a common vision and goals. A human-centred workplace culture is underpinned by a participative management style and needs to be role modelled by managers and senior executive staff if they wish to witness a change in nursing behaviour (*Framework guidelines for addressing occupational violence in the health sector*, ILO, ICN, WHO, PSI, Geneva 2002).

Organisational workplace culture is often derived from both implicit and explicit messages people receive about what is considered to be acceptable behaviour in the workplace. These messages demonstrate to staff what is valued, what is important and what staff are expected to do in order to fit in, be accepted and be rewarded. Nurses internalise these messages, adapt their behaviour and, in doing so, reinforce the culture by sending these messages to other colleagues. Subsequently, to achieve a cultural shift within an organisation from one that accepts bullying as 'part of the job' to one that does not tolerate bullying behaviours, requires a well developed plan of action endorsed by senior management.

Staff observe the behaviour of managers at all levels within an organisation. Managers are role models and subordinates carefully observe their behaviour. Their actions frequently send messages about 'what is expected around here' and these expectations are often much more influential in shaping behaviour than any spoken messages. Subsequently, managers have a responsibility to model behaviour that does not endorse bullying and send a clear message that it is unacceptable; their actions and communications must consistently reflect this viewpoint. The decisions and responses that managers and executive staff make about bullying in the workplace will have a significant impact on the workplace culture.

To establish a successful no bullying program requires each individual to advocate that bullying is unacceptable and the implementation of strategies to prevent and/or address bullying. Adopted strategies have to be conveyed to nurses via the role modelling behaviour of managers and the establishment of appropriate systems in the hospital setting to report and address bullying in the workplace.

Key principles of a no bullying program include:

- senior executives are explicit about their commitment to the implementation and support of bullying minimisation strategies
- it is made clear that appropriate action will be taken to prevent and manage occupational violence and aggression and to protect staff, patients and visitors from the effects of violent and aggressive incidents
- all members of the health service community are aware of and accept responsibility for maintaining a safe workplace

- encouragement and support for appropriate staff action and response is provided by all levels of the organisation, including feedback on the outcomes of these responses
- appropriate responses to acts of bullying are consistently enforced
- managers are held accountable for preventing and managing violence in the workplace. Their strategies require adequate support, for example, via the allocation of legitimate authority and resources, to support their role in reducing workplace bullying.

Workplace culture

Bullying behaviour is shaped and influenced by workplace cultural factors. The culture of an organisation permeates every aspect of its daily activities and processes. As such, workplace culture must be considered as a key factor in the development and implementation of all strategies aimed at minimising and preventing the occurrence and impact of bullying towards nurses.

Exposure to violence has been intrinsically linked to being a nurse. Nurses perceive violence and aggression as being 'all in a day's work'. As a consequence, many nurses portray a complacent attitude towards bullying and treat it as an untoward aspect of the role.

Therefore, it is suggested that the following principles be adopted when developing bullying prevention programs:

- focus on prevention rather than management (which already has well-defined processes but is associated with considerable investment of time and emotion by all parties involved)
- base recommendations for prevention of bullying on principles of empowerment, dignity and respect
- stress the importance of positive messages rather than negative ones.

Environmental factors also shape and influence bullying behaviours and directly impact on the prevalence and risk of violence in the workplace. Factors include:

- physical environment
- consumer expectations
- communication systems
- workloads
- change management processes.

Management strategies

Issues management

A proactive step in curtailing and managing bullying in the workplace is to appoint a bullying contact officer who is responsible for ensuring that violence vulnerability risk assessments of the workplace are undertaken that are objective and are reported regularly. The timeframe of reporting should be clearly specified in organisational policies, that is, normally within three working days of an incident. In the event of a serious breach of policy, immediate reporting is required.

Change management

Encouraging a participatory management style, fostering teamwork, ensuring that procedural guidelines are always followed, and improving communication channels will all reduce anxieties in times of change and help reduce the potential for bullying. Excessive levels of stress and environments dominated by inflexible managerial styles have a higher likelihood of contributing to bullying behaviors.

Performance management

Legitimate management criticisms or performance management needs to be constructive, clear, supportive and balanced (Keastly, 2004: 257).

The approach to performance management needs to incorporate the principles of natural justice and each organisation's disciplinary procedures should be consistent with award or agreement procedures. Examples of natural justice are when the person alleged to have behaved unacceptably has:

- the right to be treated as innocent until the allegations are proved to be true
- the right to have a representative with them when they are informed of concerns relating to their performance
- appropriate time to respond to concerns relating to their performance
- the opportunity improve their performance
- any allegation investigated promptly.

Recommendation 23

That health services establish consistent management strategies that include:

- clear organisational policy with 'safe' reporting to an objective, senior, listener
- timely and consistent response from management
- support for realistic outcomes.

Recommendation 24

That health services establish management education strategies that:

- explore and articulate mechanisms to assist organisations to manage situations where, despite investigation, no clear resolution to bullying is obvious and/or possible
- emphasise positive behaviours in the workplace
- raise nurses' awareness of the differences between bullying behaviours and legitimate business practices, for example performance management and organisational change
- minimise ambiguity so that bullies and victims are aware of the subtleties and trivialities that comprise bullying in nursing.

