

VIOLENCE: PART OF THE JOB FOR AUSTRALIAN NURSES?

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Accepted for publication August 2000

Key Words: violence, workplace, emergency nursing, nursing practice, research

ABSTRACT

According to a recent Australian Institute of Criminology report (1999) the health industry is the most violent industry in Australia. In this paper the authors aim to highlight violence as an important professional issue for Australian nurses that is currently concealed as 'part of the job'. National and international studies bring attention to the severity of the problem for nurses with a particular focus on emergency nurses. Some of the issues identified and discussed include increased waiting times and frustration; increasing use of weapons; inadequate systems of security; culture of silence; inadequate support for emergent mental health needs; lack of reporting; lack of institutional concern and systems of support, and; demands of triage nursing. The nature of workplace violence in emergency departments in New South Wales and South Australia will be explored based on the authors' research. A research pathway to explore national impact and implications of violence for nurses and nursing practice in general will be outlined.

INTRODUCTION

The health industry is the most violent industry in Australia (Australian Institute of Criminology 1999). Dealing with violence is an important professional issue for Australian nurses that currently seems concealed as 'part of the job'. This paper will draw on available national and international studies to bring attention to the severity of workplace violence for nurses. With a particular focus on emergency department nursing the following factors have been identified as contributing to workplace violence:

1. increased waiting times and frustration;
2. increasing use of weapons;
3. inadequate systems of security;
4. culture of silence;
5. inadequate support for emergent mental health needs;
6. lack of reporting;
7. lack of institutional concern and systems of support; and
8. demands of triage nursing.

Completed and ongoing research projects will be used to illustrate the nature of workplace violence in emergency departments (EDs) in New South Wales (NSW) and South Australia (SA). A research pathway to explore national impact and implications of violence for nurses and nursing practice in general will be outlined.

Is workplace violence an issue for nurses?

The Perrone report from the Australian Institute of Criminology (1999) identifies the high level of violence in the health industry in Australia. Findings that registered nurses are the second highest in violence-related worker's compensation claims, outranking prison and police officers, are shocking to say the least (AIC 1999:46). Enrolled nurses rank an equally alarming fourth. It is important to note these findings are based on accepted

claims which adds further concern for those incidents that are not so formally recognised. International statistics also indicate that one in three nurses are likely to be subjected to physical or verbal abuse at work compared to one in four police officers (Holt 1999).

As reported in international literature (Cruikshank 1995; ENA 1991; Holt 1999; Levin Hewitt and Misner 1998; Rippon 2000; Whittington 1997) the problem of violence towards health care professionals in general, and emergency nurses in particular, is now firmly established as a high priority issue. EDs in particular, and hospitals in general, are public places where potential perpetrators of violence include all people the nurse encounters during a shift (Lyneham 1999; Bradley 1993). Levin, Hewitt and Misner (1998:250) note that emergency nurses report their lifetime exposure to workplace violence as very high. The International Council of Nurses (ICN), in adopting a position on violence in the nursing workplace claimed that nurses working in emergency departments are especially vulnerable (1999). Recent Australian research also makes links between reduced psychiatric services available in the community, ED violence, hostility and aggression (Heslop et al 2000:142).

By contrast, recent research (Stouffer and Varnes 1998; Simonowitz Rigdon and Mannings 1997) suggests that most nurses are unaware of the incidence and prevalence of violence which impacts on their profession. This is of real concern considering the potential risks to individual nurses which include psychological trauma and symptoms of post-traumatic stress disorder; physical injury and even death (Harulow 2000; Rippon 2000). Not only are hospital-based nurses at risk, but community nurses also experience their own difficulties with violent incidents (Koch and Hudson 2000). The increasing incidence of violence within all areas of the Australian health care system is a serious concern to nurses and requires immediate action (Harulow 2000:28).

'Part of the job'-what is violence?

