

Proceedings of the first International Conference on
**Workplace Violence
in the Health Sector**
Together, Creating a Safe Work Environment



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KAVANAH

Workplace Violence in the Health Sector

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Editors

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Together, Creating a Safe Work Environment

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Preface

It is now universally acknowledged that violence is a major challenge within the health care sector. This is a rather disturbing finding considering that the function of the health care sector is to provide care to those experiencing health difficulties. Not only does violence diminish the quality of the working life of staff and the care experience of service recipients, but also imposes very significant costs on health services in terms of human and financial resources.

Violence in the health care sector can be categorized as either ‘Vertical’ occurring between health care professionals and the care recipients, or ‘Horizontal’ occurring among health care professionals or among care recipients. Vertical violence may be from care recipients toward carers or, to a lesser but more disturbing degree, from carers toward care recipients. Horizontal violence has become an overtly discussed issue within the last decades for example in the concept of bullying.

There is a lack of universal consensus as to what constitutes violence within the health sector context and demarcation lines between violence and related concepts such as aggression, hostility, or sexual intimidation are often poorly defined.

For the purpose of this conference we will refer to ‘violence’ in a very general and broad manner to encompass all these terms. This broad understanding will encompass numerous manifestations of violence which can range from mild verbal hostility to potentially fatal assaults. Considering the complexity and diversity of the problem, and the need for integrated responses, the conference has been structured to provide a comprehensive exploration of key issues which have been organized into eight conference sub-themes:

- Economical aspects and implications of workplace violence (chapter 2).
- Gender aspects and implications of workplace violence (chapter 3).
- Legal and/or ethical aspects and implications for the employer and employee of workplace violence (chapter 4).
- Nature, epidemiology, patterns and trends of workplace violence (chapter 5).
- Policies and Operational Strategies regarding workplace violence: local, national, international and global guidelines, standards, reporting, prediction, risk assessment, prevention, management, after care and rehabilitation (chapter 6).

- Scientific, methodological, operational aspects and instruments regarding workplace violence (chapter 7).
- Social and psychological theoretical perspectives on workplace violence (chapter 8).
- Staff training and education issues regarding workplace violence (chapter 9).

There are very considerable regional, national and cultural variations in how the problem is understood and managed. Notwithstanding these variations, the participation of presenters and participants from the world's five continents clearly demonstrates that violence is a global issue in health care settings. This global representation presents the opportunity to incorporate cultural and regional variations in broadening the debate, and exploring solutions in a manner which will help the participants come closer to achieving the three general aims of the conference:

- To sensitize stakeholders to the issue of workplace violence.
- To understand the manifestations and the human, professional and economic implications of workplace violence.
- To promote effective policies and strategies to create safe work environments

We therefore hope and wish that the conference in Amsterdam will give us all the opportunity to exchange ideas, network with international colleagues and, most importantly, to consider strategies and solutions which will inform efforts in delegates respective homelands in the creation of safer places of service in which to receive or provide services. With this desire in mind we would like to wish everyone a fruitful conference "Together, Creating a Safe Work Environment".

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- International Hospital Federation (IHF)
- Public Services International (PSI)
- Centre of Psychiatry Rheinau (Switzerland)
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Chapter 1 - Keynotes

Creating work environments that are violence free

Keynote

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Keywords:

Workplace violence, health care sector, nursing, job satisfaction, health, absenteeism

Introduction

Workplace violence toward health care workers is a serious and growing occupational hazard that is of concern at the global level. The WHO defines workplace violence as, "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."^{26,27} By this definition workplace violence can take many forms, from the more overt forms of physical attacks and verbal assault, to the more subtle coworker bullying and inter-professional incivility.

Research into the consequences of workplace violence over the past two decades has brought about a heightened awareness of how widespread and damaging these assaults are, yet evidence suggests that the prevalence of workplace violence remains unacceptably high. For example, a recent Statistics Canada report found that in 2004 approximately "17 % of all self-reported incidents of violent victimization" took place in the workplace. In the United States homicide is the second leading cause of death at the workplace, and a staggering 2 million non-fatal workplace assaults are estimated to take place every year³⁷. Findings such as these are echoed by studies across the globe that report high incident rates of workplace violence³¹⁻³³, with some studies even reporting an increase in workplace violence in recent years¹⁶.

In healthcare environments occupational violence has been especially prevalent^{4, 9, 19, 35, 44, 47, 48}. Studies have repeatedly shown that workers in this occupational group are subject to higher rates of verbal and physical assault than almost any other occupational group^{13,41}, with workers being subject to abuse from patients, family members, peers and employers. It is an established fact that even among healthcare workers the rates of workplace violence in nursing are particularly high, with a 2000 British Crime Survey showing the likelihood of nurses being assaulted is second only to security and protective services occupations⁵. Studies conducted internationally clearly indicate that this is not an isolated phenomenon but is, in fact, a cause for global concern^{4, 5, 7, 12, 14, 24}. What is startling is that when one considers that underreporting of workplace violence in nursing is an all too common phenomenon^{11, 17, 27}, the prevalence of violence against nurses is likely even higher than is being reported in the literature.

Just as an array of actions and behaviors can constitute workplace violence, equally complex and layered are the consequences of this violence on the quality of one's work life and health. Although physical injury is one potential result of violence, it has been reported that acts of workplace violence causing serious injury or physical harm occur far less frequently than assaults which result in little or no physical harm²¹. While the immediate effects of this type of violence may be less obvious, some of the more prominently reported consequences of this violence include: "anger, fear or anxiety, PTSD symptoms, guilt, self-blame, and shame"³⁹. Additionally, others have reported that the psychological or emotional fallout of workplace violence impact work-related outcomes, resulting in poor work attitudes, decreased affective commitment, increased turnover intentions, increased job neglect and decreased job performance and productivity²³.

Researchers investigating the impact of this violence on nurses show that it can interfere with normal working and leisure activities for months or years after the incident²⁹. In a recent review of the non-somatic effects of patient aggression against nurses it was reported that assaults can undermine the nurse-patient relationship by causing behavioural sequelae such as a decreased eagerness to spend time with patients, decreased willingness to answer patients' calls, avoidance of patients, adopting a passive role in treatment, or even causing callousness towards patients^{8, 17, 20, 25}. Likewise, verbal abuse in the workplace has been linked to decreased morale, productivity and nursing care delivery, as well as increased workload and errors⁴⁶. The anxiety and stress about personal safety following workplace violence can also indirectly complicate or exacerbate other work stressors¹⁰, and for nurses working in more remote areas a fear of personal safety can persist even when off-duty¹³.

Another important, though perhaps more insidious, means by which level of violence is impacting the nursing environment is through the normalizing of violence in the workplace. Erickson and Williams-Evans¹⁰ have asserted that most nurses have come to accept violence and assault as part of their job, and they argue that as a result violent acts and aggression have become accepted as a normal part of the workplace. Others have further suggested that this normalization of workplace violence has fostered an environment in which institutional violence or bullying and intimidation tactics by other nurses and nurse managers have become commonplace²⁰. In fact, there may be an acceptance of a culture of violence in healthcare institutions which then increases the likelihood of underreporting of violent incidents and a consequent lack of awareness of the scope of the problem⁹.

Apart from the effects on psychological health, personal well-being, employee morale and nursing care delivery as described above, a direct link has also been reported between aggressive incidents at work and sick leave, drug and alcohol use, burn out, staff turnover and desire to leave the profession in nurses¹¹. This is substantiated by studies such as those by Cox⁸ which reported 16% of nursing turnover was directly related to factors associated with verbal abuse. Other authors have reported similar findings, showing significant positive correlations between verbal abuse and variables such as "looking for a new job" and thoughts of "quitting within the next 6 months"⁴⁶. A significant negative correlation has also been reported between job satisfaction levels and the number of different types of violence experienced by nurses over their most recent five shifts²².

The review highlights consistent findings of links between incidents of workplace violence and deterioration of health care workers' work life and health, and how it consequentially impact the health care system seen in patient care delivery and health human resource planning on recruitment and retention. While it is clear based on currently available findings that workplace violence is a serious source of deterioration of nurses' work life and health, there is a need for more large-scale studies based on a representative sample and sophisticated statistical analysis methods to promote a better understand of the issue. For example, study findings are limited by the selection of small sample sizes and the participation of only registered nurses (or nurses from a particular specialty) which restricts its generalizability¹⁹. Cross-sectional designs prevent drawing of conclusion about direction of causal effects between work-related factors and occurrence of violence⁷. Only then can organizations and regulatory bodies appropriately respond to nurses who have experienced workplace violence and address feelings of career dissatisfaction and willingness to leave the profession. As the international shortage of nurses looms toward a global crisis, there is a clear need for further research that contributes to violence prevention and accurate assessment of the impact of violence on health care workers.

Methods

This study used data of a Canadian national survey administered in 2003 to registered nurses (RNs), licensed practical nurse (LPNs), and registered psychiatric nurses (RPNs) to examine the impact of workplace violence on health care workers' work life and health. Data were collected

using a disproportional stratified sampling design by strata of three nursing groups, province/territory (ten provinces and three territories), sector (hospital vs. non-hospital) and age (under 39 vs. 40 and above). A total of 37,868 valid surveys were mailed; 13,620 nurses returned the survey, with a response rate of 36%.

Since this study was based on a complex sample design, statistical analyses were conducted using SAS 9.1 survey procedures to allow for more accurate statistical inference. As noted by Freeman, Livingston, Leo and Leaf¹⁴, complex survey data analyses using standard statistical packages that do not take into account complex sample designs tend to underestimate the variances and inflate estimates of statistical significance. In the latest version of SAS, survey procedures, including SURVEYFREQ, SURVEYMEANS, SURVEYREG and SURVEYLOGISTIC, take into account the complex sample design and use Taylor series expansion theory to estimate the covariance-variance matrix of the estimated regression coefficients¹⁵.

Incidences of violence were reported as the sum of incidences experienced in the last ten shifts across all sources, including patients, patients' relatives, physicians, coworkers and others, and across all types, from physical assaults, threats, verbal aggression, to emotional abuse. Four outcome variables were studied. Absenteeism was measured by the number of missed work days due to short-term illness in the past year, job satisfaction was based on the nurses' responses on six five-point Likert scale items relating to job satisfaction, and mental health and physical health were measured by the SF-12, a twelve item survey frequently used to measure general health status. All continuous outcome variables were dichotomized. SF-12 scores were dichotomized as health better or poorer than the general female population, absenteeism was recorded if there were any missed worked days in the past year, and job satisfaction represented averaged scale scores above 3.5 (out of 5).

Two-way cross-tables were first present to describe the binary relationship between the experience of workplace violence and nurses' work life and health reflected in absenteeism, health, and job satisfaction. Then, the effect of workplace violence on the nurses' work life and health was estimated in logistic regression analysis after controlling for variables that may confound the relationship between workplace violence and work life and health outcome measures. The control variables included demographic variables and workplace environment factors relevant to the outcome measures. For example, total worked hours, health status and Worker Compensation Claims were included as control variables as they may also affect the number of sick days taken, thereby confounding the effects of workplace violence factors alone. A few nursing work index variables and structural empowerment variables were included in the job dissatisfaction model as control variables as literature has suggested nursing work environment is important in predicting nurses' job satisfaction. Job stress from heavy workload (measured by receiving coffee or meal break) and shift change, other than age and nurses' life style, may influence, independently, the physical and mental health of nurses. Since the outcome variables are dichotomous, logistic regression models were conducted using SAS 9.1 survey procedures.

Results

Table 1 provides sample characteristics and descriptive statistics of work environment variables that were used in the multivariate logistic regression analysis. The data showed the average age of nurse was 45, much older than the average age of the Canadian female workforce, 39. RNs accounted for nearly three-fourths of nurses. Less than 5% of the nurses sampled were male, and one-fourth of all nurses had bachelor's degrees or higher. The majority of nurses worked in direct care (89%) or hospitals (48%). Six tenths worked full-time and only one-sixth of nurses planned to change their employment status. The work environment of the nurses surveyed was stressful: four fifths had worked overtime in the past year, one-third changed shifts at least twice in a two-week period; one-third did not receive coffee or meal breaks, an indication of heavy workload; one-fifth

experienced job instability in the past year due to restructuring; and one tenth had reported Workers Compensation injuries in the past year. The mean scores of NWI-R in leadership, resource adequacy and autonomy, and Condition of Work Effectiveness that measure structural empowerment of nurses revealed that the practicing environment is only moderately acceptable.

The descriptive statistics of the four outcome measures of work life and health are presented in Table 2. One-fourth of nurses had missed work days due to short-term illness in the past year, the average of which was 4.6 days for the overall sample and 6.6 for those who had reported missing work days. Two-thirds of all nurses surveyed were dissatisfied with their current position. In addition, one-third of nurses reported their physical health as worse than that of the general female population, and nearly half of the nurses reported their mental health as being worse than that of the general female population. The quality of nurses' work life and health shown in these statistics, is consistent with findings in other studies, is alarming

Table 3 details the prevalence of workplace violence in nursing. More than half of the nurses surveyed had experienced some form of violence in their last ten shifts; 29% reported 1-4 incidences in ten shifts, 18.8% reported 5-14 incidents, and 8% reported more than 14 incidents in a mere 10 shifts, or more than once per work day. The most common type of violence was verbal aggression (54.3%), followed by emotional abuse (23.7%), physical assault (17.2%), and threats (16.3%). Patients were the primary source of all forms of violence, identified by more than 90% of nurses as a source of physical assault and threat, and to a lesser extent for verbal aggression and emotional abuse. Horizontal violence was also prevalent; physicians, co-workers and managers combined were a significant source of violence in the form of emotional abuse and verbal aggression, identified by nearly half and one-quarter of nurses, respectively, as a source of these violent acts.

Binary relationships between workplace violence and four work life and health measures are presented in Table 4. The number of violent incidences experienced in the last ten shifts, approximately equating a two-week period, is grouped into four groups: none, 1-4 times, 5-14, and 15 and more. The data shows that those encountering violence 15 or more times in two weeks were more likely to have missed work days than those experienced none (42% vs. 20%). They were also less likely to be satisfied with their job than those did not encounter violence (85% vs. 58%). The physical and mental health of the frequently attacked victims was also comprised, with a greater percentage of victims reporting poor physical health than those who did not report any workplace violence (43% vs. 25%), and a markedly higher percentage of these nurses reporting poor mental health than nurses who had not encountered any violence in their past ten shifts (61% vs. 37%). It appears the more violent incidents that were experienced, the more adversary outcome to nurses' work life and health.

