

Trends in workplace violence in the remote area nursing workforce

AUTHORS

Tessa Opie

B. Psych (Hons.) PhD Candidate
Centre for Applied Psychological Research, University of South Australia, City East Campus, Adelaide, South Australia.
Tessa.Opie@postgrads.unisa.edu.au

Sue Lenthall

RN, B. Ad Teach, MPH&TM
Project Manager, Back from the Edge Study, Centre for Remote Health, a joint centre of Flinders University and Charles Darwin University, Alice Springs, Northern Territory.

Professor Maureen Dollard

PhD
Director, Centre for Applied Psychological Research, University of South Australia, City East Campus, Adelaide, South Australia.

Professor John Wakerman

MBBS, MTH, FAFPHM, SACRRM
Director, Centre for Remote Health, a joint centre of Flinders University and Charles Darwin University, Alice Springs, Northern Territory.

Professor Martha MacLeod

RN, BA, MA, PhD
Chair, School of Nursing, University of Northern British Columbia, Prince George, BC, Canada.

Associate Professor Sabina Knight

RN, MTH
Remote Health Practice, Centre for Remote Health, a joint centre of Flinders University and Charles Darwin University, Alice Springs, Northern Territory.

Professor Sandra Dunn

RN, ADN, BN, MScN, PhD, FRCNA
Director, Graduate School for Health Practice, Charles Darwin University, Casuarina, Northern Territory.

Greg Rickard

RN, PhD
Principal Nursing Adviser, Northern Territory Department of Health and Families.

ABSTRACT

Objective

To assess incidence of workplace violence in the remote area nursing workforce and to compare present data to data collected 13 years previously.

Design

The research adopted a cross-sectional design, using a structured questionnaire.

Setting

Health centres in very remote Australia.

Subjects

349 nurses working in very remote regions across Australia.

Main Outcome Measure

The main outcome measure was posttraumatic stress disorder (PTSD) symptoms, as assessed using the PTSD Checklist (PCL).

Results

Findings indicate increases in all incidents of reported violence in the workplace between 1995 and 2008. Verbal aggression, property damage and physical violence are the most frequently experienced forms of violence as perpetrated directly towards remote area nurses, with statistically significant positive correlations between all types of workplace violence and PTSD symptoms. Verbal aggression, physical violence and property damage are the most commonly witnessed forms of violence occurring between other people. Statistically significant positive correlations were also found between each type of witnessed violence and PTSD symptoms, excluding sexual abuse/assault. Nurses working in very remote regions in Australia are fearful for their personal safety.

Conclusion

Working in fear for your personal safety can function as a major occupational stressor. The research has implications for the implementation of workplace policies that target the identification, management and prevention of violence in the remote area nursing workforce.

KEY WORDS

Remote Area Nurse, Workplace Violence, Posttraumatic Stress Disorder (PTSD).

INTRODUCTION

The health industry may be one of the most violent industries in Australia (Perrone 1999). Nurses reportedly experience workplace violence at a rate four times greater than the average employee (Gallant-Roman 2008), with more violence-related workers compensation claims (1995/1996) than correctional officers and police officers (Deans 2004 p14). Furthermore, an American National Crime Victimization Survey on violence in the workplace (1993-1999) found that nurses experienced work-related crime at twice the rate of any other health care provider.

In Australia, there are decreasing numbers of health practitioners with increasing remoteness across the country (Productivity Commission 2006), and nurses represent the largest and most evenly distributed health discipline across urban, rural and remote areas. They play a critical role in the delivery of services in very remote regions. Nurses working in isolated, remote areas are also subject to multiple stressors, one of which is violence in the workplace (Lenthall et al 2009). Violence in the workplace has been identified as a significant contributor to turnover in the remote area nursing workforce (Morrell 2005; Kelly 1999; Fisher et al 1996). Whilst the issues of violence and personal safety in this context have long been acknowledged by numerous government and organisational bodies (CRANA 1992), it was not until the mid-nineties that Fisher et al (1996 p1) documented that remote area nurses experienced "frequent and serious episodes of violence, with verbal aggression, property damage and physical violence the most common". Furthermore, the researchers reported that remote area nurses in small communities experienced more workplace violence than their metropolitan counterparts. Specifically, 86% of respondents had experienced aggression, and 43% of respondents had experienced abuse. Occupational violence has a significant impact on the well-being of nurses (Deans 2004), with research suggesting that, as a result of increased exposure to violent or traumatic incidents in the workplace, remote area nurses are at a greater risk

of developing conditions such as PTSD (Kelly 1999). It has also been argued that there is an increased susceptibility to anxiety, impaired professional function and difficulties sleeping (Rippon 2000; Robbins et al 1997; Fisher et al 1995).