There is a lack of consensus in available national and international literature on what constitutes violence and aggression, and also a lack of uniform standards against which such violence and aggression can be measured (Rippon 2000:435). Definitions of violence vary and may include verbal abuse, threatening behaviour and physical attacks (Schnieden and Marren-Ball 1995). Canadian researcher Rippon has recently attempted to provide a more comprehensive definition of aggression and includes:

behaviour with intent that is directed at doing harm to a living being whether harm results or not...[it] can be physical, verbal, active or passive and forced on the victim(s) directly or indirectly...with or without a weapon...with or without the manifestation of anger to oneself or others (Rippon 2000:456).

Workplace violence is defined as '...any incident or situation where a staff member is abused, threatened or assaulted in situations or circumstances relating to their work' (WorkCover 1998:5). Using the term violence within this paper the authors are mindful of the complexity of language and 'dependent meanings' evident in nursing practice (Lawler 1991). The term 'violence' is employed cognisant of its use in media and everyday speech. Of particular interest is the meaning of violence to Australian nurses in the context of their daily work life. The following definition of violence was provided by a NSW nurse participating in Lyneham's (1998) study. Violence is:

'Anything that makes you feel unsafe, fearful or anything that does not allow you to perform your job through intimidation, repression, fear of repercussions or not respectful of you as a person in your own right as a nurse, be it from medical colleagues, clients, management, relatives etc. Where your concerns are pushed aside and they make you feel inadequate' (Participant 4, Lyneham 1998)

Violence has been identified as a hidden aspect of emergency nursing work which manifests in daily encounters with patients, their relatives and significant others, and work colleagues (Jones 1999a,b). In order to further develop an understanding of violence within the context of emergency nursing, Jones (2000) is currently researching South Australian issues employing qualitative techniques. The aim of the study is to explore the impact and implications of violence on emergency nursing practice that arose from the many examples of overt violence uncovered in doctoral research by Jones (1999a). For example, as part of exploring the nature of nursing work in the ED one nurse graphically told of 'being punched in the face by a distressed relative' then having to get on with the next patient. This was not reported and was considered 'all in a days work' (Jones 1999a). Lyneham's (1999) survey research in NSW elicited many similar incidents.

Professor Megan-Jane Johnstone, a prominent Australian nurse author, has posed a challenge that nurses take legal action against violent patients and their families, and reframe an understanding that violence against nurses is unacceptable. Such action challenges the very core acceptance of patients' crises that many nurses accept and expect as part of their job. She adds 'there is an almost unconscious betrayal of the patient when we're criticising them for beating us up' (cited in Harulow 2000:28). In addition anecdotal evidence indicates that many who have taken legal action have encountered further problems.

Despondency and cynicism with the legal system is evident among nurses as highlighted in the the following nurse's comments:

'Following an aggravated verbal abuse and intimidation and threats by a relative he was charged. The matter was dismissed by the magistrate saying that it was OK for this person to demonstrate his feelings according to his cultural way !!! What chance do we stand !!!' (Participant 7, Lyneham 1998)

Nurses express concern that their role is to care for patients and their families. In order to provide this care do nurses around Australia need to be verbally abused, physically assaulted and threatened to the point of physical, emotional and psychological harm on a daily basis? Where do we draw the line?

Violence in the workplace is a potentially life-threatening and life-affecting hazard for nurses that is concealed as *'part of the job'* (Birkland 1991). A comprehensive picture of the impact and implications of violence on nursing practice is essential in order to effect positive change in the future. North American researchers Levin, Hewitt and Misner (1998:253) argued the need to explore the work of ED nurses in depth to assess the extent of violence in nursing and its subsequent impact on personal and professional life. The current Jones (2000) study, using in-depth interviews and focus groups, is taking up concerns by Levin et al to add personal detail to the nature of emergency nursing work. This study further builds on survey research (Lyneham 1999) which examined violence from the perspective of NSW ED nurses. In the latter study it was demonstrated that every ED nurse in the study experiences violence at least weekly and most on a daily basis. A consequence reported was that only 4.5% of respondents always felt safe at work. It was also shown that 75% of incidents were not reported, and is consistent with current examples offered in South Australia. These findings across two states are of considerable concern.