Staff awareness and education

To curtail bullying in the workplace, staff need to understand the no bullying policy, how to comply with it, how to make a report and the processes the organisation uses to address bullying. Educational programs need to offer user-friendly strategies, for example, that include how to record incidents and how to draft a letter to a perpetrator with a request to stop the bullying behaviour. Staff must be empowered to manage the negative behaviours of others, and perpetrators should have the opportunity to develop skills to prevent and/or curtail their behaviours.

Providing training to recognise bullying behaviours, identify the possible effects, and understand how access to further information and assistance can raise staff awareness of occupational violence.

Suggested strategies include formal training sessions, staff bulletins, intranet discussion boards, staff meetings and informal discussion groups. It is also recommended that information about bullying should be provided at orientation sessions for new staff members. Other strategies include engaging content expert consultants to assist with staff development and training about how to manage bullying in the workplace. It is also recommended that OH&S representatives and employees are involved in developing policies.

It is recommended that health services should have a written policy on workplace bullying and harassment, which is developed in consultation with employees and is in line with Victoria's *Occupational Health and Safety Act 2004* and the Victorian WorkSafe Guidance Note on the prevention of bullying and violence at work. This policy should include:

- a clear statement that the organisation will not tolerate bullying in the workplace

- a clear statement about the workplace behaviours that are not acceptable
- an outline of the steps that will be taken should bullying occur, including the procedure for making a complaint
- a commitment to maintaining confidentiality and a reprisal-free complaint process
- measures that will be taken to resolve conflict and discipline staff
- that counselling and support services will be available for victims.

The policy must be endorsed by the organisation, distributed throughout the workforce and displayed where employees can read it. Essential to the success of development and implementation is:

- ensuring the policy is specific to the workplace
- developing the policy in consultation with employees
- securing commitment from the board, CEO and the organisation
- ensuring the policy is adhered to and consistently applied.

It is also important to encourage reporting of bullying behaviors. Suggested strategies include:

- developing reporting procedures with employees
- establishing a database that groups past incidents, analyses the characteristics of the perpetrators, situations, causes, the department and other risk factors
- identifying an independent, trusted source for reports
- encouraging individual victims to keep a diary – time, date and feature of each incident including witnesses, interaction and outcomes
- clearly stating and enforcing management commitment to maintaining confidentiality and a reprisal-free complaint process
- taking prompt action when a report is made.

Recommendation 25

That the Department of Human services develops and disseminates a statewide ‘tool kit’ containing bullying prevention strategies (adapted from *Worksafe Victoria Guidance Note 2003*) that:

- includes examples of policies, procedures and suggestions for culture change
- ensures consistency in the approach to managing bullying
- provides a useful resource that contributes to quality improvement processes
- includes readily accessible policies, procedures, case studies and customised pamphlets for nurses
- uses innovative ways to convey messages about bullying behaviours that are relevant to nursing.

Risk management

A systematic approach to preventing and managing bullying includes risk identification, assessment and control.

Identifying risk

It cannot be assumed that a workplace is free of bullying because there are no immediate signs. Workplace bullying is often subtle or hidden. It is essential that strategies are developed to assist staff to identify risk factors.

Apart from identifying bullying from reports, audits, surveys and OH&S committees, the more indirect signals can be:

- high staff turnover
- high absenteeism
- increased complaints
- workers withdrawn

- trends in workers compensation claims
- negative results from employee surveys
- deterioration of workplace relationships
- exit interviews revealing dissatisfaction with working relationships
- signs of violence, such as physical injuries or torn clothing.

Assessing risk

Factors that can contribute to risk of bullying include:

- organisational change, for example, restructuring
- workforce characteristics, such as age, gender, ethnicity, new graduates and students
- poor workplace relationships and communication processes
- a lack of systems, knowledge and skills to manage the situation
- lack of experience and poorly defined roles
- limited resources, for example, low control over work, low skill discretion, low decision authority
- unrealistic demands on staff, for example, too high or too low or a combination – low control and high demand
- limited social resources, for example, minimal social support from colleagues and/or managers
- low predictability or job insecurity, minimal positive feedback from supervisors, and a lack of information regarding organisational changes
- low levels of reward, that is, an imbalance between effort and reward.

Controlling risk

If risk factors have been identified, the organisation is obliged to take action to eliminate or reduce the likelihood of bullying occurring. Measures should target the source of the risk. A combination of measures, including the following, may be used to reduce the risk of bullying in the workplace:

- improving communication skills by conducting workshops for staff
- recognising early warning signs
- providing regular training for managers and employees
- providing training on the appropriate use of conflict resolution and de-escalation techniques
- developing a formal conflict resolution process
- widely disseminating the no bullying policy and the procedure for compliance
- developing clearly defined roles and responsibilities for staff
- reducing excessive work hours and demands
- providing adequate resources, for example, review staff levels where appropriate
- consulting with employees and health and safety representatives prior to and during organisational change
- where employees have been identified as being at higher risk, consider instituting a buddy system for new employees, workplace relationship monitoring and additional training in workplace diversity and tolerance.

Reporting and monitoring systems

All reports of bullying should be properly recorded and monitored. If there is no reporting system in place, organisations need to develop a system and take prompt action when a report is made. Establishing and managing an up-to-date database will assist in:

- providing accurate information on the nature and extent of bullying
- assessing whether prevention measures are working
- early intervention and prevention of escalation
- providing prompt assistance to employees.