A key purpose of this paper was to build on existing empirical and anecdotal evidence and to determine whether the incidence of violence against remote area nurses has changed over time. The frequency of various forms of workplace violence and their relationships to PTSD symptoms in this population were assessed.

METHOD

Using a cross-sectional design, a structured questionnaire was distributed to 1,007 nurses working in very remote regions across Australia, according to the ARIA+ (Accessibility/Remoteness Index of Australia Plus) classification system of remoteness (AIHW 2004). Various recognised methods were adopted to maximise survey return, including pre and post survey contact with target health care facilities (Nakash et al 2006; Gore-Felton et al 2002). A database of very remote nursing positions belonging to the Council of Remote Area Nurses of Australia (CRANA) Inc. was accessed for the study. This database was refined by identifying all sites within very remote Australia that employed registered nurses and by searching the web for additional health service facilities, mine sites and tourist resorts that are also located within very remote Australia. The database was then further refined by referring the list of clinics to nurses at a national Council for Remote Area Nurses of Australia (CRANA) Inc. conference for confirmation or amendments. Ethics approval was granted by four human research ethics committees in the Northern Territory and South Australia.

The questionnaire assessed various workplace demands and resources, and further assessed both positive work outcomes and adverse psychological health outcomes. Violence in the workplace was the independent measure of particular relevance to this paper. The construct was assessed by asking

respondents how often they had experienced different manifestations of workplace violence in the preceding 12 months. Responses corresponded with a 4-point scale ranging from zero (*never*) to four (*four times or more*). Violence categories included verbal aggression or obscene language, property damage, physical violence or assault, sexual harassment, sexual abuse/assault, and stalking. Definitions of each of these categories were provided to encourage a more consistent standard of interpretation.

The outcome measure used was PTSD symptoms, which was assessed using the PCL (Weathers et al 1993). The PCL provides a list of 17 fundamental symptoms of PTSD which are clustered into three main symptom categories, including re-experiencing symptoms (e.g. nightmares or flashbacks), hyperarousal symptoms (e.g. easily startled), and avoidance and psychic numbing symptoms (e.g. trying to avoid activities, places or people). It asks respondents to rate “if and how” they have been bothered by any of the listed “reactions” (symptoms) over the past month, in relation to a traumatic experience or event. Responses correspond with a 5-point scale ranging from one (*not at all*) to five (*extremely*). Accordingly, the PCL yields a continuous measure of PTSD symptom severity. The scale demonstrates sound internal reliability ($\alpha = .93$).

Also of relevance was an assessment of nurses’ perceptions of community violence and their personal safety. This was achieved by asking respondents how often they felt concerned about “violence in the community” and their “personal safety”. Responses corresponded with a 7-point scale, ranging from zero (*never*) to six (*everyday*).

Data from the questionnaire were analysed using the Statistical Package for the Social Sciences (SPSS) for Windows, version 16. Bivariate correlations were performed to assess the relationships between types of violence and posttraumatic stress disorder symptoms. T-tests were performed to analyse the degree of difference between our results and the results from the 1995 study.

FINDINGS

Three hundred and forty-nine (349) nurses working in very remote Australia participated in the study, generating an overall response rate of 34.6%. The majority of respondents from this sample were female (88.5%), with ages ranging from 20 to 68 years ($M = 44$, $SD = 11$).

In the 12 months preceding survey completion, the form of violence most commonly experienced by remote area nurses was verbal aggression (79.5%), followed by property damage (31.6%), physical violence (28.6%), sexual harassment (22.5%), stalking (4.9%) and sexual abuse/assault (2.6%). These results represent incidents of workplace violence that were specifically experienced by remote area nurses only. These figures do not include the witnessing of violent incidents that were directed towards remote area nurses’ co-workers, family, friends or other members of the community.