Understandings and insights from these Australian studies (Jones 2000; Lyneham 1999; Lyneham and Jones 2000) form a critical step in planning long-term solutions to workplace violence. In the ED nurses can find some support from the research to date and to move towards different 'reality-based' understandings of emergency nursing practice. Armed with such insights perhaps nurses can better anticipate, manage and prevent violence in their workplace, but before any long term planning can start there must be an acceptance from all parties that violence is a real problem and is not going to 'go away'.

Nature of workplace violence in emergency departments in New South Wales and South Australia

To encourage further discussion, debate and research a brief overview of some of the significant issues arising from completed investigations reported elsewhere (Jones 1999a,b; Lyneham 1999) and early findings in ongoing research projects (Jones 2000; Lyneham and Jones 2000) will be discussed.

Increased waiting times and frustration

Tension and stress can fuel aggression. In the current climate of health care crisis in Australia both emergency nurses and patients/families are more likely to be stressed and tense due to long waiting times, congested EDs, bed closure, limited staff resources and the intensifying acuity of presenting illness. With bed closures the waiting times for non-urgent patients is likely to increase in some hospitals. Waiting time in particular has been signalled as escalating violence-related events (Jones 1999; Lyneham 1999; Rose 1997). The way in which individual nurses and patients/families respond to aggression and tension can potentiate a time bomb of escalating violence. Unfortunately, tense situations are often on full display to waiting patients adding to frustration and the need for sound communication skills during intense periods.

Increasing use of weapons

If we recognise that television influences and mediates our cultural understandings of the world we live in, then little solace can be drawn from a recent airing of the popular TV drama 'ER'. This episode showed an emergency patient waiting for psychiatric assessment who subsequently wandered into a kitchen, took a knife, and proceeded to hide in a cubicle and silently stab two doctors who came in to make an assessment. Is this mere overkill for dramatic effect or a reality? It seems that the use of weapons in EDs is increasing (Lyneham 1999). For example, in NSW 17 gun and 75 knife incidents were reported by emergency nurses in the Lyneham study. It appears that anything that is not tied down has the potential to become a weapon. The availability of hospital equipment such as syringes, furniture and so on in turn become weapons to use against staff. For obvious reasons 'lock down' of essential equipment is inappropriate within a hospital environment.

Inadequate systems of security

Some health departments and hospitals have recognised the need to protect their staff but security equipment is not a panacea for violence. Security doors can reduce the risk of violence from the outside but do not prevent violence once the perpetrators are admitted to the inner sanctum of the department. Other security measures such as onsite security staff and duress alarms are only useful once a situation has occurred. The effectiveness of these devices is dependent on the response time of the appropriate people. In many cases the personnel responsible are emergency nurses themselves (Lyneham 1999). Clearly consideration of the composition of a security team and their skill level and training is needed. Understaffing, excessive and unrealistic workloads and the physical layout of the hospital have all been identified as contributing to the ineffectiveness of current security measures. Security measures need to be tailored to

individual settings in order to appropriately address needs. Violence response policies need also to be widely understood, used and evaluated regularly within an organisation to ensure maximum effectiveness.

Culture of silence

The distinction between acceptable and unacceptable behaviour appears blurred for many nurses. Some ED nurses, for example, prefer to blame themselves for the violent behaviour of patients and relatives. Johnstone (in Harulow 2000) likens such behaviour to that of victims of domestic violence. Lanza and Carifo (1991) found that victims of violence tended to blame themselves for not preventing the incident and others blamed the victim for allowing it to happen. Reasons for accepting violence related events commonly heard from nurses who experience violence from patients and relatives include: 'oh they were confused, upset,' 'We owe a duty of care, they must not be themselves', 'we have to take all sorts, it goes with the job', etc. It seems that when nurses perceive that the perpetrator of violence is of diminished capacity their actions should be tolerated. A 'zero tolerance' policy for workplace violence is now being advocated by practitioners and leaders of nursing worldwide (International Council of Nurses 1999). However, a more pressing issue remains to be addressed and that is the culture of 'whistleblowing' and its negative outcomes for those who 'blow the whistle'. How can nurses be encouraged to openly confront long-held values about their nursing practice and concomitant workplace culture?

