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Journal article

Workplace aggression experiences and responses of Victorian nurses, midwives and care personnel

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ABSTRACT

Background

Workplace aggression is a major work health and safety, and public health concern. To date, there has been limited investigation of population level exposure and responses to workplace aggression from all sources, and little evidence on the experiences, reporting and support-seeking behaviour of nurses, midwives and care personnel in Australian settings.

Aim

To determine the 12-month prevalence of aggression experienced by nurses, midwives and care personnel from sources external and internal to the organisation, and the reporting behaviours and support sought from employers, health services, Trade Unions, work health and safety agencies, police and legal services.

Methods

An online survey of the membership of the Australian Nursing and Midwifery Federation – Victorian Branch was conducted between 1st May and 30th June 2017.

Findings

In the previous 12 months, 96.5% of respondents experienced workplace aggression, with 90.9% experiencing aggression from external sources and 72.3% from internal sources. A majority indicated they just accepted incidents of aggression, and most rarely or never took time off work, sought medical or psychological treatment, or sought organisational or other institutional support, advice or action. Levels of satisfaction with institutional services were mostly neutral to poor.

Discussion

Victorian nurses, midwives and care personnel work in aggressive and violent workplaces. The incivility endemic in health care likely sets the climate for the generation of and exposure to so much

explicit aggression and violence. It appears that any systems or processes instituted to protect health care personnel from harm are failing.

Conclusion

More targeted and effectively operationalised legislation, incentives and penalties are likely required. Further research may elaborate the extent of the impact of exposure to workplace aggression over time.

Keywords: aggression; violence; workplace; nursing; midwifery; Australia

SUMMARY STATEMENT

Problem

There has been limited investigation of population level exposure and responses to workplace aggression from all sources, and little evidence on the experiences, reporting and support-seeking in Australian settings.

What is already known

Workplace aggression in health care is a major work health and safety, and public health concern. It can impact of clinician health and well-being, workforce participation decisions, and the quality and safety of care.

What this paper adds

The extraordinarily high prevalence of workplace aggression experienced by Victorian nurses, midwives and care personnel, and their subsequent responses and support-seeking actions, including for legal redress, are highlighted. Recommendations are made for improvement to failing or inadequate systems and processes to protect health care personnel from harm.

INTRODUCTION

Workplace aggression in health care is a major work health and safety, and public health concern. In addition to a range of psychological impacts, workplace aggression has also been associated with poor health, work-related illness and injury, work restrictions or modifications, role conflict and ambiguity, job dissatisfaction and absenteeism, as well as longer term impacts on workforce participation decisions (Camerino, Estry-Behar, Conway, van Der Heijden, & Hasselhorn, 2008; Friis, Larsen, & Lasgaard, 2017; Fujishiro, Gee, & de Castro, 2011; Gerberich et al., 2004; Hills, 2016, 2017; Hills & Joyce, 2014; Nachreiner, Gerberich, Ryan, & McGovern, 2007; O'Brien-Pallas, Wang, Hayes, & Laporte, 2009; Zhang et al., 2017; Zhao et al., 2018). There is also a growing body of evidence on the negative impact of workplace aggression on the quality and safety of patient care (Arnetz & Arnetz, 2001; Houck & Colbert, 2016; Laschinger, 2014; O'Brien-Pallas et al., 2009).

Evidence from the international literature suggests that the levels of workplace aggression experienced by the nursing workforce remain intractably high and have a concerning impact on their physical and mental health and well-being (Alameddine, Mourad, & Dimassi, 2015; Clausen, Høgh, & Borg, 2012; Farrell & Shafiei, 2012; Spector, Zhou, & Che, 2014; Zhang et al., 2017; Zhao et al., 2018). While rates of exposure to workplace aggression in the Australian setting are consistent with those experienced by nurses internationally, it is nonetheless of great concern that exposure rates appear to have changed little over the last 35 years (Holden, 1985; O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000; Shea, Sheehan, Donohue, Cooper, & De Cieri, 2017). This is despite a considerable history of government policy, programs, and the implementation of initiatives such as "Zero Tolerance to Violence" (Wand & Coulson, 2006) and many other strategies directed toward the prevention and minimisation of workplace aggression (Anderson, FitzGerald, & Luck, 2010; Hills & Joyce, 2013; Hills, Joyce, & Humphreys, 2013).