Bullying can be difficult to detect because in many cases employees are reluctant to report co-workers for fear of reprisals or that no one will act on the problem. It is important to identify and address issues that may make employees reluctant to report.

The reporting procedure should be developed in consultation with health and safety and human resources representatives (see chapter on Reporting Tools in this report). The process needs to be flexible enough to support various methods of dealing with a report of bullying, such as informal discussions and formal investigations, and needs to ensure confidentiality and fair treatment for those involved.

Recommendation 26

That the Department of Human Services:

- promotes management of bullying in accordance with the *Worksafe Victoria Bullying and Violence at Work Guidance Note* (February 2003)
- further researches nursing culture to identify key factors that may trigger bullying behaviour by nurses, thereby enabling a more targeted approach to prevention
- considers sponsorship of innovative strategies to prevent bullying and disseminate ideas and outcomes to health services.

Survey on Violence in Nursing

In early discussions at the taskforce meetings, it was agreed that it was important to obtain comprehensive information of the range of mechanisms in place across Victorian health services to manage occupational violence, aggression and bullying in the workplace.

The taskforce was aware that many health services had systems in place to address such incidents but needed to determine the extent of mechanisms across the state.

A number of questions arose during discussions:

- Do health services have policy and procedures in place to address violence and bullying in the workplace?
- Is there consistency across health services to address the increasing number of incidents?
- What methods or reporting systems are in place to report and record potential or actual incidents of violence and aggression and bullying at the local level?
- Are written policy and procedures accessible to employees?
- Are policies and procedures fully supported and enforced by senior management at the health services?
- What training is provided for nurses and managers to deal with violence and aggression and bullying?
- What mechanisms are in place to support nurses who had experienced such incidents?

In response to these and many other questions, it was determined that a statewide survey would provide a thorough understanding of the current status, identify key areas of concern, and indicate services that had significant mechanisms in place for the taskforce to source further information.

The reporting tools subcommittee determined exactly what information was required and a survey was compiled for distribution across Victoria's public health facilities. A total of 147 variables in 18 categories were included in the survey.

Objective

The objective of the survey was to identify the various mechanisms currently used in nursing for the prevention and management of incidents of occupational violence and bullying.

Distribution

In May 2004, 300 surveys were sent to Victorian health services, incorporating acute, sub-acute and mental health in both metropolitan and rural health. A total of 105 survey returns were received. In some instances, health facilities submitted a single return for all campuses and programs, while many other health services submitted returns for each health facility. Taking this into account, 196 health services responded to the survey.

An analysis of the survey was undertaken by the Nurse Policy Branch and presented to the taskforce.

Survey findings

Overall, the survey found many health services had comprehensive mechanisms in place at the local level while some had limited mechanisms to prevent and manage occupational violence and aggression and bullying. This clearly indicated inconsistency across Victorian public health facilities.

Limitations

A variance between quantitative response and qualitative actuality was an ongoing theme throughout the surveys returned. For instance:

- 85% of respondents indicated that there was a central repository for storing collected data relating to incident; however, these repositories ranged from detailed databases to a locked box stacked with envelopes marked 'confidential' stored in a manager's office
- 70% of organisations had a written policy that addressed occupational violence; these ranged from one paragraph statements to 15 pages of detailed explanation of policies and procedures

- most health services collect and store data, however, no evidence was provided of what this data is being used for. Some organisations did indicate that evaluation of local polices did take place.

The survey did not attempt to capture success stories. No request was made to see if incidents had decreased since alterations to policies or procedures. The procedures in place could be identified, but it was not possible to identify if they were successful or to recognise best practice, that is, where the number of incidents of violence and bullying incidents had decreased. Further errors were discovered when the responses to the survey were matched against accompanying records for submission with the completed survey. For example, to the survey question ‘*Does your organisation have a strategy or program to prevent and manage bullying?*’, 63.8% indicated a positive response. However, further analysis of the documentation supplied and other survey questions suggests that over 80% of services had some form of strategy or program in place to prevent and manage bullying. This would indicate that the survey respondent was not completely confident with the organisation’s policy and procedures, or had misunderstood the question.

Incident forms

All respondents had an incident form of some type. These varied significantly. Some were simple one page forms with time/date and incident headings. Others were a number of pages long, with extensive tick boxes and follow up forms, as well as detailed instructions as to how to fill out the form and the procedures that would follow its completion. Interestingly, not all incident forms covered near misses, verbal abuse or bullying, however all forms covered physical violence.

Programs

Metropolitan and rural health services showed significant differences in mechanisms in place to address violence and bullying, although these could often be attributed to scale and resources. The survey informed the taskforce that metropolitan health services have a greater number of programs and procedures in place to deal with occupational violence and bullying, and a greater promotion of these polices than anticipated. It was found that rural health agencies rely heavily on the organisational orientation program to inform employees of current policies.

Written policy

Less than two thirds of rural health agencies reported having a written policy that addresses occupational violence. It was interesting to note that the rural sector had listed their Director of Nursing and Chief Executive as the persons who provide debriefing following an incident of occupational violence. Metropolitan health agencies indicated a greater use of additional written reports to inform line managers, OH&S managers and human resource managers. The situation in rural health services can be attributed to the size of the organisation in the rural health sector. A small rural health service may not have all these positions or they may be filled by one person. With regard to grievance procedures, less than half of rural health services reported having a dedicated grievance procedure in place in the case of reported bullying, as compared to over 80% of metropolitan health services.