Inadequate support for emergent mental health needs

De-institutionalisation of care for people with mental health needs has had far reaching consequences nationally, primarily the impact of a lack of community support structures and its flow through to general hospital EDs. One ED in South Australia (SA) reported seeing 55 psychiatric patients in one week and while not all of the EDs in SA see so many people with mental health needs, ED nurses are concerned about the demand for care by psychiatric patients (Jones 1999b:7; Lyneham 1999). Many ED nurses are not experienced in psychiatric nursing which can lead to a lack of de-escalation knowledge, avoidance of psychiatric patients even when other staff might need assistance and a sense of personal insecurity. Nurses' feelings of insecurity, vulnerability and intimidation are linked to invasive behaviours of violence, aggression and hostility of people requiring psychiatric care in a general hospital setting where staff do not have the skills or resources to deal with them (Heslop et al 2000:142). Crowley (2000:3) suggests that this is compounded by nurses working in EDs who experience a 'clash of cultures' between emergency care and mental health in an environment not conducive to 'privacy, quietness, safety and calmness' presumed necessary for

psychiatric management. Rather, the ED can be the antithesis of these conditions, the environment is open, busy, fast-paced and designed for maximum observation of the greatest number, thus further adding to the risk of escalating violence through heightened stimulation.

Lack of reporting

The incidence of violence experienced by nurses is hard to measure and is grossly underestimated (Levin et al 1998; Lyneham 1999). Only the most serious incidents of aggression and violence in the workplace are reported (Rippon 2000:457). The International Council of Nurses (ICN 1999) estimates that nurses only report 20% of violent incidents, and this figure is similar to the Australian experience of 25% (Lyneham 1999). Violent acts are not reported for a number of reasons. Mahoney (1991:284) states that nurses 'believe that there was insufficient time to complete reports [on violence] and that no real benefit was gained from reporting incidents.' Again, we must ask what do nurses see as a 'violent incident' and how then do they grade such violence? For violence-related injuries sustained at work to be calculated they must be reported and recorded through Occupational Health and Safety Hazard/Incident reporting mechanisms at each organisation. Public hospitals that are Workcover exempt are not included in injury-related claim statistics. If an individual is not physically injured and does not take time off work, potential non-physical violence-related injuries become concealed. In the authors' most recent research, as the aftermath of violence was explored with nurses it was apparent that the events affected the individual in many ways. Such effects include: anger, frustration, not wanting to have anything further to do with the person, avoidance behaviour, reluctance to go to work for the next shift, feelings of powerlessness, embarrassment and despair. Recognition and reporting of violence do play a part in addressing workplace violence but require support from colleagues, employers and appropriate systems of support to have any impact on positive outcomes for the nurse.

Lack of institutional concern and systems of support

Findings from the authors' research in Australia are in keeping with those of a recent Irish study (Rose 1997) suggesting that nurses believe that 'nothing will be done' if a report is made. In some cases the nurse victim was accused of causing the situation. The nurse victim becomes further victimised and traumatised. Two concerning findings from the Lyneham study (1999) were firstly that only 7% of respondents were satisfied with management's response and secondly that management was seen to be a perpetrator of violence by 22% of respondents. The latter mainly took the form of verbal abuse and threats to job security. Many comments from nurses in both NSW and SA suggests that reporting of an

incident does not guarantee action, or if action does take place it may not be communicated to the nurse by management (Jones 2000; Lyneham 1999). The authors' current national exploration across all areas of nursing also indicates if line managers were involved it was usually for incidents that the nurse felt could be handled by them. The decision to involve line management usually depended on their relationship. For example, if a supportive relationship existed then the Nurse Unit Manager was informed (Lyneham and Jones 2000). It is clear that nurses have many barriers that hinder reporting workplace violence in such a negative climate.