The binary relationship between workplace violence and healthcare workers' stressed work life and health is further substantiated in multivariate analyses where variables that may confound the relationship were controlled. A parsimonious modelling approach is taken by keeping only variables that are statistically significant in the model, which include demographic and background variables as well as work environment variables. Table 5 shows that after controlling for all other effects, workplace violence remains a significant source of stress for nurses' work life and health. In the absenteeism model, the more workplace violence experienced, the greater the likelihood that nurses would take short-term illness leave. Control variables such as age, total worked hours and nurses' lifestyle were also significant factors in predicting absenteeism. The probability of missed work days also increases when nurses worked on a casual basis and had shift changes.

Regarding the job dissatisfaction model, workplace environment factors such as leadership, resource adequacy, and workload (as measured by frequency of taking breaks) are strong predictors of nurses' satisfaction with their job, as suggested in the literature. The current findings

demonstrate that workplace violence remains a significant predictor of nurses' job dissatisfaction, even after controlling for workplace environment factors. Victims of workplace violence were statistically more likely to display feelings of dissatisfaction and frustration with their work when compared to nurses that had not experienced violence over the past ten shifts.

The two health models also show workplace violence is a significant predictor of nurses' physical and mental health status. The experience of workplace violence significantly increases nurses' risk of poor physical health. Nurses' physical health can also be comprised when working in a stressful work environment, such as working involuntary overtime hours and experiencing job instability. The link between workplace violence and nurses' mental health is even stronger, with nurses who had been a victim of workplace violence showing a significantly higher chance of being in poor mental health and showing signs of depression, loss of energy and agitation. Stressful work environment, evidenced in involuntary overtime, shift change, and workload also increased the likelihood of nurses' reporting poor mental health.

In sum, after controlling for the effects of all other variables, workplace violence remains a significant source of stress for nurses' work life and health. The occurrence of workplace violence increases the likelihood of nurses' absenteeism, job dissatisfaction, and poor physical and mental health.

Discussion

Workplace violence in the health sector is a significant source of stress that negatively affects the well-being of nurses and the quality of their nursing care. The findings of this Canadian study are supported by others that have explored the impact of violence and its implications for organizational policy and practice. As one could expect, type and number of violent episodes experienced have a significant impact on job satisfaction. In one study, nurses who had not experienced any violence reported the highest job satisfaction, while those who had experienced both emotional abuse and at least one other form of violence had the lowest job satisfaction 17. Emotional abuse alone, which was reported as highly prevalent in the workplace, also had a large impact on job satisfaction.

A link has been established between the quality of care provided by nurses and the prevalence of abuse in hospitals. It's been demonstrated that nurses who report completing fewer tasks necessary to ensure quality nursing care were more likely to have experienced emotional abuse 9. Another study showed that abuse caused nurses to be distressed because they could not provide the appropriate care to meet patients' needs, which subsequently influenced their productivity and increased their potential to make errors 12. Similarly, Arnetz and Arnetz 4 found that violence experienced by health care staff is associated with lower patient ratings of the quality of care. Taken together, these findings clearly indicate that violence is more than just an occupational health issue, but has significant implications for the quality of care nurses are able to provide. It follows then that a great concern should follow reports that frequent abuse impacting nursing care does not result in adequate support from other healthcare professionals or from administration in addressing the issue 12, 29.

Workplace violence and the subsequent inability of the nurse to provide good quality of care are detrimental to both the nurse and the healthcare institution. Emotional reactions to violence include anger, shock, fear, depression, anxiety, stress, mistrust and resentfulness, sleep disruption, tearfulness, hyper alert state or over-caution, panic attacks and dread of returning to work 27, 36. The impact of violence for staff working within an environment with a higher incidence of violence may be cumulative because the threat of violence seems constant 24. While individual nurses may suffer psychological consequences such as post-traumatic stress disorders and loss of self-confidence 22, organizations may face increased absenteeism, sick leave, property damage, decreased performance and productivity, security costs, litigation, worker's compensation,

and increasing turnover rates^{27, 32}. Workplace violence also impacts victims' career path and occupational mobility, although the extent to which the potential for assault contributes to staff turnover is unknown²⁴.

Study results show that the majority of workplace violence is not reported^{17, 18, 25}. In a study by Farrell et al.¹², respondents reported that they had received the most help from talking with colleagues following aggressive incidents, rather than with their manager or trade union or their professional organization. This suggests that while nurses may benefit from discussing their experiences of aggression, they are reluctant to make these incidents official. The consequences of unreported violent incidents include obscuring the understanding of the scope of the problem within the individual institution or sector, which may result in inadequate policies and programs to address the issue, and result in further incidents of violence. Furthermore, there is the potential for chronic pain and decreased job performance and morale to cause increased vulnerability to repeated workplace violence. Organizational well-being is threatened as care provider outcomes include restricted work, transferring to another job, obtaining a leave of absence or leaving nursing altogether.

Undue nursing workload and time pressure contributes to aggressive behavior. In a large European study, unsatisfactory working time was related to a higher frequency of violence⁷. The authors argued that much hostility surrounds the planning of time schedules and that such hostility may translate into deterioration of interactions with patients and their relatives. Workplace violence should be a concern at the organizational level as it is institutional decision-makers who are positioned to implement the most effective changes and to support organizational solutions²². Whereas approaches to violence prevention have primarily been educational and focused on the individual nurse, the issue of violence goes beyond the nurse to factors relating to organizational change, organizational culture and the value placed on nursing work and associated human resource allocation⁹.

Research findings support several approaches to address the issue of workplace violence. Camerino et al.⁶ determined that psychosocial working conditions and violence have an independent negative impact upon nurses' commitment to their organization. Therefore, interventions should be both primary (aimed at reducing adverse psychosocial factors which precede violence) and secondary (aimed at intervening at the time of the violent episode).

Primary prevention includes security personnel, violence management teams, appropriate design of interviewing rooms (especially in high-risk areas such as mental health and emergency services) and identification of patients at high risk for aggressive behavior²⁷. Furthermore, a written program or policy for job safety and security should be clearly communicated to all personnel. Physical measures to reduce violence would include removal of items that can be used as weapons, restriction of number of patient entrances and 24-hour monitoring of these entrances, proper lighting, security cameras, metal detectors, alarm or panic buttons, employee "safe rooms" seclusion areas for aggressive patients, and coded card entrances for medical personnel⁷. High workload demands and intense time pressure contributes to patient perception of substandard care that may influence the onset of patient aggression, therefore work environments should be revised to avoid poor interactions⁶.

In terms of secondary interventions, education and training of caregivers has been a commonly reported approach to workplace violence prevention. Programs are typically aimed at recognizing the warning signs of violent behavior, diffusing conflicts through aggression management, reviewing organizational policies and procedures, and familiarizing staff with legal rights and responsibilities. Workplace violence also needs to be considered in the curriculum development of undergraduate programs of education and in the development of orientation programmes

supporting new graduates in their first year of practice. Given the importance of the issue, initiatives require collaboration between education and service providers. Education needs to include theory on aggression, risk assessment, de-escalation through communication skills, breakaway skills to maintain personal safety, and within specialty areas such as mental health, the development of calming and restraint techniques to safely contain violence ²⁷.

Alexander and Fraser ¹ support such a multimodal approach, suggesting that management strategies addressing occupational violence in the healthcare sector need to be comprehensive and multidisciplinary in scope. Likewise, Cooper and Swanson ⁷ comment that a strong commitment from the health-care administration towards preventing violence in the workplace is required to ensure allocation of sufficient resources for security, risk assessment and surveillance, worker and management training in violence prevention, and care for worker victims.

When violence does occur, analysis of the incident including the preceding interactions with patients and co-workers will promote a better understanding of the problem and help to identify solutions ⁹. Effective incident report processes is needed to increase awareness of how to avoid potentially violent situations and deal effectively with aggressive patients ³. Therefore, all nurses must be educated about the needs and priorities for formal reporting, and must be actively encouraged by other staff to do so. As Duncan et al. point out, underreporting of violent incidents may be related to an acceptance of a culture of violence in hospitals. Another post-incident strategy involves crisis intervention programs to reduce psychological consequences of patients' assaults on healthcare staff. Programs such as the Assaulted Staff Action Program (ASAP) demonstrated effectiveness with a decline in the assault rate at the hospital where it was implemented ^{21,22}.

Scientifically rigorous studies are needed to combat and reduce the problem of violence at work, Future research will need to include longitudinal studies in order to accurately identify the antecedents to workplace violence, as well as provide meaningful data on the long-term effects of workplace violence on individual workers and organizations, and evaluation the effectiveness of prevention strategies. Structural equation modeling would assist in the development of theories related to the organizational and systemic determinants of workplace violence ^{12,30}. In exploring situational antecedents of violence, the role of culture (national, professional and organizational) needs greater consideration. In addition, the cumulative effects of repeated violence on both individuals and organizations need addressing.

The effectiveness of individual preventive measures needs to be evaluated and better understood. Longitudinal data would also benefit researchers in assessing the extent to which training effects may dissipate over time; thereby identifying optimum periods for providing refresher training ². Future research needs also to investigate effects of training on the number, type and severity of aggressive incidents as well as the financial costs to organizations as a result of sick leave and the overtime hours required to replace injured staff ¹⁸. Further randomized study based on larger samples and allowing for the use of advanced statistical techniques necessary would contribute to more effective program evaluation ²¹.

Conclusion

There is growing evidence that workplace violence contributes to deterioration of health care workers' work life and health, impacts patient care delivery and hinders recruitment and retention of nurses. Appropriate workplace violence interventions are needed to address the growing crisis in healthcare organizations. Future research is necessary to better understand the issue of violence and how health care providers can minimize the number and severity of violent incidents as they interact with at-risk patients.

Table 1: Descriptive Statistics of Background Characteristics and Workplace Environment Variables (Based on Weighted Sample)

Characteristics	N	%
License Type		
RN	6477	72.3
RPN	1541	2.5
LPN	5602	25.3
Highest Nursing Education Level		
BSCN	2709	25.8
Diploma and Certificate	10625	74.3
Gender		
Female	12761	95.7
Marital Status		
Married	10250	76.5
Where Born		
Foreign Born	1115	11.9
Have Children Age <16		
Yes	5613	38.1
Employment Sector		
Hospital	4680	47.9
LTC	3068	17.3
Community	1671	13.1
Other	3339	21.7
Employment Status		
Part-time/Casual	5549	42.1
Full-time	7444	57.9
Employment Preference		
Increase from P-T to F-T	1370	9.3
Decrease from F-T to P-T	930	7.5
Stay Full-time	10588	83.2
Worked in Direct Care		
Yes	11738	89.0
Shift Change		
Overtime pay		
Overtime paid	6332	47.9
Overtime unpaid	3562	33.4
No overtime	2450	18.6
Overtime		
Voluntary	2562	21.8
Involuntary	7332	59.5
No overtime	2450	18.6
Engaged in # of Healthy Lifestyle Activities		
0	106	0.8
1	772	4.3
2	2862	20.1
3	4841	36.0
4	4969	38.8

Characteristics	N	%
Received Coffee/Meal Break Less than half time	3326	31.1
Job instability experienced Yes	2573	20.6
Any work injury compensation in the Past Year Yes	1328	9.2
Shift change in a two-week period	4315	44.9
None	2335	22.7
Once	3405	32.4
>=2 times		
	N	Mean
Age	13620	45.42
Entering Nursing for Altruistic Reasons (Max score: 5)	13347	4.21
Nursing Work Index –Resource Adequacy (Max score: 16)	12421	9.12
Nursing Work Index –Leadership (Max score: 48)	12522	29.14
Nursing Work Index –Autonomy (Max score: 22)	12554	15.73
Conditions of Work Effectiveness (CWEQ-II, Max score 30)	12986	17.93
Engage in # of Healthy Lifestyle Activities	13550	3.08

Note: NWI subscale scores are based on the sum scores of items on a 4 point Likert scale. The maximum score is 16 for Resource Adequacy, 48 for Leadership, and 22 for Autonomy. The CWEQ-II consists of 19 items that measure the 6 components of structural empowerment. The items on each of the 6 CWEQ-II subscales are summed and averaged to provide a score for each subscale ranging 1-5. These scores are then summed to create the total empowerment score (score range: 6-30).

Table 2: Descriptive Statistics of Four Work Life and Health Measures

	N	%
Absenteeism ^a		
Yes	3933	27.4
No	9091	72.6
Satisfied with Current Position		
No	8705	67.6
Yes	4256	32.4
Physical Health		
Better than average ^b	8618	68.2
Worse than average ^b	4226	31.8
Mental Health		
Better than average ^b	6939	53.5
Worse than average ^b	5905	46.5

Note: ^a Absenteeism: Missed work days due to short-term illness. ^b Average as the average of general female population

Table 3: Workplace Violence Incidences Encountered in the Past Ten Shifts by Type, Source, and Frequency

	RN	LPN	RPN	Total
By Type				
Physical Assault	12.9	29.2	22.2	17.2
Threat of Assault	14.0	21.2	33.2	16.3
Verbal Aggression	51.4	61.3	65.8	54.3
Emotional Abuse	22.8	25.3	30.6	23.7
Any of the above	54.8	65.6	68.8	57.8
By Source				
Physical Assault				
Patient	96.8	98.9	98.8	97.7
Family/Visitor	9.3	3.1	0.8	6.4
Physician/Coworker*	2.7	4.0	3.1	3.2
Threat of Assault				
Patient	90.4	96.4	99.4	92.8
Family/Visitor	23.2	5.1	4.4	16.4
Physician/Coworker*	3.9	5.9	1.8	4.4
Verbal Aggression				
Patient	77.1	91.7	95.5	81.8
Family/Visitor	40.4	24.3	19.8	35.2
Physician	21.1	6.1	7.7	16.4
Co-worker*	25.2	22.9	19.2	24.4
Emotional Abuse				
Patient	49.9	63.6	74.0	54.3
Family/Visitor	29.3	24.6	20.4	27.8
Physician/ Coworker*	23.9	5.8	10.3	18.7
	45.0	45.3	42.5	45.0
%Distribution				
Number of violence incidences				
0	47.1	36.8	32.5	44.2
1-4	29.1	28.7	28.9	29.0
5-14	17.0	23.4	24.9	18.8
15+	6.7	11.0	13.7	8.0
Total	100.0	100.0	100.0	100.0

*Coworker includes Manager

Table 4: Percent Distribution of Four Work Life and Health Measures by Workplace Violence, Based on Weighted Sample

Percent Responding to the Adversary Effect									
Workplace Violence Incidences Encountered in the Past Ten Shifts	Absenteeism %		Job Dissatisfaction %		Poorer Physical Health %		Poorer Mental Health %		
	Yes	No	Yes	No	Yes	No	Yes	No	
None	20.0	80.0	58.2	41.8	25.5	74.5	36.6	63.4	
1-4	29.7	70.3	70.0	30.0	32.7	67.3	48.5	51.5	
5-14	34.4	65.6	77.8	22.2	38.0	62.0	59.2	40.8	
15+	42.7	57.3	85.1	14.9	43.1	56.9	61.3	38.7	

Note: Poorer health is defined by the average score of SF12 scores below the general female population.