Notwithstanding some important research on nurse exposure to workplace aggression in Australia (De Cieri et al., 2015; Farrell, Shafiei & Chan, 2014), there has been limited investigation of population level exposure and responses to workplace aggression from all sources. Certainly, there is little evidence in the literature relating the experience of nurses, midwives and other care personnel reporting to, or accessing advice or support from trade unions, work health and safety agencies, and police or other legal services. This report describes results from a survey of members of the Australian Nursing and Midwifery Federation (Victorian branch) to determine the 12-month prevalence of verbal or written aggression and physical aggression from external sources (patients, patients' relatives or carers and other persons external to the workplace) and internal sources (co-workers). We also investigated reporting behaviours and advice, support or action sought and received from the employer, health services, Trade Union representatives, police and legal services.

METHODS

A survey of the membership of the Australian Nursing and Midwifery Federation – Victorian Branch (ANMF-VIC), which comprised approximately 75,000 registered and enrolled nurses, registered midwives and other care personnel in the State of Victoria, was conducted between 1st May and 30th June 2017. An online questionnaire was developed and participant responses were collected using Qualtrics survey software (Qualtrics, 2017). An initial email with information on the survey and links to the online questionnaire was provided to ANMF-VIC members on 3rd May 2017. A link to the questionnaire was also included in two issues of the ANMF-VIC e-news, which were emailed to members on 12th and 24th May 2017.

The front page of the online questionnaire provided a general description of the project, a link to a detailed participant information document and requested consent to participate in the survey. Respondents providing their consent were offered the full questionnaire. The first set of questions comprised demographic items, including age, sex, registration status, number of years working in

their profession, type of work, and suburb/town location and postcode. A second set of items elicited information on participant exposure to workplace aggression from external sources (patients, patients' relatives or carers and other persons external to the organisation) and internal sources (co-workers). Internal sources included clinical peers, supervisors and other senior personnel, medical practitioners, allied health practitioners and administrative personnel.

The definition of workplace aggression was adapted from that used in a national study of Australian clinical medical practitioners (Hills, Joyce, & Humphreys, 2012; Yan et al., 2011), with workplace aggression defined in the questionnaire as:

.... any aggressive behaviour directed toward you in the last 12 months while you were working in nursing or midwifery (i.e. any circumstance or location in which you performed your role as a nurse or midwife), including:

- *Verbal or written abuse, threats, intimidation or harassment – such as ridicule, abusive email, racism, bullying, contemptuous treatment and non-physical threats or intimidation*
- *Physical threats, intimidation, harassment or violence – such as a raised hand or object, unwanted touching, damage to property and sexual or other physical assault.*

Frequency of exposure was elicited with a five-point ordinal scale, with the response options of “Frequently (once or more each week)”, “Often (a few times each month)”, “Occasionally (a few times each six months)”, “Infrequently (a few times in 12 months)” and “Not at all”. A supplementary item relating to internal (co-worker) aggression, elicited frequency of exposure from each respondent's immediate nursing supervisor, other senior nursing staff, peers (nurses at a similar grade/level), junior nursing staff, medical professionals, allied health professionals, and administrative, hospitality or other staff.

Survey participants were also asked to indicate the proportion of time they had undertaken each of 11 listed responses to workplace aggression from external and internal sources in the previous 12

months. The proportion of times that each response occurred following exposure to aggression was estimated using a five-point ordinal scale, with the response options of “Mostly (80 – 100% of the time)”, “Often (60 – 79% of the time)”, “Occasionally (40 – 59% of the time)”, “Infrequently (10 – 39% of the time)” and “Rarely / Never (less than 10% of the time)”. Further, survey participants were asked to indicate their level of satisfaction, on a five-point scale ranging from 1 (very satisfied) to 5 (very dissatisfied), with their experience of support or action from their employing organisation, their Trade Union, the State work health and safety authority, the State police and their legal advisor or representative, where applicable. A further set of items elicited information on whether respondents had previously, were currently or were intending to take any form of legal action (eg with police, solicitor, work health & safety authority) in relation to one or more experiences of workplace aggression in the previous 12 months, and if that action was directed against their employer, a co-worker, a patient, a patient’s relative or carer, or another person external to the organisation.