Results further indicate statistically significant positive correlations between all types of workplace violence and PTSD symptoms. Results are displayed in table 1.

Table 1: types and frequencies of workplace violence towards remote area nurses and their correlations with PTSD symptoms.

Type of violence (personal)	Frequency	Correlations with PTSD symptoms
Verbal aggression	79.5%	.25**
Property damage	31.6%	.16**
Physical violence	28.6%	.23**
Sexual harassment	22.5%	.21**
Sexual abuse/assault	2.6%	.16**
Stalking	4.9%	.18**

** = correlation significant at the $p < .01$

* = correlation is significant at the $p < .05$

Results also demonstrated that in the 12 months preceding survey completion, the type of violence most frequently witnessed by remote area nurses towards others was also verbal aggression (85.7%). The next most frequently witnessed types of violence towards others were physical violence (57.9%),

property damage (53.9%), sexual harassment (32.1%), stalking (14.3%) and sexual abuse/assault (10.9%). Statistically significant positive correlations were found between each type of witnessed violence and PTSD symptoms, excluding sexual abuse/assault which was found to have no relationship to PTSD symptoms. Results are displayed in Table 2.

Table 2: Types and frequencies of workplace violence witnessed by Remote Area Nurses towards others, and their correlations with Posttraumatic Stress Disorder (PTSD) symptoms.

Type of violence (witnessed)	Frequency	Correlations with PTSD symptoms
Verbal aggression	85.7%	.16**
Property damage	53.9%	.15**
Physical violence	57.9%	.24**
Sexual harassment	32.1%	.30**
Sexual abuse/assault	10.9%	.12
Stalking	14.3%	.16**

** = correlation significant at the $p < .01$

* = correlation significant at the $p < .05$

Comparisons were drawn between data from this study sample and data from a similar sample of 237 Australian remote area nurses from an earlier study (Fisher et al 1995) that also investigated violence in remote communities. As the previous study measured incidents of workplace violence as directed at “you, your family, other clients or health workers”, this study amalgamated the data (to include violence towards “you” and violence witnessed as “occurring between other people”) in an effort to make the datasets more comparable.

Results indicated a statistically significant increase in the incidence of physical violence ($p < .001$). Statistically significant increases were also found for stalking ($p < .01$), property damage ($p < .05$) and aggression ($p < .05$). Whilst there were increases in the incidence of sexual harassment and sexual abuse/assault, these were not significant. Results are displayed in table 3.

Finally, results relating to perceptions of safety revealed that 86.4% of remote area nurses indicated that they felt concerned about violence in the community, 33.2% of whom felt concerned at least once a week. Two thirds of nurses (66.4%) reported

that they felt concerned about their personal safety, 14.3% of whom indicated feeling concerned about this at least once a week.

Table 3: comparisons between the present study sample and previous study sample for type and frequencies of violence experienced by remote area nurses.

Type of violence experienced	Frequency	
	Fisher et al 1995	Data from present study
Verbal aggression	82.1%	91.1%*
Property damage	46.7%	57.6%*
Physical violence	45.1%	61.1%***
Sexual harassment	31.8%	37.8%
Sexual abuse/assault	10.6%	12.0%
Stalking	8.3%	15.8%**

*** = difference is significant at the $p < .001$

** = difference is significant at the $p < .01$

* = difference is significant at the $p < .05$

DISCUSSION

The study found that self-reported incidents of workplace violence appear to have increased significantly in the past thirteen years (Fisher et al 1995). Whilst our study considered nurses working in very remote Australia, a similar trend has been found for nurses working in the public, private and aged care sectors. According to an Australian study conducted by Hegney et al (2006), results demonstrated an increase in workplace violence in each of these three sectors, from 2001 to 2004. A number of other researchers have also argued that violence against nurses is increasing (Jackson et al 2002; Erickson and Williams-Evans 2000; Taylor 2000). This finding runs counter to the various taskforce recommendations and zero tolerance policies that have been established in response to workplace violence in the nursing profession. The Australian Nursing Federation (ANF) (2008) stipulates that “nurses and midwives have the right to expect that employers will implement policies and procedures supporting a zero tolerance approach to occupational violence and aggression”. The policy further specifies ways in which the safety and security of the physical environment can be improved, including “minimising public access points” and “implementing systems