Table 5: Logistic Regression Modeling of Four Quality of Work Life and Health Variables

Predictor	Absenteeism (Missed Days vs. none)			Job Satisfaction (Dissatisfied vs. Satisfied)			Physical Health (Poor vs. Good)			Mental Health (Poor vs. Good)		
	Est.	SE	Odds ratio	Est.	SE	Odds ratio	Est.	SE	Odds ratio	Est.	SE	Odds ratio
Region (ref: West)												
North				0.497	(0.250)	1.64*	0.409	(0.370)	1.51	-0.546	(0.257)	0.58*
Ontario				0.283	(0.120)	1.33*	0.032	(0.099)	1.03	-0.011	(0.103)	0.99
Quebec				0.817	(0.206)	2.26***	-0.331	(0.152)	0.72*	0.180	(0.159)	1.20
Atlantic				0.124	(0.078)	1.13	0.145	(0.067)	1.16*	-0.217	(0.070)	0.80**
License Type (ref: LPN)												
RN	0.314	(0.089)	1.37***	0.221	(0.102)	1.25*	-0.132	(0.093)	0.88	0.183	(0.091)	1.20*
RPN	-0.145	(0.126)	0.87	0.537	(0.145)	1.71***	-0.350	(0.115)	0.70**	-0.162	(0.130)	0.85
Age	0.035	(0.005)	1.04***				0.045	(0.004)	1.05***	0.026	(0.004)	1.03***
Sex (ref: Male)				0.580	(0.210)	1.79**						
Internationally Born (ref: No)	-0.367	(0.156)	0.69*	0.351	(0.148)	1.42*						
Marital Status (ref: Married)												
Single												
Widowed/	-0.166	(0.141)	0.85									
Divorced/Separated	-0.422	(0.138)	0.66**									
Highest Education (ref: Diploma/certificate)							-0.295	(0.116)	0.74*			
Experience of violence	0.224	(0.103)	1.25*	0.083	(0.041)	1.09*	0.220	(0.035)	1.25***	0.234	(0.038)	1.26***
Dimension of Practice (ref: Non-direct care)							0.414	(0.145)	1.51**			

Employment Status (ref: Full-time)												
Part-time	0.233	(0.129)	1.26									
Casual	0.716	(0.216)	2.05***									
Prefer Status Change (ref: Stay)												
Prefer increasing	0.554	(0.153)	1.74***			0.065	(0.140)	1.07	0.079	(0.131)	1.08	
Prefer decreasing	-0.165	(0.188)	0.85			0.464	(0.153)	1.59**	0.485	(0.180)	1.62**	
Unpaid overtime (ref: No overtime)												
Overtime-Paid	-0.309	(0.123)	0.73*									
Overtime-Unpaid	-0.280	(0.136)	0.76*									
Involuntary overtime (ref: None)												
Overtime-voluntary												
Overtime- involuntary						0.028	(0.109)	1.03	-0.010	(0.116)	0.99	
						0.265	(0.131)	1.30*	0.292	(0.140)	1.34*	
Shift Changes (ref: Never)												
Once in 2 weeks	0.195	(0.099)	1.22*									
>=2 times in 2 weeks	n/a	n/a	n/a						0.086	(0.113)	1.09	
	n/a	n/a	n/a						0.262	(0.099)	1.30**	
Job Instability (ref: No)				0.289	(0.132)	1.34*	0.292	(0.101)	1.34**			
Infrequent Coffee/ Meal Break (ref: More than half the time)				0.381	(0.115)	1.46***			0.436	(0.098)	1.55***	
Nursing Work Index												
Autonomy				-0.091	(0.023)	0.91***						
Resource				-0.092	(0.020)	0.91***						
Leadership				-0.052	(0.013)	0.95***						
Total Empowerment				-0.184	(0.017)	0.83***						
Educational Support (ref: No)				-0.312	(0.125)	0.73*						
Healthy Lifestyle (ref: Unhealthy)							-0.230	(0.045)	0.79***	-0.280	(0.047)	0.76***
Career Choice-Altruist Reasons									-0.193	(0.050)	0.82***	
Total Worked Hours	-0.01	(0.006)	0.99*									
Workers' Compensation Claim (ref: No)	0.560	(0.156)	1.75***									
Physical Health	-0.051	(0.005)	0.95***									
Mental Health	-0.030	(0.005)	0.97***									

Note: Outcomes were modeled on dichotomous scales, on the probability of short-term leave, job dissatisfaction, poor physical and mental health. Physical and mental health as predictors are measured on a continuum scale, the higher the score, the better the health. Same with the 3 NWI indices: the higher the score, the better the work environment.

*P-value < 0.05 **P-value < 0.01 ***P-value < 0.001

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Establishing an organizational response to the problem of work related aggression and violence within the health service sector at national level: an opportunity for real partnership working

Keynote

Pat Harvey

Health Service Working Group on work related aggression and violence, Dublin, Ireland

The scale of the challenges associated with work related violence and aggression in the health service would surprise most people. This is not only because it is unexpected toward the personnel and services that care for others, but also because health services have tended to significantly underestimate both the magnitude and the impact of this problem, in terms of financial, service, and human costs.

The emerging recognition of the magnitude of the problem dictates an urgency in ensuring that the health services effectively deal with the challenges that our personnel face on a daily basis. Interestingly, while our national experiences seem very similar, and many countries have struggled with this issue, a fully satisfactory response has remained elusive. Within the Irish context there has been a concerted effort over the last few years to develop a strategic unified corporate response for the health sector which could balance the duties and obligations owed to all. A working group was established which was representative of employers and employees in addition to professional and regulatory stakeholders.

The Irish response is founded upon the consensus that strategies to manage the problem will more likely achieve greater success if undertaken in partnership mode. Such an approach is consistent with the International Labour Organisation (2005) recommendation that social partners actively engage in dialogue at national and organizational level which focuses on the protection of workplace health and safety as a means toward improving services. This collaborative approach also fits comfortably with the prevailing aspirations within the Irish health sector toward employee partnership and effective interagency working.

This arrangement is a very significant joint employer/employee partnership response, of high leverage value, in response to a longstanding and very significant problem. The partnership approach infers collective ownership of the challenge to find and sponsor solutions sustainable into the future. This response extends beyond the limits that sometimes characterise partnership to more fully embrace the principles of real joint ownership of the challenge of resolving the problem, transparency, 'joint management', and accountability, while not compromising the fact that ultimately the responsibility for providing a safe working environment rests with the employer.

Achieving significant improvement required reappraisal of some fundamental assumptions regarding how the problem is understood and managed. This informed view of the complexities of the problem brought clarity to the required response. The subsequent strategy which charts the path forward for the entire service in a unified way has thoroughly considered, draws heavily on evidence and international best practice, is innovative in approach and comprehensive in scope.

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From training to institutional programs to politics

Keynote

Susan Steinman

Workplace Dignity Institute, Wilropark, South Africa

When the speaker started out with the South African leg of the ILO/ICN/WHO/PSI Joint Programme's research on workplace violence in the health sector in 2001 there was a low level of awareness of workplace violence in general. While the problem of workplace violence in the health sector in South Africa is as distressing as for other countries, it is the staff shortages, migration and attrition, violence in communities, crime, stress and the strain of the HIV/AIDS pandemic and other communicable diseases on the health care workers which calls for drastic action and intervention. The challenge was to raise the levels of awareness and this could only be achieved through sustained advocacy, training programmes and commitment from the highest levels.

The training in the ILO/ICN/WHO/PSI Joint Programme's Framework Guidelines to Address Workplace Violence resulted in measurable impact and change in reducing levels of workplace violence in participating institutions in the Gauteng Health Department. These Guidelines were developed into a programme and became fondly known as the "VETO" programme, an acronym for the V of against Violence at work, the E of an Educational, the T of Training and the O of Operational toolkit – so coined by Vittorio Di Martino who developed the training programme.

The speaker reflects on the journey over a number of years – from training to institutional programmes – to politics, to how success was attained and sustained through advocacy and by tapping into opportunities to advance the cause for violence-free (relatively speaking) workplaces.

The key elements that made this journey possible were the following:

- **Timing:** the time was right for an intervention. The pain of hanging on was greater than the fear of letting go.
- The programme was introduced in a systemic way into the health sector – psychosocial problems and employee wellness in general is addressed as a result of the programme. The message reached a critical mass which created fertile grounds for taking the programme to all institutions under the Gauteng Department of Health (the example in question).
- The enabling environment and the rise of employee wellness as a vehicle of institutional reform were used and therefore the programme soon became part of workplace programmes in the integrated health and wellness programme.
- Public commitment to the programme by the participating organisations, for example the case of the Gauteng Department of Health. Such commitment benefited a long-term commitment to the programme.
- **Flexibility:** The programme was adapted to address local sensitivities and challenges in South Africa while thorough monitoring and evaluation the training programme resulted in the sustainability of the intervention.

- The long-term focus of the speaker resulted in (a) the generic proposal to Labour Portfolio Committee of the South African Parliament to consider a Code of Best Practice to Address Workplace Violence as well as a Victim Charter for Victims of Workplace Violence and (b) the adaptation of the ‘VETO’ for the public and service sectors.

While lobbying political resources to introduce the mentioned Code and Charter, the Workplace Dignity Institute remains a non-political non-profit endeavour, committed to dignity and respect and the driving force and inspiration which has made an impact on the South African workplace and is likely to influence workers in years to come.

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From workplace violence to wellness

Keynote

Mireille Kingma

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Abstract

Violence in all its forms has increased dramatically throughout the world in recent decades. It has become a public health concern of epidemic proportion with extensive ramifications both for those who provide and those who receive health care.

Violence is a generic term that incorporates all acts causing physical and/or psychological harm. Violence may be interpersonal or self-directed, physical and/or psychological. The definition of violence includes acts of commission and acts of omission, including deliberate exclusion.

Violence crosses all boundaries, including age, race, socio-economic status, education, religion, sexual orientation and workplace. Health personnel have a particular interest in eliminating violence. As care givers, they often have first line contact with the increasing numbers of the victims of violence. A fortunately small number of health workers have also been known to be the aggressors. Data, however, repeatedly demonstrates that health personnel are a major target or victim of workplace violence. Studies have found that the risk of health care workers experiencing violence is 16 times greater than the risk for other service workers, including prison guards, police officers, transport workers, retail or bank employees.

The pervasive impact of health sector workplace violence is alarming and may lead to the:

- Deterioration of the quality of care provided
- Deterioration of the work environment
- Abandonment of the profession by workers, thus reducing health services available to the general population
- Negative effect on recruitment to the health professions
- Perpetuation of unacceptable societal behaviours
- Increasing health costs
- Deterioration of staff health.

There needs to be a concerted effort to eliminate violence and its negative consequences. A multi-pronged zero tolerance campaign must be reinforced. The International Council of Nurses has developed strategies in the following domains: legislation, clinical management, organizational climate, physical environment, and staff competence. ICN has also worked with the International Labour Organization, the World Health Organization and Public Services International to fill the information gaps and promote the application of their joint Framework Guidelines on Addressing Workplace Violence in the Health Sector through workshops. These training programmes are supported by a jointly developed Training Manual, which presents and promotes evidence-based violence-reducing strategies.

With support from the Norwegian Agency for Development Cooperation (NORAD) the Norwegian Nurses Organization and the SADC Aids Network of Nurses and Midwives (SANNAM), ICN has been working with five African National Nurses Associations – Botswana, Lesotho, Mauritius, Swaziland, and Tanzania. This project is making a difference – raising awareness, providing tools,

developing policies and changing practices at the local, regional and national level to reduce workplace violence in the health sector. In some of these countries, there is a unique link with another ICN project – the Wellness Centres – which, among other activities, supports the victims and mitigates the negative consequences of violence.

Violence in society is an increasing challenge of already epidemic proportions. Health personnel are known to be at higher personal risk of abuse and violence in the workplace. Violence in the health sector is seriously destructive and has a negative impact not only on the professional and personal lives of health care workers but also on the quality and coverage of care provided. This presentation will demonstrate the effectiveness of strategies specifically developed for the health sector which can lead us from workplace violence to wellness.

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Guidelines on workplace violence in the health sector anno 2008

Keynote

Christiane Wiskow

International Labour Office (ILO), Geneva, Switzerland

Abstract

There are many ways to tackle workplace violence in the health sector and many initiatives worldwide, including those discussed at the Conference, draw a remarkable picture of the diversity of means and approaches used in recent years to prevent and eliminate violence at the health workplace, or mitigate its negative impact. Workplace violence is a structural problem rooted in societal, organizational and personal factors. The response should take into account all dimensions of the problem.

The International Labour Office (ILO), the International Council of Nurses (ICN), the World Health Organization (WHO) and Public Services International (PSI) launched in 2000 a joint programme in order to develop sound policies and practical approaches for addressing violence in the health sector. As one outcome, the Joint Programme has developed a set of guidelines as a basic reference tool for the development of workplace policies. They are intended to guide through the complexity of issues to be considered when developing anti-violence strategies for all work-settings in the health sector.

This paper takes the Joint Programme Framework Guidelines as a starting point to look into question what kind of instruments and approaches are needed to effectively address workplace violence in the health sector. The underlying approach of the Framework Guidelines will be explained, and insights given into their elements and components, strategies and recommendations. An overview on the status and use of relevant major instrument types, such as legislation, guidelines, codes will shed light on the possibilities and the limitations of guidelines in general. The paper takes a little “tour d’histoire” in considering the state of the art at the time when the Guidelines were developed (where do we come from) and looking into current developments in this field in terms of emerging trends and challenges, and on recent instruments (where do we stand). Finally, it looks into the question, what lessons can be learnt, also from other sectors, and which approaches are recommendable for effective strategies to create a safe work environment in the health sector.

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Impact of workplace violence on the recruitment of nurses

Keynote

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Preventing workplace violence in the health sector has been a priority for the World Health Organization and a shared goal with the International Labor Organization (ILO), International Council of Nurses (ICN) and Public Services International (PSI) since we began conducting research and developing guidelines together at the beginning of this decade.

The publication of joint Framework Guidelines for Addressing Workplace Violence in the Health Sector and the accompanying training manual demonstrate the growing recognition of workplace violence as a public health and workplace problem that has an impact not only on the health workforce but also the overall environment of care and quality of patient care.

The 2006 World Health Report on Human Resources for Health recognized the critical shortage of health personnel globally and called for the support and protection of health workforce, improving working conditions, compensation for and protection of the occupational health of health-care workers.