Ethics

The conduct of the study was approved by the Monash University Human Research Ethics Committee (MUHREC) and conformed to the National Statement on Ethical Conduct in Human Research 2007 (National Health and Medical Research Council, 2015). In this study, the first section of the online questionnaire asked participants to read the explanatory statement. This outlined benefits and risks of participation and the information they would be asked to provide. It also indicated that participation was entirely voluntary and that they could withdraw from participation at any time, as well as providing details for contacting the researchers and the MUHREC regarding any issues of concern. Participants were required to indicate their consent to participate before they could proceed with the questionnaire. Respondent names or residential addresses were not requested in the primary sections of the questionnaire.

RESULTS

The initial email notification of the online survey was sent to 66759 ANMF-VIC members' email addresses. From this contact, 22448 members opened the email and 1501 clicked on one of the survey links within the first two weeks of the distribution. In the two subsequent ANMF-VIC e-news issues, on average, 20545 members opened and 210 clicked on the link to the online survey questionnaire in the first week following distribution of each e-news email. The 1920 members known to have selected a survey link represented approximately 3% of those who opened an email notifications. This data is indicative only and does not include when ANMF-VIC members opened the email notices to follow the link at a later date or when the link was accessed in unknown ways (such as through a shared link on Facebook or other website postings). At the close of the survey, 1322 people had commenced the online questionnaire. Of those, 1,308 (98.6%) consented to participate in the survey and 1,222 (92.4%) proceeded to respond to questionnaire items.

Respondent profile data are detailed in Table 1. The age of respondents (n=1221) ranged from 22 to 77 years, with a mean of 47.4 (95% CI 46.7-48.0) years. The length of professional experience (n=1181) ranged from 0 to 56 years, with a mean of 20.8 (95% CI 20.0-21.5) years. Of the 1201 respondents reporting a main workplace (Table 1), 318 (26.5%) reported a secondary workplace, which included public hospitals (29.9%), aged care facilities (19.2%), private hospitals (12.3%) and other (16.7%).

TABLE 1. Profile of respondents

	n	%
<i>Sex</i>	1222	
Male	124	10.15
Female	1098	89.85
<i>Education level</i>	1222	
Certificate/diploma	443	36.25
Bachelor degree	349	28.56
Postgraduate qualification	430	35.19
<i>Registration status</i>	1222	
RN	820	67.10
RM	52	4.26
RN & RM	86	7.04
EN	14	1.15
None	250	20.46
<i>Work hours status</i>	1222	
Full-time	330	27.00
Part-time	753	61.62
Casual	139	11.37
<i>Clinical work status</i>	1222	
Mainly clinical	888	72.67
Clinical & non-clinical	218	17.84
Mainly non-clinical	116	9.49
<i>Main workplace</i>	1201	
Public hospital	645	53.71
Public community health service	64	5.33
Non government organisation	11	0.92
Private hospital	133	11.07
Private community health service	16	1.33
GP / Primary care	28	2.33
Specialist practice	51	4.25
Aged care facility	6	0.50
Other private clinical	231	19.23
University	7	0.58
Public training college	5	0.42
Private training college	2	0.17
Other	2	0.17

Rates of exposure

Victorian nurses, midwives and care personnel responding to the survey reported high rates of exposure to workplace aggression. Overall, 96.5% of respondents to all of the aggression exposure items (n=959) experienced some form of workplace aggression in the previous 12 months.

Aggregated by source, 90.9% (1048) experienced some form of aggression from external sources and 72.3% (693) experienced some form of aggression from internal sources in the previous 12 months. It should be noted that the 14 respondents from educational organisations also reported exposure to aggression from across the four sources investigated in this study.

As shown in Figure 1, workplace aggression was perpetrated in decreasing prevalence by patients, their relatives or carers, co-workers and others external to the workplace. Exposure to verbal or written aggression was much more prevalent than exposure to physical aggression from any source in the previous 12 months, but rates were nonetheless very high for both forms of aggression.

While 12-month rates of exposure to aggression from patients and relatives is very high, overall, more than 71% of nurses, midwives and care personnel experienced verbal or written aggression and almost 35% experienced physical aggression from their co-workers. As shown in Figure 2, the most prominent perpetrators of co-worker aggression were immediate supervisors and other senior staff, peers and medical practitioners. While most of the exposure was verbal or written aggression, between 19% and 28% of nurses, midwives and care personnel reported that they had experienced physical aggression from these sources in the previous 12 months.