for staff to screen patients". Of particular relevance to remote area nurses is the recommendation from the Australian Nursing Federation that employers "develop and implement policies and procedures for nurses and midwives working in isolation or external to the facility" in relation to violence and aggression in the workplace. Despite such policies and recommendations, however, the incidents of workplace violence do appear to be increasing.

Nurses working in very remote Australia are also fearful for their security and well-being, with two thirds of the population reporting concerns for their personal safety. Those remote area nurses who reported higher levels of exposure to violence also reported higher levels of PTSD symptoms, including difficulty sleeping, difficulty concentrating, irritability, feeling distant or cut off, reliving of the trauma and feeling emotionally upset when reminded of the trauma.

Working in fear for your personal safety can function as a major occupational stressor, and indeed, violence in the workplace has been cited as a common reason for resignation in the remote area nursing workforce (Morrell 2005; Kelly 1999; Fisher et al 1996). Alarming, nurses are not only resigning from the field, but fewer candidates are choosing to enter (Gallant-Roman 2008).

Whether our results reflect a real increase in actual workplace violence, or whether they reflect an increase in the ability of remote area nurses to better identify it, cannot be absolutely stated. Different sampling strategies were used for the two studies. Respondents from the 1995 sample held membership with the Council for Remote Area Nurses of Australia (CRANA) Inc., while the present study sample included participants irrespective of memberships with professional bodies. Furthermore, the issue of workplace violence is a difficult one to research as victims are often traumatised and receive inadequate emotional support (Rippon 2000). Such experiences may have deterred potential participants from responding to this survey. Fisher et al (1996) further note that nurses working remotely may often choose not to report incidents, such as workplace

violence, so as to avoid any unwelcome media attention that may emphasise community problems. However, despite different sampling strategies and the potential for under-reporting, workplace violence against remote area nurses is occurring at unacceptable levels and is "a fundamental violation of their human rights" (Fisher et al 1996 p198).

RECOMMENDATIONS

Workplace violence poses significant threat to the physical and psychological well-being of remote area nurses (Kelly 1999; Fisher et al 1995). Whilst this issue has been acknowledged and responded to at a policy level, there is an increasing need to actively implement these policies in administration and practice. The robust implementation of such policies will require the participation and collaboration of all stakeholders, including remote area nurses themselves, state and federal governments, unions, occupational health and safety representatives, and other professional bodies, such as CRANAplus. We need a firm and united front that sends a clear message of zero tolerance of workplace violence.

There is also the capacity to establish zero tolerance assessment teams (Clements et al 2005) to evaluate the needs of the workplace and oversee worksite-specific policies and procedures. Such teams may also support the role of an occupational health nurse who implements compulsory education programs that target the identification and management of violence in the workplace. Additionally, there may be systems for mandatory reporting of violent and aggressive incidents, as well as mandatory debriefing for those individuals affected. Management may also benefit from training that focuses on best-practice provision of staff support. Future research may assess which of these strategies are most effective. Further to education programs, improved psychosocial care and mandatory reporting systems, workplace interventions should target the physical work environment itself, including improved security in the home, workplace and when attending to on-call or out-of-hours duties.

Previous research has demonstrated that while nurses acknowledge the existence of policies for the management of workplace violence, they also report that policies do not necessarily ensure safety (Hegney et al 2006). The time has come to transform policy into robust practice.