We know that workplace safety including workplace violence has an impact on health workers decision of choice of work, decision to continue work, and whether to migrate or quit the profession. Research in Africa, the European Union and the United States document unsafe working conditions as one of the major factors in employment decisions. As one psychiatric nurse stated in a focus group, “I think about quitting every time an act of abuse or violence occurs”.

WHO takes a multidisciplinary approach to the prevention of workplace violence with collaboration between the Departments of Human Resources for Health, Violence and Injury Prevention, and the Department of Public Health and Environment from where the occupational health programme on protecting health-care workers is based.

Despite many years of work on this issue and growing evidence of the efficacy of a public health approach to prevention and control, workplace violence continues to be a major problem. Violence at work is often considered to be a reflection of a more general and pervasive pattern of violence in the society at large and as a result is considered inevitable and uncontrollable.

The recognition of workplace violence as an important occupational hazard facing health workers should receive the same amount of attention and same approach to its prevention and control as other workplace hazards in the health sector including: biological hazards such as HIV/AIDS, hepatitis and Tuberculosis; chemical hazards such as disinfectants, sterilants and hazardous drugs, ergonomic hazards such as lifting patients; physical hazards like radiation and noise; and psychosocial hazards such as short staffing, shift work and stress.

We know now that violence in the workplace is preventable and that programmes organized to address this hazard have been demonstrated to be effective.

The discipline of occupational health and safety applies a hierarchical approach to the prevention and control of all hazards including workplace violence. These control measures include the elimination of the hazard, use of engineering controls such as call lights and bullet proof barriers, administrative controls such as adequate staffing and reducing waiting times to eliminate these contributing causes to violence in the health sector, work practice controls such as the methods and location for providing medication to psychiatric patients and personal protective equipment.

In 2007, the World Health Assembly endorsed the Global Plan of Action on Workers' Health - all workers including special attention to the occupational health of health-care workers. This 10 year Plan of Action from 2008 - 2017 calls on Ministries of Health to develop national programmes for the occupational health of their own workforce - the health care workers which will include the prevention and control of workplace violence as a major component.

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The management and non-management of workplace violence in the health care environment

Keynote

P.A.J. Waddington

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Introduction

The scourge of workplace violence has reached virtually epidemic proportions throughout the world, not least in healthcare. However, this paper will argue that the problem has not been adequately diagnosed. Detailed interviews with a self-selected sample of workers who believed that they had been victims of 'violence, threats and intimidation' revealed a situation far more complex than is often portrayed. The implications of these complexities will be considered and a possible way of dealing with the problem will be advanced.

Diagnosing the problem

It is fundamental to good clinical practice for thorough and accurate diagnosis of a condition to precede its treatment or management. Yet, this good practice has not been followed with respect to the problem of violence towards healthcare staff. This is for two reasons: first, there has been an over-reliance on questionnaire surveys that invite respondents to say whether they have suffered a violent episode during a defined period. However, it is usually left to respondents to decide what qualifies as 'violence' for these purposes. This approach risks systematic errors being incorporated into research findings if, for instance, one group of workers apply a higher threshold to what counts as 'violence' than does another group of workers. Secondly, there has been the widespread adoption of 'inclusive' definitions of violence by academics [see, for example, 1], international bodies (such as the European Union [2, 3], International Labor Organisation [4-7], World Health Organisation [8], UK National Audit Office [9, 10]) and trade unions/staff associations [11-19]. The problem here is that there is little consistency in just how inclusive the definition of violence actually is.

Our research [20] was designed to remedy the superficiality and inconsistency of so much previous research on workplace violence by asking people working in the most violence-prone occupations to describe in detail what actually happened to them. Following British Crime Survey data [21-23], we focused on occupations with the highest levels of reported violence at work: the police, healthcare (A&E and Community Mental Health), and social work. Our sample, consists of self-selected volunteers in each occupation who believed that they had suffered episodes of 'violence, threats or intimidation' (a pretty standard 'inclusive' definition). This yielded 54 police officers, 22 Accident and Emergency staff, 20 community mental health professionals, and 20 social workers (working predominantly in the Children and Families section). Each person was interviewed using 'cognitive interviewing' methods [24] about their most recent experience of 'violence, threats or intimidation', the aim being to collect information about 'normal' episodes of violence rather than the most extreme experiences, which can lead to sensationalism.

What did we find?

What emerged from our research was a picture very different from that normally associated with this issue. Most notably there were very few physical injuries amongst any of the occupations represented in our research and amongst healthcare professionals only four episodes of physical violence were reported, the most injurious of which was reported by a nurse whose experience

pre-dated her current post in A&E and referred to an assault by a elderly senile man who had repeatedly struck her with his walking stick. In the three other cases staff were hit, but no injuries were sustained. For the most part what staff experienced during episodes described as 'violent' were overt displays of anger and hostility: shouted threats, accusations, demands and obscenities; florid complexion and contorted facial features; occasional violence towards others and destruction of property. In short, it was very different from the portrayal of workplace violence in campaigning publicity materials and fictional depictions.

Yet, this is no 'moral panic'. All those interviewed (apart from the police) were disturbed by the episode and some were quite distressed at recalling it. One male nurse still felt very uneasy whilst at work two years after he was attacked by the companion of a patient who punched him in the shoulder and pulled him to the ground before being overpowered by security staff. Another interviewee (a Community Psychiatric Nurse [CPN]) began to hyper-ventilate when she recounted how a patient had threatened to make a formal complaint because she had declined to attend the police station after the patient had been arrested on a minor public order offence.

Understanding 'violence'

What frightened and disturbed our interviewees? First, was the display of anger and hostility, especially if it erupted for no apparent good reason. A tirade of abuse launched into the face of a social worker by a visitor to the home of her client 'came out of the blue'; it shook any sense of predictability and demonstrated her vulnerability whilst working with drug-abusers in the community. However, the behaviour of the other party to an encounter was less important than the context within which it took place. When and where the encounter occurred was obviously important to the context for it heightened or diminished the professional's sense of vulnerability. Visiting patients alone in their homes could obviously prove perilous: a formidable person (such as someone bigger and stronger than the professional, or who had a fearsome reputation) could exemplify the dangers that lurk in 'the community'. This might even occur when such a person meant no harm: one CPN found herself inadvertently 'trapped' in a basement kitchen by a large man who meant her no apparent harm but who related to her the paedophilic fantasies he harboured about a child who (unknown to him) was a family friend of the nurse. Vulnerability may also be felt by A&E staff working at night. This was illustrated by an incident in which two youths brought a girl companion into A&E whom medical staff believed may have been a victim of a 'drug-rape'. The youths demanded to see the girl and when that was refused they tried to batter down the door that separated the treatment area from the waiting room. The nursing sister in charge called the police urgently and locked all doors into the treatment area, acutely aware that everyone on duty that night was female. When people feel alone and isolated, others do not have to behave particularly badly to make them feel vulnerable.

What added to the sense of vulnerability was the appearance of the other party. A shaven-headed male psychiatric patient, adorned with tattoos professing allegiance to the neo-fascist movement, with a criminal history of violence and accompanied by a large aggressive dog, needed only to leap to his feet and denounce the quality of treatment he was receiving from his CPN (and with good reason) to instill sufficient fear to cause the latter to flee in panic. Likewise, a bejewelled black youth who had the appearance of a drug-trafficker, and who was in A&E as the result of a fight that had left his adversary fighting for his life elsewhere in A&E, needed only to demand attention to his head-wound, to put the diminutive female nurse in fear of her life.

It was also clear that members of different occupations applied different thresholds in judging whether an episode had been 'violent' or not. Police officers and social workers tended to be quite tolerant of expressions of anger and threats even though they suffered the more serious episodes of violence. A&E staff were the least tolerant, objecting strongly to obscenities that they often declined to repeat verbatim in interviews. Mental health professionals had a hybrid attitude: if

someone was genuinely ill (in their view), then they would tolerate even overt acts of aggression; but if they deemed the person to be 'bad' rather than 'mad', then their tolerance evaporated. What explains these differences? Police were quite explicit that 'We don't expect them to love us!' That is, they recognise that they wield authority over others that may be unwelcome and expect resistance, including obscenities and threats. 'You get used to it' — a sentiment echoed by many police officers. A&E staff by contrast implicitly held the view that they deserved to be treated better: patients needed the A&E staff's professionalism, often at unsociable hours of the day, and the least that the staff could legitimately demand was respect for their professionalism and compliance with the requirements of treatment. Hence, if good clinical practice was to X-ray a cranial wound before stitching it, then it was wholly unacceptable for a patient (who knew nothing of the dangers of a depressed cranial fracture) to demand that the wound be stitched without an X-ray. To do so, angrily and using obscenities compounded the offence. It amounted to a breach of the implicit 'moral contract' between patient and clinician.

Managing workplace violence in healthcare

Criticism of management was almost universal amongst our interviewees, even though they were not invited to raise the matter. There was general agreement that managers did not care about the fate of their workforce, failed to provide sufficient resources to counter difficulties, whilst providing themselves with lavish facilities (mobile phones were a particular bone of contention at a time when they were uncommon and expensive); were likely to take action against staff if a complaint was received from a member of the public but very unlikely to take action against a member of the public who had been violent or abusive to staff. The irony was that this was felt most acutely by those whose safety and security had received most investment — A&E staff! The A&E department was built like a fortress: the reception area was surrounded by a security screen, monitored by CCTV and waiting patients and their companions were required to speak into a microphone in order to be heard. Inside the treatment area private security personnel patrolled; numerous 'panic' alarms adorned the walls at strategic intervals; there was a dedicated phone line to the police control room and I was told that police responded promptly to any calls. Yet, the staff complained that it was not secure enough: the panes of the security screen could be knocked out if banged heavily enough; the security staff were warned to use force only in clear cases of self-defence; and those arrested by the police were not convicted, or if convicted given a light sentence. Akin to the way in which the public in many developed countries refuse to believe that crime has fallen in recent years to an unprecedented degree, A&E staff refused to believe that whatever management did was adequate.

Amongst the most common prescriptions offered by experts is to train staff better to cope with violent situations. Of course, this is hampered by the failure to diagnose adequately the detailed nature of those 'violent situations'. An example of how training can be so badly ill-fitted to reality comes not from the health sector, but from another of our violence-prone occupations — policing. During recent times, police officers in many jurisdictions have acquired vastly enhanced protection in the form of body armour and also increased weaponry. They also receive training in how to use this equipment, but that training is premised upon police officers needing to ward off attack. In reality, almost all violent encounters recalled by our interviewees involved suspects trying to escape and resisting arrest. This produced a massive disjunction between training and reality, for whilst training assumed that the attacker needed to be kept at a distance, reality found officers grappling with suspects who were struggling to free themselves. A further implication of this misdiagnosis of the problem, is that whereas training assumes that the officer has at least one hand free with which to grasp a baton or CS spray canister, in reality officers usually found themselves with their hands literally full as they grappled with the suspect. As a result, 'officer safety training' amounted to little more than a gesture. The health sector has no need of body armour and weaponry, but it should learn from the experience of the police that failure to diagnose the problem adequately produces training ill-suited to the problem it is intended to address.

Another version of ill-suited training is so-called conflict management manuals for which abound [13, 14, 25-33] and whilst many contain useful tips, they mostly over-estimate the extent to which violent encounters can be avoided. Certainly, it is always possible in retrospect to identify courses of action that would better have not been taken, such as the CPN who descended into the basement kitchen with no exterior door, but then she was not to know when she accepted the invitation that her host's paedophilic fantasies referred to a child she knew personally. Moreover, some of the standard prescriptions demand that health workers should pursue their personal safety in ways inconsistent with their professional mission: community health workers are supposed to befriend as well as help their patients and this usually entails entering the patient's home as a guest, and guests do not insist on sitting where they can easily escape! Indeed, it is even questionable whether the cautious, calculating and defensive posture that so many manuals of guidance recommend is compatible with an open and trusting relationship. Nor is it easy to see how even health workers can avoid provocation, even if they anticipate an aggressive response, for they may be duty-bound to take courses of action (such as not stitching over a potential fracture) of which the patient or their companions disapprove.

A common prescription is that professionals should acquire as much information about their patients as they can, so that they are better able to assess the risks that contact may entail. However, such knowledge can serve to increase rather than decrease the feeling of vulnerability and invest otherwise innocuous behaviour with added menace. A CPN was warned by a colleague in occupational health that a male patient they shared had confessed to harbouring homicidal fantasies about the CPN. As a result the CPN took elaborate precautions for her next scheduled meeting with the patient, but the emotional toll in anticipating the risk of the patient trying to enact his fantasies was extreme. Likewise, knowing that a patient had a history of making complaints about healthcare staff, served only to increase the pressure felt by a CPN in all transactions with the patient.

Perhaps because of these gaps between prescription and reality, training in handling difficult situations lacks credibility. The National Audit Office report concluded that 'Training programmes were largely "off the shelf" and the syllabi were based more on the experience and preference of the trainers than a rational analysis of training needs' [10].

An alternative adopted by many healthcare authorities is the adoption of 'zero tolerance' policies: notices adorn public areas announcing that anyone assaulting staff will be prosecuted. However, as the National Audit Office observes:

"while most NHS trusts have promulgated the policy of zero tolerance . . . translating theory into practice has proved difficult for some. In particular, while there is no central data on prosecutions, staff surveys show that prosecutions are rare. Although all trusts were required to assess the need for a policy on withholding treatment by April 2002 . . . In practice, most trusts have found it difficult to implement. [9: 5]

Implementation failure need not reflect lack of managerial will: first, in order to prosecute anyone an identifiable criminal offence must have been committed, but in many instances of which staff complained in our research there was no offence that could be readily identified. Secondly, there needs to be evidence in support of guilt that exceeds the criminal standard of proof, that is, 'beyond reasonable doubt'. Even if the evidence could be assembled, the cost of doing so is likely to be disproportionate to the seriousness of the offence. Convincing the police and public prosecution authorities of the need to proceed with prosecutions in such instances is likely to prove difficult. Some trade unions and staff associations have taken action on behalf of their members when management has, in the view of the union, failed to do so, but the light sentences handed down by the courts are likely to create even greater annoyance to staff. Finally, many of those who are accused of 'violence' towards healthcare staff may legitimately claim that they

were temporarily or permanently in a distressed condition. Someone who is receiving treatment for trauma, or suffering a psychiatric episode or illness can hardly be expected to behave with decorum. The police, A&E staff, community mental health workers, and social workers all deal with people in and with difficulties from whom some departure from normal standards of good conduct might be expected. Finally, if prosecution offers little hope of deterrence and retribution, the prospect of denying treatment seems unlikely to be any more effective as a substitute. One of our interviewees, a doctor in A&E, tried to deny treatment to a patient who punched him on the arm. However, no other doctor was willing to treat someone who had assaulted a colleague with the result that the patient remained in a cubicle awaiting treatment that doctors refused to administer. As the log-jam grew, so the pressure on the doctor to treat the abusive patient himself increased until he eventually relented. Ultimately, zero tolerance fails because those who provide services to people with difficulties must accept that if they do not do so, then who will?