Responses to aggression at work

Nurses, midwives and care personnel who had experienced workplace aggression from external and internal sources in the previous 12 months were asked to indicate how frequently they responded to this aggression in 11 specified ways (Figure 3). A majority of respondents indicated that they mostly, often or occasionally did nothing, just accepted incidents of verbal or written workplace aggression

from internal or external sources. Smaller proportions indicated they did nothing because they were afraid to do anything in relation to incidents of verbal or written aggression from external sources. For verbal or written aggression from internal sources, however, almost 50% indicated that they mostly, often or occasionally did nothing because they were afraid to do anything.

In relation to reporting incidents of workplace aggression, more than 50% of respondents mostly, often or occasionally reported incidents of verbal or written aggression and physical aggression from external sources. In comparison, almost 50% of respondents rarely or never reported incidents of verbal or written aggression from internal sources, but almost 70% of respondents indicated that they rarely or never reported physical aggression from internal sources. For the remaining eight workplace aggression response actions, most respondents rarely or never took time off work, sought medical or psychological treatment, sought organisational or Trade Union support/action, or sought WorkSafe, police or other legal advice/action as a result of exposure to workplace aggression in the previous 12 months.

Satisfaction with institutional responses

Table 2 shows the reported levels of satisfaction of respondents who indicated they had sought support/advice or action from their employing organisation, their Trade Union, the State work health and safety authority (WorkSafe), the State police, or their legal advisor or representative following one or more incidents of external and internal aggression in the previous 12 months. While the proportion of respondents seeking support ranged from quite high to very low, some clear patterns are apparent. Relatively greater proportions of respondents were dissatisfied with organisational support or action in relation to aggression from external sources and even more so for aggression from internal sources. Relatively greater proportions of respondents were also dissatisfied with Trade Union and WorkSafe support/advice or action in relation to aggression from external and internal sources. Responses were relatively evenly spread from very satisfied through to very

dissatisfied, though marginally more satisfied but clustering around a neutral response for advice or action received from Police and other legal professionals.

Intentions to take legal action

Table 3 shows the proportions of respondents who had previously, were currently or were intending to take any form of legal action in relation to exposure to one or more incidents of workplace aggression in the previous 12 months. Proportionally very few respondents had taken, were currently taking or intended to take legal action as a result of experiencing one or more incidents of workplace aggression.