Further analysis of the survey data illustrated similar patterns when comparing organisations by type and size. Larger organisations have more procedures in place, a higher reliance on written reports and greater levels of promotional media when compared to medium-sized organisations which, in turn, had more procedures in place than small hospitals.

Evaluation

The survey findings reported that more than 70% of all health agencies evaluated programs.

Mental health facilities showed the greatest degree of evaluation of the effectiveness of local policies for the prevention and management of occupational violence and bullying. Mental health facilities showed the greatest amount of promotion of occupational violence strategies, using several media to make sure staff were fully informed. A limitation of the survey was that information was not requested with regard to the results and implications of evaluations.

Responses to the survey from aged care facilities showed a very different picture, with the smallest number of mechanisms used for the prevention and management of incidents of occupational violence and bullying. Data from the survey were not able to determine any contributing factors for this variance.

Uniformity

In instances of multiple returns from a health service agency, it was noted that policy and procedures were not uniform across the health service. A claim from a returned survey indicating a response for an entire agency was refuted when a satellite campus of the health service submitted a return with dissimilar results. This occurred in every instance of multiple returns from each campus of the same health service. There was not one case of a 'perfect match', although the degree of variation of returns was not always of a large nature.

Conclusion

In summary, the data gleaned from the survey showed all health facilities had an incident form for reporting incidents of occupational violence, bullying and aggression. All health services had some form of policies and procedures in place to address occupational violence and bullying.

The survey data illustrated that, although a number of reporting processes and reporting systems were in place in health services, there was no uniform instrument for reporting violence and bullying. The survey also pointed to a lack of comprehensive systems regarding policy and procedures at a number of health services. In order for a health service to have a clear understanding of the prevalence and patterns of occupational violence and bullying, it must have a robust and uniform central collection of data. The incident reporting systems should include procedures for investigation, evaluation and review of the systems and procedures.

Reporting tools

The aim of the Reporting Tools Subcommittee was to establish mechanisms that promote monitoring and evaluation of strategies to prevent and reduce occupational violence.

Key objectives included developing a reporting framework for use by health services and education providers that:

- facilitates consistent statewide reporting of incidents and potential incidents of occupational violence and bullying, as defined in the *Worksafe Guidance Note*
- facilitates standardised data collection and analysis of incidents of occupational violence and bullying
- provides a mechanism to monitor the impact of strategies to prevent incidents of occupational violence and bullying
- provides a mechanism to monitor the impact of strategies to manage incidents of occupational violence and bullying.

The purpose of this report is to inform the Department of Human Services' Taskforce on Violence and Bullying in Nursing of recommendations for the development of a policy and framework that guides appropriate action for reporting violence and aggression to nurses in the health setting.

Definitions

Lack of consistency in definitions poses a significant problem with understanding or preventing occupational violence and bullying in health care. OH&S organisations and researchers often restrict their working definitions of occupational violence to incidents that involve actual or attempted physical assault (NIOSH 2002; VWA 2003; Wright, Gary, Parkes and Gournay 2002). This means that many other types of behaviour that may be considered by some people to be 'violent', such as verbal abuse or sexual harassment, are defined as separate phenomena or are not defined at all. Some researchers do not define violence or describe acts of violence from their personal perspective (Lyneham 2002). The lack of a uniformly accepted definition of occupational violence is a core reason for inadequate and inconsistent recording (Mayhew & Chappell 2001).

This has significant implications for:

- identifying the nature, scope and prevalence of occupational violence
- comparing findings
- identifying broad trends
- understanding the impact of strategies to prevent and manage occupational violence and bullying.

Under-reporting of incidents

The literature review indicated significant under-reporting for both violence and bullying incidents. Research on the topic offers little guidance due to the lack of consistent terminology, extensive use of self reports, the variety of tools used to collect data, and the under-reporting of violent incidents (Department of Human Services, unpublished 2003).

Mayhew and Chappell (2001a) estimated, at best, one in five work-related incidents are reported, therefore, around 80% of incidents remain unreported. Fry et al. (2002) found 58% of the incidents described by health care workers (n=92) were not normally reported. Another study by Erickson and Williams-Evans (2000) found that 29% of the assaults described by emergency nurses (n=82) also went unreported.

In the research study commissioned by the Department of Human Services (2005), the researchers compared data collected by security (who are mandated to collect prevalence statistics as part of their role) and nursing staff (who are not expected to routinely report incidents of client aggression and violence unless injury or damage to property is sustained) and found that nurses vastly under-report incidents of occupational violence. This finding is consistent with work commissioned in the UK by the Trade Union Congress (TUC), which found significant under-reporting of occupational violence and aggression among nurses (TUC 1999). It is imperative that cultural attitudes in nursing that promote under-reporting and maintain a passive acceptance of violence as part of the job, change in order to address the issue (ANF 2002).

Under-reporting of violent and bullying incidents occurs for a number of reasons. Staff often do not report incidents because they believe:

- some incidents are not important enough to be reported (Fry et al. 2002)

- violent incidents to be ‘part of the job’ (Erickson & Williams-Evans 2000; Fry et al. Poster 1996)
- they did not incur an injury or feel adversely threatened, that the incident was not considered serious enough (Fry et al. 2002)
- that incident reports will not be taken seriously (Lyneham 2002)
- that nothing would be achieved or changed by report the violent incident (Erickson & Williams-Evans 2000).