There are also occasions when even otherwise sober members of the community might lose patience with an under-performing public service. It is difficult not to have some sympathy with patients and their companions who are asked to wait for an interminable period in a crowded and possibly rowdy waiting room. In one episode a patient's relative had driven some distance to collect the patient from the A&E after treatment. Upon inquiring about the whereabouts of the patient at the reception desk, the relative was told that they had been 'discharged' and so the relative returned home, only to discover a message from the patient awaiting them on the telephone answering machine asking when the relative was going to arrive at the hospital. Once again, the relative drove to the hospital and approached the reception desk where the initial error was now recognised by the reception staff. They apologised and tried explaining that the computer system only recorded whether or not a patient had been clinically 'discharged', not whether they remained on or had left the premises. The now infuriated relative took this admission as an opportunity to step away from the reception screen and announce to the full waiting room that the hospital staff were wholly incompetent. As humiliating as this was for the receptionist (who had not made the initial mistake), it would be difficult not to sympathise with a patient's relative who had needlessly been inconvenienced. It would hardly be consistent with commitments to high quality public service to penalise such a person because they humiliated an innocent member of staff.

One might take the view that even understandable irritation should not be expressed in ways that are unacceptable. Even if someone is kept waiting for treatment for many hours, that does not justify becoming intimidatingly angry and obscene. However, the problem with outlawing unacceptable means of expressing dissatisfaction is that it privileges the articulate middle class and effectively excludes those without the cultural capital to make their complaints heard through acceptable channels. It also fails to recognise how threatening and intimidating the prospect of receiving a complaint can be. References to threats of malicious complaints either made or anticipated was a repeated refrain in our interviews and seemed to affect staff most profoundly. As one interviewee reminded us, a punch might inflict a bruise lasting a few days, but a complaint could ruin a career. A middle class parent suspected of suffering Munchausen's Syndrome by Proxy, struck fear into a psychiatric social worker because she also 'knew her way around the system' and would create career-threatening dangers.

Clearly, some people use complaints schemes maliciously, but others equally clearly use them to draw attention to poor quality service. Management is under a duty to consider all complaints properly and that conflicts directly with its obligation to support staff. Those staff against whom complaints had been made, felt that the organisation had turned upon them just because they had done their job. Even when complaints were eventually dismissed, staff found the process of investigation deeply painful and troubling. They found that even the most innocent of actions were greeted with scepticism from managers and minor peccadilloes were seized upon as grounds for punishment even when they had no bearing upon the complaint itself.

This became a very tangled web in respect of one often cited cause for complaint - racism. On the one hand, interviewees said that violent or abusive person(s) had either alleged that the interviewee or others were being racist, or that they feared that such an allegation would be made. For example, the two youths who accompanied a girl who the clinical staff suspect had been drug-raped alleged that they were being refused the opportunity to speak to the girl because of their race (they were both black). On some occasions, interviewees were at pains in the interview to establish their non-racist bona fides. On the other hand, there was a vein of racism in some accounts, for instance the interviewee freely admitted that the bejewelled youth who angrily demanded that his head would be stitched was all the more credible as threat because of his race. Had he complained of racism, then he would have had good reason to do so.

Conclusion

In this paper, I have tried to grapple with the reality as revealed to us by detailed cognitive interviews with self-selected staff who felt that they had been exposed to 'violence, intimidation and threats'. On the one hand, 'violence' is not as it is normally depicted: an unwarranted serious physical assault upon a member of staff. Instead, it consists of a wide variety of behaviour that owes as much to the context in which it takes place as it does to the hostile intentions of the other party. On the other hand, simple prescriptions for dealing with the problem, such as 'zero tolerance' do not stand up to close scrutiny because they fail to recognise the subtleties of many 'violent' episodes.

Can anything be done? There was the faint suggestion of a way out of the conundrums that surround this area. Those few staff who praised the response of their (usually immediate) managers did so because of the latter's speedy social and psychological support that they provided. Where staff gathered around the 'victim' and literally offered 'tea and sympathy', the member of staff expressed satisfaction and gratitude. As is the case with a great deal of overt violence, the injury is more symbolic than physical [34]. A CPN who had been accused by her patient of 'unprofessional conduct' described this deeply traumatic experience as 'like being violated'. She was not physically harmed at all, but her professional self-image had been near-fatally undermined. What is needed in such circumstances appears to be the support of colleagues and managers who restore the damaged self-image and repair the moral universe by treating their colleague as 'a victim'. Of course, this is less easy to do when the 'injury' is inflicted by means of a complaint that needs investigation, but even here it should not be beyond the wit of management to adopt a dual-track of support from line-management with parallel independent investigation. Certainly, so long as management opts to pursue 'quick fix' solutions, such as 'zero tolerance' they are likely to continue to fail to address adequately this problem. It is unlikely that this problem will ever be eliminated, but that is no reason why it need not be managed more effectively.

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Violence at work – a general overview

Keynote

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Violence at work, ranging from bullying and mobbing, to threats, physical attacks and sexual harassment, is increasing worldwide. It affects all countries, sectors and occupations. It is global and pandemic.

There is growing awareness that in confronting violence a comprehensive approach is required. Instead of searching for a single solution good for any problem and situation, the full range of causes which generate violence should be analysed and a variety of intervention strategies adopted. There is also growing awareness that violence at work is not merely an episodic, individual problem but a structural, strategic problem rooted in wider social, economic, organizational and cultural factors. And it is increasingly recognised that violence at work is detrimental to the functionality of the workplace, and any action taken against such problem is an integral part of the organizational development of a sound enterprise.

The global cost of workplace violence is also recognised. The price of violence at work is enormous and costing millions of dollars. Here the emphasis is not only on traditional enterprise direct and indirect costs such as accidents, illness, disability, absenteeism, turnover, reduced morale, reduced commitment, but also on the new intangible assets of the modern enterprise, such as knowledge, learning, creativity and quality, whose development is totally incompatible with the presence of violence at work. The introduction of an economic dimension in organising the response to violence is proving a powerful weapon in effectively addressing this problem.

One of the sectors more affected by both physical and psychological violence is the health – sector. Violence is so common among workers in contact with people in distress that it is often considered an inevitable part of the job. Frustration and anger arising out of illness and pain, old-age problems, psychiatric disorders, alcohol and substance abuse can affect behaviour and make people verbally or physically violent. Increasing poverty and marginalization in the community in which the aggressor lives; inadequacies in the environment where care activities are performed, or in the way these are organized; insufficient training and interpersonal skills of staff providing services to this population; and a general climate of stress and insecurity at the workplace, can all contribute substantially to an increase in the level of violence.

Health care workers are at the forefront of this situation worldwide. Cross-national research shows that all workers in this profession are extensively exposed to the risks of both physical and psychological violence.

As no category of health workers appears immune, so no workplace in the health sector is safe from workplace violence. General hospitals, emergency care units, psychiatric wards, old age care units are all, although in different ways and to a different extent, exposed to the risks of workplace violence.

Growing awareness of the need to tackle workplace violence has spawned the development of new and effective prevention strategies. “Best practice” from local and national governments, enterprises and trade unions from around the world are increasingly applied and successfully implemented.

At the international level the ILO has adopted in 2004 the Code of Practice, Workplace violence in services sectors and measures to combat this phenomenon. More specifically, in 2005, the ILO, the International Council of Nurses, the World Health Organization and Public Services International have developed Framework Guidelines to combat workplace violence in the health sector and a Training manual based on these Guidelines.

The Guidelines and the Manual promote a forward looking approach and action that are Preventive, Participative, Culture sensitive, Gender sensitive, Non discriminatory and Systematic. Making the lessons and messages of the Guidelines and the Manual a reality is the great challenge at stake.

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Violence towards nurses

Keynote

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Safe workplaces are safe healing places. Like you, nurses in the United States, want to work in places where health, safety, and personal well being are ensured for all. Just as we are advocates for safe and quality health care for our clients, we must be champions for creating a safe work environment for ourselves. Like you, I am very glad to be here as we collectively address violence in the health sector.

As an emergency room and intensive care staff nurse, licensed in 7 states, working in rural and urban areas over a period of thirty years, in the 1990's, I began to see the violence on our streets enter our hospitals, and wanted to know what could be done. I wanted incidents where healthcare workers were injured, even killed, to be examined thoroughly to see what needed to be done to prevent it from happening again. Most of all, I wanted nurses to be a part of enhancing the safety of their workplaces, reducing the incidence and impact of violence.

Much of my work has included the prevention of workplace violence. And I have done this work with the Illinois Nurses Association, the Kansas State Nurses Association, the Colorado Nurses Association, the American Nurses Association, and the Center for American Nurses. I have attended ICN conferences as a presenter in British Columbia and in Copenhagen.

Here are some of the newspaper headlines and stories that bring me here: Karla Roth, Emergency Room nurse shot in the back as she ran from a hostage taker in Sandy, Utah in 1991. In 1995, Debbie Burke was killed in a San Diego Emergency Room by a distraught man after his father died during surgery at that hospital. In 1996, a wheelchair bound patient shot and killed his home health nurse, Edna Hooks in Loveland, Colorado, and then turned the gun on himself. When Laura Gattas stepped of the elevator of a Colorado Springs Hospital in 1996 her ex husband was waiting. As she turned to run he shot her at the base of her skull. In July, 1999 an RN killed a nurse manager and critically injured the assistant superintendent of nursing. The gunman, Dennis had been fired from the hospital after working there for more than a decade. And just recently in Georgia, a man who held a grudge against a nurse who cared for his mother three years earlier, stormed the hospital, killing an administrative assistant, a man getting out of his car, and a nurse – it turned out that he was not the nurse who had cared for the killer's mother.

We all know a story of workplace violence, and most of them do not end in homicide. The US Bureau of Labor Statistics measures the number of assaults resulting in injury at work per 10,000 full time workers. In 2000, healthcare workers overall had an incident rate of 9.3. The overall private sector injury rate was 2. The rate for social workers was 15, and for nursing and personal care facility workers 25 (OSHA, 2004). In 2007, sixty percent of the assaults and violent acts (by person) occurred in healthcare and social assistance and mainly involved assaults by healthcare patients (U S Department of Labor, 2007).

That healthcare workers suffer a high number of non-fatal assaults should not be a surprise. Many clients treated in hospitals, long term care facilities, and in home health situations have a high risk for violence. Problems associated with violence include hypoglycemia, electrolyte imbalances, anemia, alcohol intoxication, pain, the use of cocaine, PCP, LSD, and other drugs, and dementia.

The wave of de-institutionalized mental health patients has increased the number of disturbed and potentially violent patients appearing in community emergency departments. Both the victims and perpetrators of gang violence are treated in hospitals and long term care facilities. Victims of domestic violence are treated in healthcare facilities. Sometimes domestic violence follows the employee to work. There is easy access to potential weapons, such as scissors and scalpels. And healthcare workplaces are not immune to the effects of poor management practices and the actions of disgruntled employees. The frustration levels of patients and families seem to increase as staffing levels decline. Security departments too, are often understaffed and lack adequate training and resources. It is a complex and global issue.

In graduate school, at the University of Kansas, I developed the Violence Potential Assessment Tool, copyrighted in 1995. This tool was used as the framework for the ANA grant project: Violence Assessment in Hospitals in Kansas in 1995. As part of the assessment of 2 urban and 2 rural hospitals, 500 nurses responded to a survey. More than 90 % defined the term “workplace violence” to include physical violence such as kicking, pushing, slapping as well as physical violence with a weapon. More than 80 % included sexual assault and verbal abuse. Sexual harassment was included in the definition by 78 % (Carroll and Sheverbush, 1996).

In 1997, almost 600 nurses in seven states responded to a Colorado Nurses Association survey adapted from the Kansas project. As in the first survey, more than 30 % of nurses reported having been the victims of workplace violence in the previous year. In addition, when given the chance to add other types of workplace violence, nurses most frequently referred to “intimidation”.(Carroll and Morin, 1998).

In an American Nurses Association Health and Safety Survey in 2001, almost 5000 nurses responded on line. Sixty one percent (61%) spent more than half their time engaged in direct patient care, and twenty five percent (25%) named an on- the- job assault as a great concern. Seventeen percent had been physically assaulted in the previous year, and more than half (57%) had been threatened or verbally abused in the previous year at work (ANA, 2001).

So what can we do? The costs of violence are high in terms of well being and job satisfaction to the individual, and to the organization in terms of efficiency, staff turnover, morale, workman’s compensation, and liability. And of course, a safe workplace is safer for clients and their families as well.

Prevention is the key. What can organizations do to reduce the potential for violence? What do students, employees, nurses, and physicians need to know in order to participate in their own survival?

1. Select a safety team that meets regularly. The responsibilities include the oversight of threat assessment, training and prevention, and trauma response. Members of this team should include human resources, security, risk management, and the PR representative. Personnel working in high risk areas, and consultants in workplace violence should also be considered.
2. Establish goals. “We are a safe place, and are committed to making it safer.” is one example.
3. Conduct a violence assessment. This is what we did in the Kansas project.
4. Design and implement policies and procedures, for instance, “What to do if there’s a hostage situation?”
5. Train everyone. In one state in the US, all Emergency Department nurses are required to attend classes in the management of aggressive behavior. Emergency Department physicians are not required to attend and some do not. When the decision for an appropriate response is made by a physician without the training, the situation can become more hazardous. And what about students, should they wait until their psychiatric rotation to learn techniques of managing aggressive behavior?

6. Conduct an annual review. It sounds like the nursing process: Assess, plan, implement, and evaluate.

In the Kansas State Nurses Association project, the Violence Potential Assessment Tool was used. It is a comprehensive checklist type tool designed to allow a safety team to do their own assessment, and then focus on areas that show up for them as priorities. A survey was done of all nurses, and a description of the project was published in the hospital newspaper. The rationale behind the assessment was to provide them with an opportunity for self-diagnosis, and the motivation for a customized approach to workplace violence.

The safety team was asked to collect retrospective data about violent incidents and prospective data using the easiest reporting system for the specific units to provide a comprehensive picture of assaults. Reviews were done of hospital policies (e.g. Patient restraint, hostage, crisis management, sexual harassment), state and local laws, staff training, security presence and training, crisis management plans, and counseling available to victims of assault. They were asked to list continuing educational programs provided for staff members during the previous year. Other issues were assessed, such as: Are employees required to wear ID badges? Is the lighting in the parking lots adequate? Is crime increasing in the geographic area?