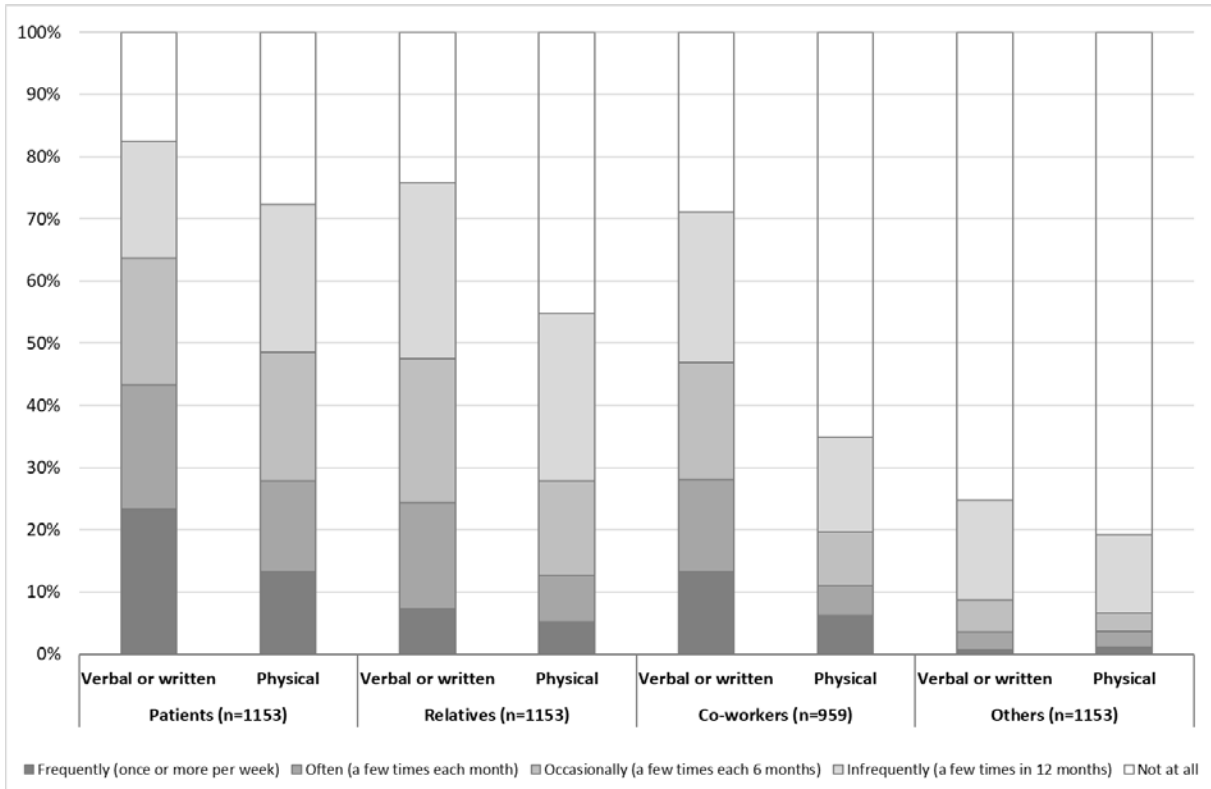


FIGURE 1. 12-month rates of exposure to workplace aggression

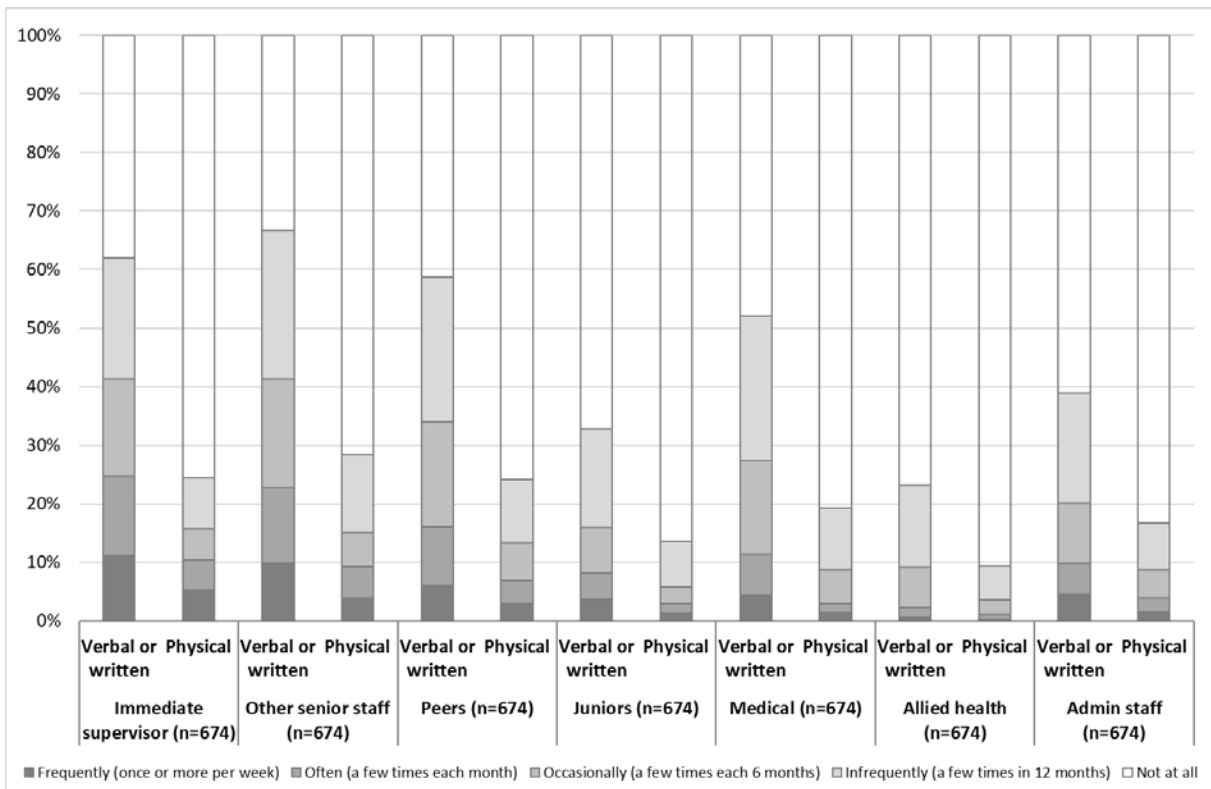


FIGURE 2. 