Reporting incidents enables employers to:

- identify accurately the nature and extent of occupational violence and bullying
- act quickly on issues being reported to ‘nip them in the bud’
- assess whether measures are making a difference
- ensure employees involved in an incident receive prompt assistance through employee assistance or debriefing programs. (Worksafe Guidance Note 2003)

Reporting mechanisms

As there is no central collection of data, it would be difficult for any health service to have a clear understanding of the patterns of occupational violence and bullying, risk factors, high risk clients or scenarios where staff might be more vulnerable. Most importantly, without comprehensive data it is virtually impossible to tightly target preventive interventions (Mayhew & Chappell 2003).

A robust reporting mechanism is needed to ascertain the true prevalence of violence and bullying. Also needed is:

- an agreed methodology for interpreting data
- implementation of a uniform strategy for disseminating the data and using it to inform the development of proactive strategies to reduce further incidents
- agreed definitions of violence and bullying across the health care industry and related research.

In addition, nurses need to be actively encouraged and supported by senior management in reporting violent and bullying incidents. The subcommittee believes a readily accessible, simple to implement reporting procedure will encourage reporting, as will prompt, sensitive and appropriate follow-up by all managers.

The reported information is required to determine:

- event, type, location and severity
- day and time
- perpetrator characteristics
- possible causes and contributing factors.

This information will assist health services in identifying high risk circumstances, times and locations, tasks and employee groups and will provide a base for identifying risk control measures.

Collecting data on workforce violence and bullying will enable:

- the establishment of effective incident reporting systems that include procedures for investigation, evaluation and review of systems and procedures
- the accurate maintenance of records of incidents
- analysis and trends of data.

A statewide survey conducted by the Nurse Policy Branch sought to identify and review existing processes to address occupational violence and bullying currently in place across public health facilities in Victoria. The survey data illustrated that while a number of reporting processes and reporting systems were in place, there was no uniform instrument for reporting violence and bullying. The survey also pointed to a lack of comprehensive systems regarding policy and procedures at a number of health services.

Reporting systems and IT

RiskMan and AIMS are two key computerised health data systems currently used across a number of health services and were presented in detail to the subcommittee. The subcommittee assessed the systems to ascertain:

- how data was collected
- the type of information collected
- how practical it would be to introduce another system across all health facilities
- whether the data currently being collected is useful in informing and shaping policy and procedures
- whether the data provided outcomes that facilitate monitoring of performance.

A number of questions emerged, including:

- Is it possible to create a system specifically to capture the reliable and valid data about violence and bullying in the workplace?
- What system would be the most user-friendly, promote compliance and be adaptable to any size facility?
- Do remote and rural areas have the IT capacity?
- Is there a data system that could provide sufficient consistency across all health services?

Additionally, a major obstacle to establishing a comprehensive statewide database was the perceived inability to incorporate an IT system that could be readily adopted and implemented with current reporting systems.

The subcommittee made several suggestions regarding how a coherent, minimal impact and user-friendly centralised IT database could be developed. The key elements for a new data system would be ease of access and use, capacity to accommodate any health service—small, rural, remote or major—and reporting systems that are simple and accessible to all staff.

A core requirement of violence and bullying risk identification, assessment and management is access to reliable and valid data. Therefore, it is recommended that all health services should have in place a uniform system for reporting and recording occupational violence and bullying incidents, irrespective of whether the incident resulted in injury or not.

Standardised minimum data set

The most effective and efficient way to address the previously mentioned challenges is to develop, implement and evaluate a minimum data set that would be collected at a state level by the Department of Human Services.

This will assist organisations to:

- identify prevalence and nature of incidents in their health service
- establish a baseline of incidents and benchmarks in nursing across like health services
- respond with appropriate interventions, review processes and provide feedback to staff
- encourage a culture that actively supports an open reporting process, including written reports, and strongly discourages a culture of acceptance of violence that diminishes staff concerns and promotes a no blame culture
- evaluate the impact of strategies implemented.

There is a need to identify critical fields of the minimum data set. This would include the type of data that is required and why, how the data will inform policy, how will the information be used, and its relevance at both local and state levels.

The advantages of a standardised approach that is monitored centrally include:

- enabling analysis of implemented strategies and accurate evaluation of their impact
- providing an opportunity to learn from others and share examples of best practice
- regular review of data by all public health facilities by reporting biannually to the department
- providing an opportunity to develop and implement guidelines for the management and prevention of occupational violence and bullying in a timely fashion.

Recommendation 27

That the Department of Human Services:

- develops a statewide minimum data set that includes key critical fields with reference to the critical fields identified by the Reporting Tools Subcommittee
- develops guidelines to assist health services to understand the significance of data collection related to violence and bullying and to collect critical field information
- pilots the data set across a sample of Victorian health services prior to implementation.

Recommendation 28

All health services submit minimum data set to the Department of Human Services on a biannual basis.

Recommendation 29

That the Department of Human Services makes aggregated local data results available to health services and WorkSafe Victoria to compare local prevalence and nature of events and create statewide benchmarking.

Critical fields identified in the minimum statewide data set and recommended for implementation

The subcommittee reviewed incident report terms and results of the survey undertaken and has recommended the adoption of specific fields for the minimum data set.