The assessment was more than one question deep. For example, Does the facility have closed circuit television? If so, are they operational? Who monitors them? What do they do if they see a violent incident occurring? Are the televisions recorded, and if so, how long are the tapes saved? (Carroll, 1997).

Fifty percent of nurses in the 1997 Seven State Survey indicated the need for all facilities to place more emphasis on reporting violent incidents. There are lessons to be learned. Every incident should be evaluated and decisions made to prevent future incidents. More than 70% of the nurses called for training on the prevention and management of assaultive behavior to reduce the incidence of violence in their workplace. This training that covers techniques to recognize escalating agitation, and high risk behavior and discusses appropriate responses. It is often provided to psychiatric nurses in their workplaces. Over and over, nurses in other areas have indicated that they need this training in the long term care setting, in the community health environment, on medical units, and most other areas.

Nurses know what makes them nervous about their workplace. They want policies in place and they want to know what they include. Employees hope that safe hiring practices are in place. One consultant on workplace violence suggests that the best deterrent to non-stranger violence is not to hire violence prone individuals in the first place. Employers can arm themselves by asking the right questions, knowing the profile to look for, conducting drug screening and thorough background checks (Mantell and Albrecht, 1994). If an assault does occur, nurses and other health care workers want to be able to call for help, and have a team of trained individuals respond immediately.

The environment can be made safer in many ways including the use of adequate lighting, lockable bathrooms, safe seclusion rooms, access control, panic buttons, and Closed Circuit TV's. Employees should never work alone, and if they do, they should be provided with 2 way communication at all times. Security devices such as metal detectors and cameras can be installed. Security escorts to the parking lots at night is recommended. Waiting rooms designed to accommodate visitors and patients help those who may have a delay in service. Triage areas and other public areas should be designed to minimize the risk of assault. Deep service counters or bullet – resistant glass enclosures can be installed. Furniture and other objects, such as IV poles, should be arranged or stored to minimize their use as weapons (DHHS (NIOSH) Publication, 2002).

Nurses are being assaulted and the feelings of anger, depression, and fear have nurses deciding to leave the profession. Marilyn Lanza has long studied nurses who have been assaulted. Her research finds that some nurses feel assault is part of the job, and attribute blame to themselves. Coworkers and administrators also place blame on the victim. Adequate support services, one on one counseling, as well as meeting with coworkers and a counselor can enable the victim and peers to talk about the incident, learn from it, and give each other support (Buser, 1998).

Another issue impacting nurses' job satisfaction, commitment to the organization, and decisions to quit is disruptive physician behavior. Dr. Rosenstein reported on the original research in 2002, and defined "disruptive physician behavior" as any inappropriate behavior, confrontation or conflict, ranging from verbal abuse to physical and sexual harassment. When 1,121 nurses responded to the question "Do you know of any nurses leaving the profession as a result of physician disruptive behavior?" Thirty percent (30%) said they did. Here's where programs on conflict management, teamwork, and collaboration can help. Policies need to be applied quickly, consistently, and fairly. We need to highlight the connections between teamwork and improved quality, safety, and patient outcomes (Rosenstein, 2002).

There are shared responsibilities in making the workplace safer. Employers should maintain a safe working environment, assess the workplace for violence potential, provide in-service programs on security hazards, and provide training in the management of assaultive behaviors. Employers have the responsibility to encourage employees to report incidents and suggest ways to reduce risks, to develop and implement a violence reduction plan, and to provide counseling for assaulted employees. Employees have the responsibilities to report hazards, incidents, and suspicious individuals, to participate in the violence assessment, to attend in-service programs, and to use communication skills. Nurses and other employees should work to develop policies, participate in the planning, implementation, and evaluation of a violence reduction plan, and utilize counseling if assaulted (Carroll, 1997).

Like you, nurses in the States want more involvement on the part of every employee in making work safer. They want to know that administration cares about the safety of all. They want a good relationship with a well supported security department. Like you they want more emphasis on violent incident reporting, and they want improved staffing. They don't want to fear their co-workers. They want these problems to be handled before they escalate out of control by a panel of thoughtful people who embrace reason over rigid strict punishment. The key to workplace conflict is fair and quick intervention. Healthcare workers can pool their strengths, working together to reduce the incidence and impact of violence in the workplace. The sign in the lobby should read "This is a No Violence Zone: A Work in Progress."

The World Health Organization, the International Labour Office, the International Council of Nurses, and Public Services International collaborated in 2000 to study the global implications of and approaches to healthcare workplace violence. In 2002, they released Framework Guidelines for Addressing Workplace Violence in the Health Sector (WHO/ILO/ICN/PSI, 2002).

In 2003, the US Occupational Safety and Health Administration published the Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers. This document lists the four main components to any effective safety and health program, as well as preventing workplace violence: 1) management commitment and employee involvement, 2) worksite analysis, 3) hazard prevention and control, and 4) safety and health training (OSHA, 2003).

Much work has been done by many to address violence in the health sector in many areas, including the US, Canada, the UK, Turkey, Switzerland, Ireland, Norway, Australia, India, New Zealand, Sweden, Germany, Wales, South Africa, Taiwan, Denmark, Singapore, Botswana,

Finland, Austria, Pakistan, the Netherlands, Japan, Slovenia, and Hong Kong, Thank you to the organizers of this International Conference for hosting this opportunity to share our work, and support each other in our efforts to create safer work environments , and provide for excellence in care for all.

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Chapter 2 - Economical aspects and implications of workplace violence

Creating a Safe Environment with “High Observation” in clinical practice

Paper

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Abstract

Observation is an important skill for all nurses, but in the acute phase of mental illness, some patients become a risk to themselves or others. The aim is then to prevent potentially suicidal, violent or vulnerable patients from harming themselves or others. The nurse’s therapeutic skills may be tested by patients challenging behaviours, and skills in observation and therapeutic engagement contribute directly to the maintenance of a safe environment, and the ongoing process of risk assessment.

The relationship between the nurse and the patient is central to the art of nursing, and the use of strategies such as seclusion and special nurse observation, risks undermining this relationship. Seclusion or Specialing are often viewed as the only effective strategies available to minimize risk of harm to nurses, colleagues, or other patients. Seclusion has been reported as clinically indicated for containment and isolation, but also has been identified as a potentially traumatic and distressing experience for patients. (Tilley & Chambers 2005, Marangos-Frost & Wells 2000, Meehan et al, 2000). Feelings of threat and punishment are common patient responses to seclusion (Terpstra et al.,2001). These responses also include hostility, anger, anxiety, fear, panic, claustrophobia, terror and resentment.

Special observation by mental health professionals is often the recommended approach for patients deemed to be as at risk, however, patients have perceived this practice as intrusive and controlling (Cleary et al, 1999). Special nurse observation is seen to be more custodial than therapeutic, can be very stressful for both the patient and the nurse, is very restrictive, and impinges on the dignity of the patient.

Research has challenged the benefits of specialing patients who are defined as ‘at risk’, and a more humane engagement process is recommended (Stevenson C. & Cutcliffe J. 2006). At the Department of Psychiatry, special nurse observation was a cause for concern that had serious financial implications, with a significant demand on limited nursing resources.

There is growing support for the use of interventions that have demonstrated clinical efficacy and are of proven benefit to patients. (Oestrich et al, 2007) The introduction of ‘high observation’ at the Department of Psychiatry (Midland Regional Hospital Portlaoise) challenged the practice of seclusion and specialing, which resulted in significantly reducing the episodes of these practices. Within the Department of Psychiatry ‘High Observation’ is identified as a clinical area that provides a safe, secure, and therapeutic environment, where multidisciplinary care is given and intense nursing and medical care is provided for the acutely ill patient who requires higher levels of monitoring and supervision.

High observation is a method of observation and engagement, which provides a collaborative and coordinated approach that meets the needs of patients who require high levels of support, and monitoring. Nurses at the Department of Psychiatry enable patients with their families to participate actively in their own recovery. Encouraging communication, listening and conveying to the patient that they are valued and cared for in a safe environment, is one of the core principles of high observation.

This study will illustrate the enormous potential the practice that High Observation has, as an alternative to seclusion and to special nurse observation. The study will demonstrate High Observation to be a therapeutic intervention in a safe and normalized environment within an acute psychiatric admission unit and a much more effective utilization of scarce and expensive resources.

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Threats to Health Care: Economical Impact of Workplace Violence in the Health Care Sector

Poster

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Keywords:

Economical burden, workplace violence, threats in health organizations

Abstract

Background

Workplace violence in health care setting imposes as significant economic toll as any other violence. Researches in Australia estimated costs of \$ 5582 per victim and \$ 837 million annually which are damaging Australian economy. Furthermore, 600 non-fatal workplace violence claims were made in United States of America and each claim gave \$ 3694 compensation. The International Labor Organization has found cost of violence with a range from \$ 4.9 billion to \$ 43.4 billion in USA only. Many studies are not able to give exact magnitude of violence in the health settings and hampered by data difficulties and non-validated research tool.

Purpose

1. To discuss the concepts of workplace violence in health care sector.
2. To explore the economical burden in health settings associated with workplace violence.
3. To determine some strategies of preventive programme to reducing violence's incidence in health care settings.

Method

Systematic review of literature from 20 research articles published from 1998 to 2008, collected through electronic medium by using Google, pubmed, black-well synergy, yahoo and BMJ search engines. The keywords inserted to search these articles were 'economical burden', 'workplace violence' and 'threats in health organization'.

Results

According to International Labor Organization, losses from stress and violence at work estimates from 1% to 3.5% of gross domestic product (GDP) of several countries. Mainly, two types of economical costs are confronted by health care industries due to workplace violence i.e. direct and indirect. Direct costs are mainly directly resulting from the act of violence (e.g. costs of legal services, medical, security costs, judicial costs). Whereas, indirect costs include long-term effects of the violence (e.g. psychological disturbance, work loss, decrease work productivity, bad publicity, insurance costs, new hiring).

By increasing economical costs in health industries, there is a need of training programme for employees regarding violence's prevention. In the training programme, all employees should understand their rights, and responsibilities through organization's policies. They should know about rate and risk factors of violence in their organization. Emergency preparedness during violence should learn in the training programme. Lastly, role of management should emphasize on policy making regarding reporting system of workplace violence in health organization.

Limitations

The limited research articles related to workplace violence were available in developing country especially in Pakistan. Those available researches of developing countries were not relevant to our phenomenon of interest.

Recommendations

Internationally, there is a need of those researches that can estimate economical consequences of violence and types of economical costs. Therefore, this paper recommends that standardized methodology should be made to categorize types of economical losses of workplace violence. Secondly, there should be need of a strong reporting system which can support victims and evaluate the incident with more accuracy.

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Workplace Violence and Intentions to Quit: Results from a survey of London nurses

Paper

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Abstract

Study Objective

Work-place violence, harassment and abuse is an increasing feature of nurses' experience of work in many countries. There is some evidence that the experience of workplace violence affects levels of job satisfaction (Hesketh et al 2003) and career decisions (e.g. Mayer et al 1999, Fernandes et al 1999). This paper reports on verbal and physical abuse by patients, relatives and carers, as well as racial and sexual harassment in Acute Hospitals in London and investigates whether workplace violence affects nurses' intentions to leave either their current job or the nursing profession, controlling for a number of other factors that are known to affect career decisions, such as workload, pay and own health.

Method

A questionnaire designed by two of the authors (Reeves and West) to assess many different aspects of nurses work life was used in a postal survey of nurses grades A to I practising in twenty London acute trusts in 2002. A total of 6,160 clinical nurses were mailed the questionnaires and 2,880 returned completed questionnaires, resulting in an overall response rate of 47%, discounting undelivered questionnaires. Respondents worked in a wide variety of clinical settings but mainly in acute medical and surgical wards. In addition to descriptive statistics, results were analysed using logistic regression with robust standard errors: the appropriate test when the dependent variable is dichotomous and the individual respondents clustered within units (nurses working within hospitals are not statistically independent).

Results

Our results show high levels of racial (%), sexual (%) and other, unspecified forms of harassment (%), as well as verbal and physical abuse (14% had been physically assaulted with 5% being assaulted more than once), over the previous 6 months. A very small number (1%) reported experiencing all three forms of harassment; 12% two forms and 29% one form. Only 45% of this sample intended to stay in nursing for at least 3 years; 40% were undecided and 15% intended to leave. Logistic regression estimates showed that reported levels of abuse and harassment had a significant impact on respondents' career intentions, even in models that controlled for known factors affecting career decisions. About 70% of our respondents reported that they had had too little training in dealing with aggressive behaviour—or none at all—but there was no statistical relationship between lack of training and reported assaults.

Conclusions

The international shortage of health care workers is due at least in part to low retention rates. It is crucial to investigate nurses' experiences of work to identify the factors that shape their career

decisions. Workplace violence is increasingly acknowledged as an international, service-wide, health care problem. This paper adds to the literature that shows that workplace violence has an impact on nurses' career decisions. The implications for managers and policy makers are that strengthening systems of security and providing nurses with training in interpersonal relationships including dealing with aggressive patients could slow nurse turnover.

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Chapter 3 - Gender aspects and implications of workplace violence

Canadian women's experiences of workplace abuse in the health care sector

Paper

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Abstract

In order to address the gap in knowledge of how workplace bullying affects women's patterns of engagement in the workforce, particularly from the perspective of women themselves, we conducted a grounded theory study of English-speaking women in eastern Canada with a history of workplace abuse. In this presentation, we report our findings related to interviews with 20 health care workers who were recruited as a community sample of women bullied in the workplace.

In Canada, 57.8% of women are employed (Statistics Canada, 2004) and 19.1% of women work in the health care sector (Statistics Canada, 2008). Workplace abuse presents a barrier to women's successful engagement in the workforce by creating hostile work environments, affecting mental and physical health, and causing social, economic, and career consequences. Workplace abuse in the health sector is said to be increasing (International Council of Nurses, 2000). In a survey of workplace abuse in 32 countries, Canadian women had one of the highest self-reported incident rates of workplace abuse (Leck, 2000).

Broadly defined, workplace abuse is repeated physical, psychological, or sexual abuse, threats, harassment, or hostility within workplaces. Bullies may be male or female and may be supervisors, co-workers, subordinates, or clients. Workplace stress and workplace abuse have serious consequences for physical, mental, and social health (Dewa et al., 2004; Glendinning, 2001; Lewis et al., 2002; MacIntosh, 2005) and affect women's workforce participation, contributing to long-term career consequences. In health care, nurses are three times more likely to experience workplace abuse than other occupational groups (Di Martino, 2002) and the large majority of nurses are women.