12-month rates of exposure to internal workplace aggression by source

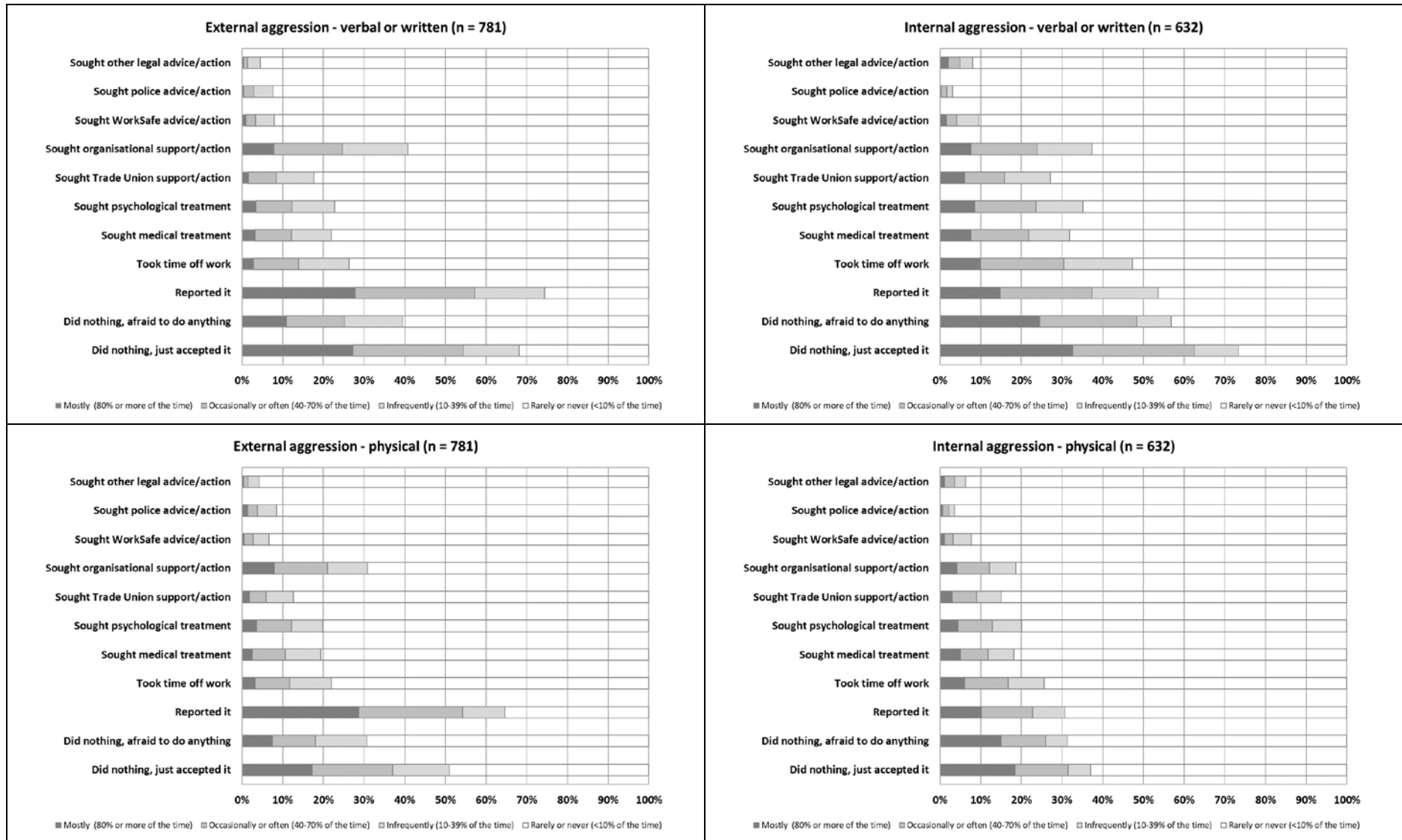


FIGURE 3. Proportions responding to incidents of external and internal workplace aggression