INCIDENT	Program area (eg: ED or maternal and child health)	These areas encompass the broad categories that nurses work in. Categorising in what areas incidents occur will allow the identification of problem/high risk areas.
	Incident type	Three key areas as identified by literature
	Demonstrated behaviour	Violent behaviour to be coded as per Aggression and Violence Subcommittee definition/classification. Once coded, the incident can be classified at a particular level. Allowing standardisation of incidents at a central point.
	Days lost to incident during reporting period	Used to measure cost of the incident, as well as severity. Measurement is consistent with WorkCover and insurance company data/KPI.
	Date incident occurred <i>(only applicable to violence)</i>	By tracking date and shift it will be possible to identify any 'hotspots' once trend data is established. For example, is Friday night shift more likely to have an incident than Tuesday am shift?
	Shift incident occurred <i>(only applicable to violence)</i>	
	Date incident commenced	For use with harassment and bullying, how long the incident had been going on before reported.
Date incident reported	Identify time frame between incident occurrence and incident reported.	
VICTIM	Division	Division, grade and year, gender, length of service aids in capturing and determining more at risk employees.
	Grade/Year	
	Employment Status	
	Gender	
	Length of service with organisation	
SOURCE	Relationship to victim	Relationship to victim, reporting relationship to victim, gender and age aids in capturing and determining trends and possible high risk problem areas.
	Reporting relationship to victim	
	Gender	
	Age	
	Status	Status of the source will allow further analysis of the circumstances around the incidents. Once trend data is established, cross-tabulation will allow identification of particular source status in high problem areas.

Part 4. Appendices

Appendix 1: Questions and totalled results from Violence in Nursing Survey

Survey to identify the various mechanisms currently used in nursing for the prevention and management of incidents of occupational violence and bullying. Three hundred surveys were sent to Victorian health services, incorporating acute, sub-acute and mental health in both metropolitan and rural health; 196 health services responded to the survey.

Organisations were asked to select all responses for each question that were applicable to their organisation. Organisations with multiple procedures/reporting practices in place for a particular question could have several positive responses to the survey.

Results (Weighted)

Question	Option	All	Metro	Rural
1. What method is used to report incidents of physical violence experienced by nurses in your organisation?	Incident form	100.0%	100.0%	100.0%
	Verbal report to (please indicate)	85.2%	89.5%	83.5%
	Verbal report to Line Manager	80.6%	87.7%	77.7%
	Verbal report to OHS Manager	28.6%	26.3%	29.5%
	Verbal report to HR Manager	15.8%	19.3%	14.4%
	Verbal report to OHS representative	26.5%	21.1%	28.8%
	Written report to (please indicate)	63.8%	77.2%	58.3%
	Written report to Line Manager	51.0%	56.1%	48.9%
	Written report to OHS Manager	40.8%	47.4%	38.1%
	Written report to HR Manager	17.9%	35.1%	10.8%
	Written report to OHS representative	16.3%	10.5%	18.7%
	Grievance procedure	31.6%	29.8%	32.4%
	Survey	7.7%	12.3%	5.8%
	Employee Support Service	30.6%	38.6%	27.3%
	Other	18.9%	28.1%	15.1%
No mechanism available	0.0%	0.0%	0.0%	
2. What method is used to report 'near misses' experienced by nurses in your organisation? (emergency/ security response to potential threats of violence eg Code Grey)	Incident form	95.9%	96.5%	95.7%
	Verbal report to (please indicate)	78.1%	84.2%	75.5%
	Verbal report to Line Manager	72.4%	84.2%	67.6%
	Verbal report to OHS Manager	26.0%	17.5%	29.5%
	Verbal report to HR Manager	9.7%	7.0%	10.8%
	Verbal report to OHS representative	23.0%	10.5%	28.1%
	Written report to (please indicate)	52.0%	68.4%	45.3%
	Written report to Line Manager	44.4%	47.4%	43.2%
	Written report to OHS Manager	33.7%	33.3%	33.8%
	Written report to HR Manager	13.8%	22.8%	10.1%
	Written report to OHS representative	13.8%	3.5%	18.0%
	Grievance procedure	11.7%	10.5%	12.2%
	Survey	5.6%	10.5%	3.6%
	Employee Support Service	13.8%	10.5%	15.1%
	Other	30.6%	17.5%	36.0%
No mechanism available	0.5%	0.0%	0.7%	