REFERENCES

- Australian Institute of Health and Welfare (AIHW). 2004. Rural, regional and remote health: a guide to remoteness classifications. AIHW. Cat no. PHE 53. Canberra: AIHW.
- Australian Nursing Federation (ANF). 2008. ANF Policy: Zero tolerance of violence and aggression in the workplace. Available at: www.anf.org.au/pdf/policies/P_Zero_tolerance_violence_aggression.pdf
- Clements, P.T., DeRanieri, J.T., Clark, K., Manno, M.S. and Kuhn, D.W. 2005. Workplace violence and corporate policy for health care settings. *Nursing Economics*, 23(3):119–124.
- Council of Remote Area Nurses of Australia Inc (CRANA). Occupational Health and Safety of Remote Area Nurses. Position paper prepared by Queensland Members of CRANA Executive, 1992.
- Deans, C. 2004. Nurses and occupational violence: The role of organisational support in moderating professional competence. *Australian Journal of Advanced Nursing*, 22(2):14–18.
- Erickson, J. and Williams-Evans, S. 2000. Attitudes of emergency nurses regarding patient assaults. *Journal of Emergency Nursing*, 26(3):210–215.
- Fisher, J., Bradshaw, J., Currie, B.A., Klotz, J., Robbins, P., Reid Searle, K., and Smith, J. 1995. *Context of Silence: Violence and the Remote Area Nurse*. Bundaberg: Central Queensland University.
- Fisher, J., Bradshaw, J., Currie, B., Klotz, J., Robbins, P., Reid Searl, K., and Smith, J. 1996. Violence and remote area nursing. *Australian Journal of Rural Health*, 4(3):190–199.
- Gallant-Roman, M.A. 2008. Strategies and tools to reduce workplace violence. *American Association of Occupational Health Nurses Journal*, 56(11):449–454.
- Gore-Felton, C., Koopman, C., Bridges, E., Thoresen, C., and Spiegel, D. 2002. An example of maximizing survey return rates. Methodological issues for health professionals. *Evaluation & the Health Professions*, 25(2):152–168.
- Hegney, D., Eley, R., Plank, A., Buikstra, E., and Parker, V. 2006. Workplace violence in Queensland, Australia: The results of a comparative study. *International Journal of Nursing Practice*, 12(4):220–231.
- Jackson, D., Clare, J., and Mannix, J. 2002. Who would want to be a nurse? Violence in the workplace – a factor in recruitment and retention. *Journal of Nursing Management*, 10(1):13–20.
- Kelly, K. 1999. Preventing job-related post-traumatic stress disorder among remote health practitioners: Best Practice Guidelines. Alice Springs: Council of Remote Area Nurses Australia (CRANA) Inc.
- Lenthall, S., Wakerman, J., Opie, T., Dollard, M., Dunn, S., Knight, S., MacLeod, M., and Watson, C. 2009. What stressors remote area nurses? Current knowledge and future action. *Australian Journal of Rural Health*, 17(4):208–213.
- Morrell, K. 2005. Towards a typology of nursing turnover: The role of shocks in nurses' decisions to leave. *Journal of Advanced Nursing*, 49(3):315–322.
- Nakash, R.A., Hutton, J.L., Jørstad-Stein, E., Gates, S., and Lamb, S.E. (2006). Maximising response to postal questionnaires – A systematic review of randomised trials in health research. *BMC Medical Research Methodology*, 6(1):5.
- Perrone, S. 1999. *Violence in the workplace*. Australian Institute of Criminology. Research and Public Policy Series: 22.
- Productivity Commission. 2005. Australia's Health Workforce, Research Report, Australian Government: Canberra.
- Rippon, T.J. 2000. Aggression and violence in health care professions. *Journal of Advanced Nursing*, 31(20):452–460.
- Robbins, I., Bender, M. and Finniss, S. 1997. Sexual harassment in nursing. *Journal of Advanced Nursing*, 25(1):163–169.
- Taylor, D. 2000. Student preparation in managing violence and aggression. *Nursing Standard*, 14(30):39–41.
- U.S. "Violence in the Workplace 1993-1999", US Department of Justice, National Crime Victimization Survey, December 2001. Available at: <http://www.ojp.usdoj.gov/bjs/pub/pdf/vw99.pdf>
- Weathers, F.W., Litz, B.T., Herman, D.S., Huska, J.A., and Keane, T.M. 1993. *The PTSD Checklist: Reliability, validity, and diagnostic utility*. Paper presented at the Annual Meeting of the International Society for Traumatic Stress Studies, San Antonio, TX.