TABLE 2. Levels of satisfaction with support/advice or action received following incidents of aggression (%)

Agency	Aggression source (N)	Those seeking support/advice /action – n (%)	Very satisfied	Somewhat satisfied	Neither	Somewhat dissatisfied	Very dissatisfied
Employing organisation	External (709)	481 (67.8%)	8.52	19.75	20.17	17.26	34.30
	Internal (612)	429 (70.1%)	6.53	11.42	12.59	20.05	49.42
Trade Union	External (709)	207 (29.2%)	14.01	17.87	27.05	20.29	20.77
	Internal (612)	237 (38.7%)	13.08	19.41	18.57	16.88	32.07
WorkSafe	External (709)	102 (14.4%)	6.86	13.73	43.14	13.73	22.55
	Internal (612)	83 (13.6%)	7.23	12.05	34.94	12.05	33.73
Police	External (709)	98 (13.8%)	16.33	24.49	26.53	16.33	16.33
	Internal (612)	43 (7.0%)	4.65	11.63	46.51	13.95	23.26
Other legal professionals	External (709)	52 (7.3%)	9.62	15.38	55.77	5.77	13.46
	Internal (612)	66 (10.8%)	15.15	18.18	34.85	13.64	18.18

TABLE 3. Intentions to take legal action as a result of experiencing workplace aggression (%)

Target of legal action (N=864)	Yes, I have previously	Yes, I am currently	Yes, I intend to do so	No, I have not / will not	Not applicable
Employer	2.89	1.16	3.24	38.31	54.40
Co-worker	1.74	0.81	2.43	39.12	55.90
Patient	3.01	0.93	0.81	37.96	57.29
Carer	0.58	0.12	0.46	37.04	61.81
Other person	0.58	0.12	1.04	32.41	65.86

DISCUSSION

Australian health professionals work in aggressive and violent workplaces, and this is exemplified in the very high levels of exposure experienced by Victorian nurses, midwives and care personnel. With 96.5% of respondents experiencing workplace aggression from any source in the previous 12 months (almost 91% from external sources and more than 72% from internal sources), the prevalence rates are at least 20 percentage points higher overall than the levels of exposure experienced by Australian medical practitioners (Hills et al., 2012), which is consistent with the literature (Hills & Joyce, 2013). Exposure rates in nursing have been consistently very high in Australia over a 35-year period (Hegney, Eley, Plank, Buikstra, & Parker, 2006; Holden, 1985; O'Connell et al., 2000; Shea et al., 2017), but are quite possibly increasing, particularly from co-workers. It must be acknowledged, however, that prevalence rates and impacts are known to vary across health professionals' personal and professional characteristics, and different workplaces and specialties (Guay, Goncalves, & Jarvis, 2014, 2015; Hegney et al., 2006; Hills, 2017; Hills et al., 2012; Shea et al., 2017).

It seems clear that these high levels of workplace aggression are of a different order of intensity to the very high levels of incivility experienced and witnessed routinely in many workplaces (Mikaelian & Stanley, 2016; Schilpzand, De Pater, & Erez, 2016). As suggested in broader studies (Schilpzand et al., 2016; Taylor & Kluemper, 2012), however, it is the incivility that is endemic in so many health care workplaces, including in relation to those who work in and interact with health care organisations, that likely sets the climate for the generation of and exposure to so much explicit aggression and even violence that is inherent in health care work. Certainly, this is an association that needs to be further explored in future research.

In terms of responses to workplace aggression exposure, a very large proportion of survey respondents indicated that they did nothing, just accepted incidents of verbal or written workplace

aggression from internal or external sources. Smaller proportions indicated they did nothing because they were afraid to do anything. In relation to verbal or written aggression from internal sources, however, fear underpinned the decision by almost half of respondents in mostly, often or occasionally doing nothing. Unfortunately, poor aggression incident reporting practices are well-documented as being the norm in health care workplaces, mostly driven by a range of barriers or negative factors. These include poor follow-up or action by managers, fear of retribution or derision for reporting incidents, tolerance of routine aggression or a minimization of the seriousness and impact, as well as issues relating to the reporting systems themselves, such as insufficient time or support to complete incident reporting, confusion about what should or should not be reported or difficulties using the available incident reporting systems (Ferns & Meerabeau, 2009; Gifford & Anderson, 2010; Griffiths, Morphet, & Innes, 2015; Hills & Joyce, 2013; Lovell, Skellern, & Mason, 2011; Mayhew & Chappell, 2001; Pich, Hazelton, Sundin, & Kable, 2011; Pompeii et al., 2016).