Question	Option	All	Metro	Rural
3. What method is used to report incidents of verbal abuse experienced by nurses in your organisation?	Incident form	93.9%	94.7%	93.5%
	Verbal report to (please indicate)	83.2%	84.2%	82.7%
	Verbal report to Line Manager	80.1%	84.2%	78.4%
	Verbal report to OHS Manager	25.5%	22.8%	26.6%
	Verbal report to HR Manager	14.8%	15.8%	14.4%
	Verbal report to OHS representative	24.0%	15.8%	27.3%
	Written report to (please indicate)	42.9%	35.1%	46.0%
	Written report to Line Manager	41.3%	33.3%	44.6%
	Written report to OHS Manager	29.1%	26.3%	30.2%
	Written report to HR Manager	12.8%	14.0%	12.2%
	Written report to OHS representative	16.8%	10.5%	19.4%
	Grievance procedure	28.6%	35.1%	25.9%
	Survey	6.1%	10.5%	4.3%
	Employee Support Service	24.0%	24.6%	23.7%
	Other	25.0%	15.8%	28.8%
No mechanism available	0.5%	0.0%	0.7%	
4. What method is used to report complaints of bullying experienced by nurses in your organisation?	Incident form	74.0%	77.2%	72.7%
	Verbal report to (please indicate)	85.2%	91.2%	82.7%
	Verbal report to Line Manager	81.6%	89.5%	78.4%
	Verbal report to OHS Manager	19.4%	19.3%	19.4%
	Verbal report to HR Manager	39.3%	70.2%	26.6%
	Verbal report to OHS representative	28.6%	31.6%	27.3%
	Written report to (please indicate)	63.8%	70.2%	61.2%
	Written report to Line Manager	59.7%	68.4%	56.1%
	Written report to OHS Manager	24.0%	19.3%	25.9%
	Written report to HR Manager	30.6%	54.4%	20.9%
	Written report to OHS representative	12.2%	10.5%	12.9%
	Grievance procedure	56.6%	82.5%	46.0%
	Survey	15.3%	29.8%	9.4%
	Employee Support Service	39.8%	52.6%	34.5%
	Other	22.4%	15.8%	25.2%
No mechanism available	0.5%	0.0%	0.7%	
5 Does your organisation have a written policy that addresses occupational violence?		69.9%	87.7%	62.6%
6 Does your organisation have a strategy or program to prevent and manage occupational violence?		61.2%	93.0%	48.2%
7 What are the key components of your occupational violence strategy or program?	Aggression management training	67.3%	96.5%	55.4%
	Customer service training	40.3%	63.2%	30.9%
	Communication training	37.8%	43.9%	35.3%
	Other	36.2%	52.6%	29.5%

Question	Option	All	Metro	Rural
8. Does your organisation promote its policy, strategy or program for the prevention of occupational violence in nursing in any of the following programs?	Organisational Orientation Program	64.3%	57.9%	66.9%
	Graduate Nurse Program	35.7%	52.6%	28.8%
	Preceptor Program	8.7%	8.8%	8.6%
	Return to Work Program	22.4%	22.8%	22.3%
	Re-entry/Refresher Program	17.9%	17.5%	18.0%
	Post-Graduate Programs	10.2%	10.5%	10.1%
	Professional Development Programs for nurse managers	33.2%	59.6%	22.3%
	Annual In-service Program	29.6%	17.5%	34.5%
	Other	30.1%	47.4%	23.0%
9. Who provides defusing/debriefing following an incident of occupational violence in nursing?	Peer support	54.6%	78.9%	44.6%
	Nurse Manager	89.8%	98.2%	86.3%
	Counsellor/social worker	45.4%	35.1%	49.6%
	HR personnel	23.5%	31.6%	20.1%
	OHS Manager	19.4%	21.1%	18.7%
	OHS representative	10.2%	12.3%	9.4%
	External professional provider	44.4%	66.7%	35.3%
	Other	25.5%	14.0%	30.2%
	No support available	0.0%	0.0%	0.0%
10. Who provides post-incident support for nurses experiencing occupational violence in your organisation?	Peer support	53.1%	78.9%	42.4%
	Nurse Manager	74.0%	93.0%	66.2%
	Counsellor/social worker	52.6%	40.4%	57.6%
	HR personnel	40.8%	59.6%	33.1%
	OHS Manager	33.7%	40.4%	30.9%
	OHS representative	9.2%	12.3%	7.9%
	External professional provider	59.7%	77.2%	52.5%
	Other	21.4%	10.5%	25.9%
	No support available	0.0%	0.0%	0.0%
11. Does your organisation have a written policy that addresses bullying? (Positive responses)		88.3%	98.2%	84.2%
12. Does your organisation have a strategy or program to prevent and manage bullying? (Positive responses)		63.8%	68.4%	61.9%
13. What are the key components of your bullying strategy or program?	Aggression management training	41.8%	57.9%	35.3%
	Customer service training	26.0%	38.6%	20.9%
	Communication training	47.4%	56.1%	43.9%
	Other	21.9%	28.1%	19.4%
14. Does your organisation promote its policy, strategy or program for the prevention of bullying in nursing in any of the following programs?	Organisational Orientation Program	74.0%	84.2%	69.8%
	Graduate Nurse Program	38.3%	49.1%	33.8%
	Preceptor Program	8.7%	7.0%	9.4%
	Return to Work Program	20.4%	12.3%	23.7%