Many women who experience workplace abuse find it difficult to return to hostile work environments or to seek other employment because their self-confidence has been eroded (MacIntosh, 2005). Targets of abuse report less satisfaction with their work and careers (Tepper, 2000) and may feel forced to leave their jobs, disrupting their career paths and incurring financial burdens (Zapf, 1999). This abuse has a significant impact on Canada's economy because emotional and mental health problems cost .5 billion annually in workforce productivity and account for 1/3 of all disability claims (Dewa et al., 2004).

In our study, we interviewed 20 English speaking women in eastern Canada who had experienced workplace abuse while working in the health sector. These women were employed as registered nurses, social workers, nursing assistants, care attendants, and therapists ranging in age from 24 to 58 years. 'Doing Work Differently' was the process that women used to address the central problem of disruption and we will show how this process varies according to the nature of the workplace, including the influence of working in the health care sector. We hope to provide an opportunity to discuss with those attending the implications of these findings for the health care sector.

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Domestic Violence in the Workplace: What We All Can Do

Workshop

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Abstract

Domestic Violence in the Workplace: What We All Can Do details a unique, new partnership between the Alberta Council of Women's Shelters (ACWS) and the Health Sciences Association of Alberta (HSAA). Together we address domestic violence in the workplace. The workshop we propose is dialogic and 2-part:

1. Outline partnership and outcomes achieved
2. Participant discussion on issue, international approaches and transferability

1. Presentation

This section outlines the background to the ACWS/HSAA partnership; the identified nature, patterns and trends of workplace violence in Alberta and Canada; and, results achieved to date. The ACWS is a non-government organization providing leadership and representation for all the 41 women's sheltering organizations in the province (www.acws.ca). The HSAA is a province-wide union representing healthcare workers and is the project funder (www.hsaa.ca). Together, we address the fastest growing category of workplace violence in Canada: domestic violence. ACWS has leading Canadian expertise on domestic violence. With our multi-year aggregate data on women resident in shelters and participation in a 3-province longitudinal domestic violence study (both include workplace matters), ACWS is well positioned for relevant analysis. Additionally, for nearly 40 years HSAA has provided leadership for their members (85% women). They have long-term, direct experience with domestic violence as it occurs in the health sector workplace. The ACWS/HSAA partnership addresses an identified knowledge and intervention gap on workplace violence. The ILO ranks Canada fourth in numbers of women reporting assault and sexual assault in their workplace (of 32 countries; 1998). Yet, less than 50% of Canadian workplaces have policies to manage this risk (Conference Board of Canada 2001). We are developing materials, processes and training that contribute towards keeping Alberta's employees safe and enable employers to prevent and intervene with informed promising practice. The gendered aspect of domestic violence in the workplace will focus on its invisibility in the health sector, which are predominately women. We are responsive to two gender aspects concerning domestic violence in the workplace:

- Violence against women—overwhelmingly, the victims are women and children
- The role of men: the situation will not be resolved without proactively including them in the process

To that end we work with men to ensure a safer workplace environment in Alberta. Men are key players in finding solutions to end violence in this domain. New ways of imaging professional and personal responsibilities for workplace well-being emerge when men make violence against women a priority. As employers, men need to understand the issues and provide a compassionate and thoughtful response. As employees, men deserve safe and supportive employment; we need men to be informed! We will present a number of key initiatives undertaken that represent promising practice in this area.

2. Structured participation

This workshop will encourage discussion on the following:

- SWOT capacity analysis on:
 - The value of such NGO/community partnerships
 - Men and prevention of workplace violence: what is needed
- Trends: domestic violence in the (international) workplace, marginalized yet growing
- What we all can do: transitioning from reactive to proactive response

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Implication of sexual harassment on female nurses at work place background

Poster

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Abstract

Background

Harassment among the workers of several sectors is becoming very common. Both men and women working in the health sector experience violence or harassment to certain extent, although women appear to be more vulnerable than men. This risk of harassment is even higher among women especially sexual harassment. According to the literature 76% of the nurses in USA, 66% in UK and 60% in Turkey have encountered sexual harassment at least once at their work place.

Purpose

The purpose of this review is to identify various impacts of sexual harassment on the female nurses from 1998 to 2008 publications.

Method

A systematic review of the literature of last ten years to date i.e. 1998 to 2008 was done in order to identify the gender implications on work place harassment. The review included twelve literature reviews articles and as well as research articles.

Findings

The finding from the researches revealed that most of the female nurses, being the victim of sexual harassment, verbalized the following psychological consequences i.e. feelings of discomfort, embarrassment, indifference fear, humiliation, shame, disgust, depression, anxiety, anger, loss of self esteem, sense of helplessness, low confidence, un controlled anger, irritability, nervousness, sense of alienation and disillusionment. In addition to this, sexual harassment also effects nurses professional behaviors like decrease work motivation, decrease work efficiency, increase rates for transfer, resigning from the job and withdrawal from the work place. None the less sexual harassment also ruins nurses' physical well being that includes decrease sexual intimation, decrease skill level, increase rates of error, nausea, headaches and tiredness. Thus it was found that sexual harassment has very destructive effects. It not only disturbs the individual life but it ultimately decreases the image of the institution.

Recommendations

From the above mentioned review of literature, it is clear that sexual harassment among female nurses has many devastating effects. Therefore, we would like to recommend that awareness sessions regarding the sexual harassment should be frequently conducted in the institution. Ongoing training should be given to the nurses regarding the handling and reporting of such incidences. Policy makers can also play a vital role in this by making a zero tolerance policy for the institutions. Counseling sessions could be done for the employees who are involved in this. Prompt and strict actions should be taken against the employee who is abusing others. In this way, we will be able to create a safe and healthy work place environment which will enhance not the nurses own self concept but will also help in improving the standard of care provided by the organization.

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Self-esteem of raped women

Poster

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Abstract

This qualitative study that shows the results of workshops performed with health workers and public health users (raped women), with the objective of elevating these women self-esteem and to touch the health workers who see them. With the Neuro-Linguistic Programming techniques it was possible to bring back lives experiences, making possible a re-reading and to minimize the factors for low self-esteem. Themes as repugnance, fear and the rape fruit; image and place; death; revenge; support and solidarity; domestic violence and the bad assistance to the victims were tackled in the meetings. The stories were transcribed and analyzed, keeping the fidelity of the contents. Negative experiences lived in the home and with sweetheart people, and mainly those came from the rape answered for the low self-esteem. One of the positive points in this study was the opportunity to prepare three raped women attend at the Women's Health House of São Paulo Federal University, who were motivated to multiply the self-esteem workshops in their communities. The most noticeable situation in the group of employees was one professional's statement revealing that she had asked not stand so much suffering anymore. In response, the women who participated in the groups opposed her attitude and convinced her to her importance to welcome the victims at the House, at such a discouraging time. We believe that this research and the self-esteem workshops should continue, in order to improve the self-esteem assessment method before and after each cycle, i.e. in terms of "minimizing the phantom" of the rape situation, besides offering support to other support groups for women victims of violence, as a way of helping them to better cope with the situation and also as a way of preparing professionals who deliver care to these women. The evaluation pointed the workshops as opportunity of reflection, normal life retaking and self-esteem reconstruction for the raped women as well as for the health workers who take care of them.

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Sexual Harassment of Nurses by Patients in a Hospital in Turkey

Paper

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Abstract

Background

Sexual harassment is an important and widespread public health problem particularly in nursing and healthcare. Nursing is the profession with the highest rates of sexual harassment. The nature of the nursing profession is such that it involves working physically and emotionally close to both patients. This closeness may explain why nurses must often deal with sexual harassment in the workplace, conduct that has been identified as one of the critical issues that has been affecting the nursing profession for a considerable time (Bronner 2003, Hibino et al. 2006). Sexual harassment emphasize the essence of harassment as any unwelcome, offensive and undesirable sexual conduct that interferes with an employee's ability to perform their job. Sexual harassment is referred to as behaviour which is sexual in nature and directly or indirectly adversely affects or threatens to affect a person's job security, prospects of promotion or earning, working conditions, or opportunity to secure a job, living accommodation, or any kind of public service (Bronner 2003, Kane-Urrabazo 2007). A broad range of behaviours can be experienced by staff. In the most of the studies nurses listed offensive sexual remarks, unwanted physical contact, unwanted nonverbal attention, requests for unwanted dates, sexual propositions and physical assault. Harassment can be categorized as verbal sexual conduct (from sexual jokes and teasing remarks to proposals for intimacy) or as nonverbal (including sexually suggestive expressions or exposure of sexual material or body parts). Physical harassment can involve a variety of behaviours ranging from patting, pinching and caressing to attempted rape.

Most publications refer to sexual harassment as a major workplace problem that causes humiliation and embarrassment and damages health care workers' performance. When nurses are sexually harassed, they experience frustration and mental health problems that may include depression, anxiety, and post trauma stress and may prompt high levels of burnout, staff turnover, and inefficient care delivery. Sexual harassment may cause decreased work effectiveness, productivity, and morale and high absenteeism and staff turnover (Hibino et al. 2006, Kisa 2002, Kane-Urrabazo C 2007). Nursing is the profession with the highest rates of sexual harassment; however, few studies of sexual harassment in nursing were found in a review of the literature. In Turkey Kisa et al. (2002) found that 61 % of the nurses reported that they had been subjected to sexual harassment in the workplace. And in other studies Çelik found 37.1% of participants had been harassed sexually (Celik/Çelik 2007).

Purpose

To determine the prevalence and details of sexual harassment of nurses by patients and nursing reactions.

Methods

A self-report questionnaire survey was used to collect the data in the study in a hospital in Turkey. The questionnaire used in this study was developed by the researchers with the help of material

based on the literature. It consists of two parts. Part I consists of 6 questions pertained to the socio-demographic characteristics of participants. Part II included 10 open and close-ended questions on sexual harassment types, sources, feelings, results, and coping methods after sexual harassment behaviors had occurred. Sexual harassment behaviors were defined as being subjected to unwanted sexual jokes, stories, questions, or words; receiving unwanted mail or telephone calls; being shown someone's body sexually; having the participants' body touched; or experiencing an attempted assault. The participants were asked to check the listed sexual harassment.

Results

After completion of the study the results will be presented.

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Violence against Nurses in Swedish Psychiatric Care

Paper

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Abstract

Narratives on a Gendered Culture from the first half of the 20th Century

During 1982–93, interviews were conducted with 22 female general nurses, specially trained in psychiatric nursing, who had been active in Swedish psychiatric care before the 1950s. All Swedish Nurses were female at the time. Their experiences and perceptions of violence from male and female patients were investigated. Analysis was based on phenomenological hermeneutics with a gender perspective.

Violence toward nurses and other male and female personal is stated as rare. Patients are perceived as being able to exercise self-control. Occurring violence is associated with specific situations stressful to the patient, inappropriate treatment routines, and the attitudes or lack of knowledge of caregivers. In this context, violence refers to serious threats of violence or violent actions resulting in serious bodily harm. Female patients are described as more aggressive and prone to attack female personnel, than male patients. Attacks by women are described as unpleasant, but relatively less dangerous.

Emerging from the nurses' accounts are behaviour patterns aimed at containing personal fear and developing a body language that signals non-violence. Outlines can be found of gender contracts intended to control fear and prevent violence. Nurses describe male patients as having a protective attitude. A picture emerges of nurses conforming to a contemporary ideal patterned on traditional female subservience, non-confrontation and asexual demeanour that does not challenge masculinity as constituted by protection and chivalry towards women.

Nurses' statements are seen to reflect self-understanding and a collective professional identity. The findings are discussed in relation to contemporary psychiatric literature and other discourses at the time, and in relation to present research and discourses.

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Violence against Nurses in the Workplace: An International Collaboration Part II: Every single day fear is my companion at work” - Experiencing violence: a destructive and degrading everyday factor for female nurses

Paper

*Andrea Zielke-Nadkarni, Patricia Hinchberger
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Abstract

Introduction

Violence in the workplace is an everyday experience for nurses in general and female nurses in particular in Germany. It is also a taboo topic which in Germany - as opposed to other Western European countries - has not been the focus of research. As women make up the majority of nurses and violence shows gender-specific forms we seek to concentrate on this target group. Independent of their level of training registered nurses and nursing students are threatened by verbal and physical violence, bullying and sexual harassment. Our study excludes psychiatry as this field is subject to special conditions. The study is also limited to hospitals and residential homes in order to homogenize the environmental conditions. Although the ICN and its German counterpart (DBfK) condemned all forms of violence against nurses and launched an appeal to confront them as they infringe rights on physical/ psychological integrity, incidences of violence are scarcely acknowledged by the management. - This paper presents the lived experiences of violence by female nurses including the situational causes, the forms of violence, the influential factors which bring about violence as well as the serious consequences for the women affected, for the quality of care and, thus, for the organisation are illustrated. Furthermore, educational implications are discussed.

Study objective

To gain data/narratives which present the lived experience of violence in the workplace by female nurses as a basis for the development of a preventive concept and guidelines for dealing with cases of violence in hospitals and residential homes.

Methods

This part (II) of the joint US/German project supplements part I which used a modified Self-report survey of violence in the workplace to pilot and ascertain the level of violence experienced by nursing students. In part II a systematic review of the literature including Germany, Great Britain, Sweden and the Netherlands preceded qualitative interviews which were carried out with 28 female nurses who experienced various forms of violence in clinical settings. Narrative materials were collected and analysed based on the method of Grounded Theory.

Results:

- nurses often regard acts of low-degree-violence (verbal offence, pinching, slapping) as part of their job
- women trainees and novices are more frequently the victims of sexual harassment than more experienced nurses
- little institutional provision for the victims is made, on the contrary:
- institutional conditions play an often unrecognized part in the emergence of violence
- those acts of violence which the women experience as destructive and degrading cause long-term psychological problems for many victims concerned
- Patients as well as visitors and staff are the perpetrators.

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Violence against Nurses in the Workplace: An International Collaboration Part I: US-American / Canadian / Australian

Paper

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Abstract

Objective

The growing epidemic of violence in the workplace is raising concerns among workers, employers, and governmental agencies across the US, Canada, and Australia. A review of the national and international literature identifies that the prevalence of violence in the workplace experienced by graduate and undergraduate nursing students in the college setting is largely unknown. Violence, harassment and bullying in the workplace are not new phenomena. Moreover, the prevalence of violence is now recognized as a major health priority by the World Health Organization (WHO), The International Labour Office (ILO), the International Council of Nurses (ICN), and Public Services International (PSI). Even so, the number of nursing personnel affected by this syndrome remains alarming. Violence in society and in healthcare continues to rise. The American Association of Colleges of Nursing (AACN) Position Statement (2002) recommends that all faculty prepare nurses to recognize and prevent all forms of violence in the workplace. This international research project with 2 partners, one in the USA, the other in Germany/Europe, aims to empower both nursing students and nurses in general to better understand and use the political and other processes to speak out and demand change in nursing education and health care. We seek to develop practical approaches for prevention of this public health disease.