Demands of triage nursing

It seems that the pivotal role of the triage RN in the practice of emergency nurses is also fraught with an increasing risk of exposure to violence. Triage nurses can be verbally abused face-to-face and over the telephone in full view of a waiting room full of patients and significant others, sometimes every hour while simultaneously trying to assess and prioritise waiting patients (Jones 1999; 2000). Common practice in SA involves an eight hour shift on triage, NSW have 8 hour day shifts and 10 hour night shifts, other states may have split shift options to reduce the intensity of the role demands. As the first nurse an anxious patient and their family may see, the triage RN bears the brunt of frustrations related to the duration of 'waiting time' and the triage priority system of care. The triage RN also liaises with nursing and medical staff within the ED and throughout the hospital and its associated networks. This means constant negotiations with tense, stress-filled staff each trying to get through the shift and to get patients seen as soon as possible. The communication skills and tolerance level of each RN, often under duress, become paramount in the prevention and de-escalation of violence. These attributes set the scene for a patient's transition through the ED. Consideration needs to be given to the skills and education required to fulfill a nursing triage role and to the structure of work practice at triage. Such consideration is necessary, as nurses also become frustrated and equally capable of hostile and negative actions towards the public and co-workers.

Charting a research pathway for a national study

Violence in the workplace is thus an occupational, health and safety issue and a professional issue for all nurses in Australia. Combined with the recognised issue that violence in the workplace is not reported (Lyneham 1999; Schnieden and Marren-Ball 1995; Whitley et al 1996) or ignored if it is reported (Rose 1997), it becomes apparent that to gain insights about the issues surrounding workplace violence one needs to explore the experiences of the worker. Independently the authors have tried to access complex worker experiences in the emergency

setting but are aware that the issue of violence in the nursing workplace is much larger. The authors agree with a position also recently mooted by Rippon (2000:458) that argues 'work needs to be done to develop a comprehensive instrument that can measure all types and severity of aggression... [with] universal application throughout all health care professions and other workplace environments'. Only then will the magnitude of the problem of violence and its impact and implications for all health care professionals be understood and actioned by health care organisations. In light of this a study has been commenced (Lyneham and Jones 2000) that employs qualitative and quantitative techniques to further develop an existing survey tool used in NSW for emergency nurses that can be used across all nursing areas and all regions of Australia. The results of the national survey will be known by the end of the year, with the aim to report the qualitative dimensions of the study in the interim. The authors' intent in this paper is to invite clinicians and researchers to make a contribution to this significant area of nursing practice. By sharing both independent and joint activities within a published forum there can be greater focus and enhanced developments within a critical issue for nurses, violence in the workplace.

CONCLUSION

In conclusion it is clear that 'violence' is an ill-defined concept for Australian health care professionals but one that could have immense impact on the way nurses in particular practice both now and in the future. Through reference to completed and ongoing research activities the authors have highlighted some of the complex issues that surround violence-related events experienced by nurses, with a particular focus on emergency nurses. Furthermore, the need to broaden the focus of the authors research, and that of others, has been emphasised to include all nurses practicing in all areas of Australia. In doing so the authors have charted a research pathway in the hope of scholarly debate and collegial concern. The authors would encourage nurses to participate through scholarly writing, research or peer discussions and 'have a say' in the way violence is framed and subsequently managed within the context of nursing practice in Australia. Those nurses who see violence as a 'non-issue' are also encouraged to speak out. Further consideration for nurses could be to take up challenges posed not only by Johnstone (pers.com 2000, also in Harulow 2000) in Australia, but also leading international professional bodies such as the Emergency Nurses Association in the United States. These challenges are that nurses need to take legal action against violent patients and their families in the interest of making violence visible and unacceptable to all.

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