Question	Option	All	Metro	Rural
14. (cont)	Re-entry/Refresher Program	19.9%	10.5%	23.7%
	Post-Graduate Programs	10.2%	8.8%	10.8%
	Professional Development Programs for nurse managers	34.7%	57.9%	25.2%
	Annual In-service Program	33.7%	42.1%	30.2%
	Other	12.8%	14.0%	12.2%
15. Who provides defusing/debriefing following an incident of bullying in nursing?	Peer support	47.4%	57.9%	43.2%
	Nurse Manager	81.6%	94.7%	76.3%
	Counsellor/social worker	40.8%	19.3%	49.6%
	HR personnel	46.9%	68.4%	38.1%
	OHS Manager	14.8%	10.5%	16.5%
	OHS representative	3.1%	0.0%	4.3%
	External professional provider	36.7%	63.2%	25.9%
	Other	26.5%	7.0%	34.5%
No support available	0.0%	0.0%	0.0%	
16. Who provides post-incident counselling/advocacy for victims of bullying in your organisation?	Peer support	35.7%	57.9%	26.6%
	Nurse Manager	60.7%	86.0%	50.4%
	Counsellor/social worker	48.0%	22.8%	58.3%
	HR personnel	47.4%	71.9%	37.4%
	External professional provider	26.0%	19.3%	28.8%
	OHS Manager	5.6%	1.8%	7.2%
	OHS representative	50.5%	75.4%	40.3%
	Other	25.5%	22.8%	26.6%
No support available	0.0%	0.0%	0.0%	
17. How does your organisation evaluate the effectiveness of local policies and prevention/management strategies in relation to occupational violence and bullying?	Review and analysis of data related to incidents of occupational violence and bullying	70.4%	82.5%	65.5%
	WorkCover Claims	61.7%	82.5%	53.2%
	Surveys eg Staff Satisfaction Surveys	53.1%	63.2%	48.9%
	Seek feedback from nurses/staff eg exit interviews	61.7%	87.7%	51.1%
	Absenteeism	15.8%	12.3%	17.3%
	Other	11.2%	28.1%	4.3%
	Not yet evaluated	15.3%	10.5%	17.3%
18. Is there a central repository in your organisation for the collection of data relating to incidents of occupational violence and bullying in nursing?	Yes	85.2%	96.5%	80.6%
	Yes to form attached	87.2%	94.7%	84.2%

Appendix 2: Typology of occupational violence

Perrone, S. (1999). *Violence in the workplace*. Canberra: Australian Institute of Criminology

- Homicide and other forms of physical assault (for example, manslaughter) resulting in death
- Death/injury due to employer negligence
- Sexual assault (rape, indecent assault)
- Physically abusive behaviour/assault resulting in injury (wounding, battery, kicking, biting, punching, scratching, squeezing, pinching, pulling hair)
- Physically abusive behaviour falling short of injury (pushing, pulling clothing, obstructing)
- Robbery
- Stalking (persistent, unwelcome loitering, following and attempts to contact another individual)
- Threats/intimidation (the illegitimate exercise of power to achieve objectives—this can take the form of unwanted communications and intrusions into a person’s private life, occurring: in person, via phone, mail or through an intermediary, or it can transpire internally, and may relate to employment issues, such as threatening loss of employment)
- Sexual/racial harassment (non-injurious physical or verbal abuse which is sexist or racist in nature and affronts the recipient’s dignity. May include unwelcome, unwanted or unsolicited: sexually or racially explicit language, propositions, remarks regarding dress or general physical appearance, stares/leering at bodily parts, lewd gestures, sexual innuendo, allusions or slurs regarding an individual’s private life, such as their sexual orientation, racially or sexually specific jokes or remarks, deliberate touching of, or brushing against, another and the display of offensive material)
- Bullying (coercive, unethical activities which create an environment of fear through acts of: cruelty, belittlement/degradation, public reprimand, ridicule, insult, sarcasm, destructive criticism, persistent nitpicking or devaluation of a person’s work efforts, trivialisation of views and opinions and unsubstantiated allegations of misconduct)
- Mobbing (another form of bullying, usually prolonged and systematic in nature, and conducted en-masse)
- Verbal abuse (offensive remarks and/or messages, swearing, name-calling or other taunts, profanity)
- Actively hostile behaviour (spitting, shouting, yelling, shaking of the fists)
- Physical action directed towards inanimate objects (banging a table, throwing objects, forcing a door)
- Vandalism or destruction of staff or company property
- Rude/offensive gesturing
- Generation and dissemination of gossip or false information
- Ostracism/involuntary isolation (the process of “freezing out” through social exclusion)
- Deliberate silence (sending the victim to Coventry)
- Withholding necessary information
- Passive aggression (menacing posturing, such as threatening eye contact).

Appendix 3: Abbreviations

Abbreviation

AMT	Aggression Management Team
ANA	American Nurses Association
ANF	Australian Nursing Federation
ANF (Vic Branch)	Australian Nursing Federation (Victorian Branch)
ANMC	Australian Nursing and Midwifery Council
CAL/OSHA	California Occupational Safety and Health Administration
CPTED	Crime Prevention Through Environmental Design
DHS	Department of Human Services (Victoria)
EASHW	European Agency for Safety and Health at Work
HCSA	Health and Community Services Union
HOHSE	Home Office and Health and Safety Executive (UK)
ICN	International Council of Nurses
ILO	International Labour Office
NAO	National Audit Office (UK)
NHMRC	National Health and Medical Research Council (Australia)
NHS	National Health Service (UK)
NIOSH	National Institute for Occupational Safety and Health (USA)
NOHSC	National Occupational Health and Safety Commission (Australia)
NSWNA	New South Wales Nurses Association
OH&S	Occupational Health and Safety
OSHA	Occupational Safety and Health Administration (USA)
QGWBT	Queensland Government Department of Industrial Relations Workplace Bullying Taskforce
RCN	Royal College of Nursing (UK)
VHIA	Victorian Hospitals Industrial Association
VWA	Victorian WorkCover Authority
WHO	World Health Organisation

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