As already highlighted in this report, there is ample evidence of the associated impacts and consequences of exposure to workplace aggression, stretching back at least to the seminal Australian study by Holden (1985). Yet the very systems and processes that have been instituted to protect health care providers from psychological and physiological harm, which are – at least in theory – meant to support nurses, midwives and other care personnel in notifying their employers and other institutional guardians of egregious acts of insult and assault, are failing. Further, as identified in this study, even for the relatively small proportions of nurses, midwives and care personnel who reported incidents of aggression, or sought advice, support or action from within or outside the organisation, there were very poor levels of satisfaction with the responses from these guardians. Consequently, it is not surprising that so few nurses, midwives and other care personnel reported incidents of aggression from internal or external sources, or sought support, advice or action from their organisation, their Trade Union, the WorkSafe authority, police or other legal services. Indeed, very few respondents had taken, were currently taking or intended to take legal action as a result of

experiencing one or more incidents of workplace aggression, with the relatively greatest proportion (7.3%) being directed toward employers.

There is some evidence of broader organisational and government efforts to address the high levels of workplace aggression experience by health workers in Australia. A range of prevention and minimisation measures has been established in health workplaces, both private and public, but the available evidence suggests that even some of the most readily implemented have not been adopted, are not effectively implemented or do not offer the protections that might have been expected (Hills, 2017; Hills & Joyce, 2014; Hills et al., 2013). In the State of Victoria, responding to the findings of the Violence in Healthcare Taskforce Report (Violence in Healthcare Taskforce, 2016), the State Government has recently announced a range of initiatives in an “Australian first policy to prevent violence in hospitals” (Hennessy, 2017).

Broader structural issues appear to be hampering these efforts, however. Model Work Health and Safety legislation, designed to provide a degree of uniformity in work health and safety laws and regulations across the nation, has recently been implemented across most jurisdictions (Safe Work Australia, 2018), but specific provisions on workplace aggression have not been included. Further, as highlighted in a key report from the Australian Productivity Commission (2010), psychosocial hazards such as workplace aggression have been given considerably less attention in work health and safety laws than have been physical hazards, and they have also been found to be a marginal area of State work health and safety inspectorate activity (Johnstone, Quinlan, & McNamara, 2011). Victoria has enacted specific legislation targeting workplace bullying (“Crimes amendment (bullying) bill 2011,” 2011), and recently amended Commonwealth legislation (“Fair work act,” 2009) provides for individuals who experience bullying at work to apply for an order to stop the bullying. As highlighted in a recent analysis, however, the introduction of these laws and the instigation of organisational

policies and codes of practice in response to their enactment are unlikely to be effective in the absence of wholesale culture change (Hanley & O'Rourke, 2016).

There are some limitations to this descriptive, cross-sectional study. There is the potential for sampling biases to have contributed to the population prevalence of workplace aggression being overestimated. Although a definition of workplace aggression was provided, responses were subject to clinicians' and carer personnel's own perceptions of experiencing aggression from each source. Recall bias was minimised, however, as questionnaire items were designed to elicit realistic estimates of exposure in a range, rather than exact frequencies. Finally, as a descriptive study, analyses of associations between different variables have not been conducted or reported.

CONCLUSION

Workplace aggression in health care is a major work health and safety, and public health concern. The results of this study demonstrate the alarming rates of exposure experienced by Victorian nurses, midwives and care personnel from those for whom they provide clinical services and with whom they are supposed to work collaboratively in service delivery. More targeted and effectively operationalised legislation, incentives and penalties are likely required to prevent or minimise the likelihood and consequences of workplace aggression in health care settings. This could include more targeted and effective incident reporting, inspection, investigation and accreditation mechanisms and capacity, organisation-level funding incentives and penalties, and individual accountabilities, incentives and penalties. Further research is also required, to determine any impact of State and Commonwealth initiatives designed to prevent and minimise the high prevalence and resulting consequences of this largely unresolved and ongoing assault on the health and well-being of Victorian nurses, midwives and care personnel.

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