Methodology

A modified Self-report survey of violence in the workplace (The Metropolitan Chicago Healthcare survey from Guidelines for dealing with Violence in Health care, 1995) used to pilot and ascertain the level of violence experienced by nursing students in clinical placements. A convenience sample of graduate and undergraduate nurses at a university campus served as the population. The survey administered online, contained 10 questions. Key variables posed included who, what, when, where, and how the incident actually occurred in the workplace, in addition to predisposing factors.

Results

A convenience sample of one hundred and twenty-six students participated. The majority of students were BSN (63) followed by MSN (42) and Masters Entry Professional Nurse (MEPN) (21) clinical nurse leaders. Of the 126 respondents, 100% have experienced or observed violence in the workplace. Findings are similar to those found among staff nurses. The perpetrators were most often staff members followed closely by patients. These findings have the potential for supporting the development of curriculum, which dispels the customary belief that “violence is an accepted part of nursing”.

Conclusion

Additional global research on violence among undergraduate and graduate college nursing students during clinical placement can provide rich data for prevention of national and international predisposing factors associated with violent behavior in health care. Collaboration and comparative results (Part II) with a colleague in Germany will lead to developing effective strategies modified by the conditions of our national and international health care systems.

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'Why don't you just leave?' Horizontal violence and the experience of men who are nurses

Paper

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Abstract

A significant challenge for the nursing profession is the paradox between caring as the central focus of the profession and the interpersonal violence that occurs between nurses. Nursing has a long tradition of the young and less experienced being the targets of victimization and increasing attention is being given to the problem of horizontal violence in the profession. As the nursing workforce remains predominantly female, the majority of the published studies focus on female nurses' experience of horizontal violence.

This paper will draw upon the published literature related to nurse on nurse aggression and interviews with 18 New Zealand to reveal that men who are nurses also subject to the victimization of horizontal violence. This paper does not attempt to reframe men as victims; rather it argues that that horizontal violence in nursing is a complex phenomenon. It proposes that space be given for the consideration that not only are men actively involved in acts of violence and oppression, but that as nurses, they are also victims of such acts perpetrated by both men and women in the nursing profession.

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Chapter 4 - Legal and/or ethical aspects and implications for the employer and employee of workplace violence

Ethical, Legal and Sociocultural Issues (ELSI) Principles for the Employer in Workplace Violence

Paper

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Abstract

Purpose

Understanding the importance of ethical, legal and sociocultural issues (ELSI) are crucial in creating a safe workplace. The purpose of this paper is to outline ELSI and translate the principles derived from them into creating a safe workplace. Individual values, beliefs, and philosophy play a major role in ethical decision making. Ethics is a set of philosophical beliefs and practices concerned with distinctions between right and wrong; values, human rights, dignity, and freedom; and with duties to others and to society. Ethical dilemmas occur in situations in which an employer must choose between two or more undesirable or mutually inconsistent courses of action in creating a safe workplace. Most ethical principles are derived from historical events of humanity's inhumanity in the name of research, treatment, safety, or advocacy. Legal issues are sets of questions that can only be answered by applying a set of theories in law. Sociocultural issues are less understood because they are not discussed openly in classrooms and workplaces.

Ethical Issues

Two ethical theories from which ethical principles flow are consequentialism and nonconsequentialism. The two ethical positions advanced in the theory of consequentialism are that (1) acts are right to the extent that they produce good results and wrong to the extent that they produce bad results, and (2) acts are right by figuring the net of good consequences minus bad consequences for each person affected and adding them up to arrive at the total net good. This position minimizes needs and wants and maximizes good outcomes for the greatest number of people. Ethical principles are also derived from the opposing ethical theory of non-consequentialism, also known as deontology or duty-based ethical theory. It advances the ethical position that rightness and wrongness are inherent in an act or duty, independent of the consequences.

Legal Issues

There are four sources of the law: stare decisis (case law from past decided cases), legislative, administrative, and constitutional. The employer needs to understand that to create a safe workplace the sources of the law and the rules and regulations flowing from them must be considered. From these sources, legal principles can be ascertained: tort, contract, and criminal or property law. From these principles, a finer categorization needs to be done. For example, tort law is divided into three categories: Intentional, Unintentional, and Quasi-intentional. Further, the employer needs to sort out which theory: negligence theory, assault and battery theory is intentional or unintentional tort in creating a safe workplace.

Socio-cultural Issues

They are often the subject in closed trusting conversations with family, friends, or confidants, peppered with diversity, inequality, traditions and stereotypes. In this presentation, we will discuss openly sociocultural issues as crucial to the employer's role in creating a safe workplace.

Sociocultural issues are uncomfortable subject matter for many, because they give rise to difficult conversations and responses. The subject may challenge the employer's personal assumptions and conjures up the concepts of powerlessness, frailty, disparity, and control. We will synthesize and transform these three distinct concepts (ethical, legal, and sociocultural) into ELSI and translate into practice.

Conclusions

Translating ELSI into practice do not add to the workload, instead lighten it. It is not time and resource consuming, it is time and resource saving. However, it requires tough choices and energy from the employer to play an active role in hedging against the inevitable health, social, economic, and political winds that may undermine the creation of a safe workplace.

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In Healthcare or Anywhere, Violence is a Crime: Holding Perpetrators Accountable: Massachusetts Nurses Association efforts on behalf of nurses and other victims of workplace violence in the health sector

Poster

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Abstract

MNA, through the efforts of the Workplace Violence and Abuse Prevention Task Force members (WVAPTF) and MNA staff have worked to advance the understanding that in healthcare or anywhere, violence is a crime. MNA believes that perpetrators of violence should be held accountable for their actions. This is often in conflict with the beliefs and actions of health sector employers who often see violence as a reflection on the skills of the victims, nurses and their co-workers, as opposed to the behavior of the perpetrators.

This poster will address multiple MNA activities related to holding perpetrators of violence accountable for their behavior. Educational sessions have addressed navigating through the courts and understanding the terms used by lawyers and judges. MNA works closely with District Attorneys (DA's) who have jurisdiction in specific localities where nurses have been assaulted. Massachusetts Victim and Witness Advocacy programs provide support and guidance for any victim of violence, including healthcare personnel.

The failure of employers to provide a safe work environment has prompted the MNA to involve the U. S Department of Labor, Occupational Safety and Health Administration (OSHA). This has resulted in several hospitals being required to develop violence prevention programs. Through an Alliance with OSHA, an educational session titled Workplace Violence: Healthcare is not immune was presented to 240 nurses and others.

WVAPTF members and MNA staff have met with judges, the Massachusetts State Police and local police departments to discuss violence in hospitals and the importance of holding perpetrators accountable. Both local and state police representatives encouraged nurses to call the police when needed and were surprised that nurses are discouraged from doing this.

A strong advocate for nurses and other healthcare worker safety is District Attorney William R. Keating of Norfolk County, MA. He assembled the Norfolk County Partnership to Prevent Workplace Violence in Healthcare. This group included hospital, nursing home, home health and hospice agency, local police and MNA representatives. The group developed a guidebook "Protecting our Caregivers from Workplace Violence" which is extremely useful for healthcare employers to recognize risk factors and prevention strategies associated with violence in healthcare. MNA has filed two proposals for laws addressing violence in healthcare. One mandates healthcare employers to develop comprehensive workplace violence and abuse prevention programs: training and education on risks, effects on workers and methods of reporting violence, and employers

must provide psychological interventions for workers injured by violence. The second provides police officers with the power to arrest perpetrators of violence in healthcare settings and file appropriate criminal charges. This power of arrest is similar to a process afforded to victims of Domestic Violence.

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Legal and/or Ethical Implications of Workplace Bullying and Violence in Human Services: Evidence from Australia

Paper

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Keywords:

Bullying, misconduct, ethical and legal implications, work relationships, employment tribunals, employment law, procedures

Abstract

According to the International Labor Organization (ILO) (2002a) workplace violence and bullying represent significant compliance and organisational wellness issues in the health sector. Most Government regulatory agencies responsible for workplace health and safety have legislation and compliance codes that set out obligations for implementing risk prevention strategies. In this paper, we canvass the legal and ethical issues associated with managing risk strategies in the workplace. Workplace bullying and violence pose special problems for managing risks. Based on the Australian experience, we examine compliance issues and human resource management (HRM) factors affecting the prevalence of workplace violence and bullying in the industry as determined by tribunals. Factors that contribute to the successful risk management strategies as determined by tribunals include the extent to which HRM policies and practices are articulated in the workplace, effective investigative follow-up, management communication skills, and extent and depth of employee training and development. The paper concludes by setting out an appropriate HRM and prevention strategy for preventing occupational violence and workplace bullying.

Introduction and definitional issues

Historically, workplace conflict has described a continuum of behaviours. Workplace violence and bullying are emotional constructs shaped by a range of factors, causes, responses, meanings and explanations. It is only since the early 1970's that researchers have devoted increased attention to this problem and there has emerged a multi-faceted literature. This paper draws on the relevant literature, cases and the industry experience of the authors and examines the legal and ethical implications of risk managing internal bullying and violence in Australia. It also discusses the various definitional issues and examines the way in which tribunals have approached these issues. The paper discusses the ethical issues and implications of the research, and underlines the importance of linking risk management practices to wider organisational HRM and OHS strategies as a more effective risk prevention strategy for dealing with workplace violence and bullying. The paper concludes with a suggested preventative approach.

The terms 'workplace violence' and 'bullying' are difficult to define legally. They are essentially 'global' concepts that incorporate a range of behaviours. These include: harassment, intimidation, aggressive or violent behaviour depending upon one's standpoint (Branch, Ramsay and Barker, 2007: 265). A key factor is that the behaviour is 'work related'. In 2001, the Queensland Government established a Workplace Bullying Taskforce which aimed at examining bullying comprehensively and to provide recommendations to Government (Queensland Bullying Taskforce, 2002). The Task

Force Report (2002) found that there was no single workable definition of workplace violence and suggested a behavioural approach encompassing behaviours that are repeated and that an 'average' person would find unreasonable. Despite the lack of clarity, academic and human resource management (HRM) research on workplace bullying and harassment is attracting increasing attention from researchers across the organisational and psychological literature (Rayner, Sheehan & Barker, 1999; Kieseker & Marchant, 1999; Farrell 1997, 1999; Farrell & Bobrowski, 2003). There are a number of issues confronting this type of research. First, there is the problem of definition. The International Labour Organisation (ILO, 2002a) observes that there is a wide range of different labels used in various countries to describe workplace bullying making it difficult to compare 'apples with apples'. Different labels used in various countries to describe workplace violence and bullying include terms such as 'mobbing (drawn from animal behaviours) in Scandinavia, Germany, Italy, and 'workplace harassment' or 'bullying' in Australia (Davenport et al. 1999). In the United States, the term 'workplace harassment' (Bassman, 1992) or 'mistreatment' (Spratlen, 1995) or 'emotional abuse' (Keashly, 1998) are more often used in the literature. The European Foundation for the Improvement of Living and Working Conditions Report on Violence, Bullying and Harassment in the Workplace (2004) identified a multitude of terms to describe dysfunctional workplace behaviours including physical violence, harassment, bullying, psychological violence, and sexual harassment. According to Diamond (1997) whilst there are many terms used, ultimately, terms such as 'workplace aggression', 'harassment', 'bullying', and 'violence at work' represent different facets of the same issue, namely workplace violence. Second, definitional issues arise according to Liefoghe and Olafsson (1999) due to the diversity of the literature used, ranging from scientific psychological/behavioural clinical trial type research to industry case study research resulting in a vast and diverse body of literature. This body of literature is seen as lacking a systematic approach (McCarthy & Rylance, 2001) engendering mono-casual factors and mono-dimensional explanation of complex workplace behaviours perpetuating industry stereotyping (Rylance, 2001).

The richness and diversity of occupational, industry and individual level studies have helped to expand our knowledge about the prevalence and impact of occupational violence and workplace bullying. Hoel & Cooper (2000, 2001) suggest that we now have a far more diverse and useful understanding of the differential impact of workplace violence and bullying on organizational, occupational, group and individual levels. For example, the Beyond Bullying Association (McCarthy et al. 1998) have published a number of industry case studies covering female dominated helping professions, community and pastoral care, electronic emailing and tertiary education and office administration. Other studies have extended our understanding of workplace bullying to include the helping professions, such as social work (Rylance, 2001), building and construction (Barker et al. 1999), and flight attendants and passenger abuse (Williams, 2000). At a broader theoretical level, there is a modicum of agreement. Mayhew & Chappell (2001, 2003) argue that workplace violence and bullying should be seen in the context of broader forms of internal (violence and bullying committed by individuals employed or formally employed in an organisation) and external (violence and bullying committed by persons not employed by an organisation) types of occupational violence affecting the well being of employees at work. Bowie (2002) suggests that bullying behaviour is a set of dysfunctional workplace behaviours ranging from those that adversely impact on our emotional well-being and stability to physical violence causing injury and harm, and that there is often a fine line between occupational violence and workplace bullying in terms of psychological effects such as tension and stress to heart disease and nervous disorders that have clear medical and physical symptoms. It has been suggested that workplace bullying may be expressions of naturally anger or frustration drawing on our primitive origins (Anderson & Bushman, 2002) that occur within organisations as defensive mechanisms, or from organizational characteristics such as unitarist or authoritarian managerial control, work intensification, cost minimisation and poor management skills (Ishmael, 1999). This is a particular problem in cases of the promotion of persons without relevant people handling/supervisory skills moving into managerial positions (Ishmael, 1999).

Workplace violence and bullying may also arise from interpersonal conflict, life ethics and power relationships between individuals, between groups or within groups (Diamond & Adams, 1999). Research also suggests that bullying may be common behaviours in everyday life and therefore more likely to be condoned at the workplace (Einarsen, 1999). The frequency, intensity and duration (as opposed to one off incidents or behaviours) are also relevant factors (Einarsen, 1999). It is also suggested that impact and intensity of occupational violence and workplace bullying behaviours is a gradually evolving process, and therefore, is more often difficult to detect especially if there is a climate that militates against reporting such behaviour (Einarsen, 1999, 2000). Research by the authors suggests that bullying behaviours may be vertical or horizontal, group, sub group or individual (Timo, Fulop and Ruthjersen, 2004). The use of bullying as a strategy to exercise power and control is suggested in a survey by Hoel & Cooper (2000) where 75 per cent of respondents reported having been harassed and bullied at work by supervisors and middle managers who resorted to bullying as a means for maintaining control and increasing the intensity of work. Similarly, a survey in 2000 into workplace harassment conducted by the Australian Council of Trade Unions (ACTU) found that 70 per cent of respondents reported that either a manager or supervisor instigated workplace harassment and bullying (Australian Council of Trade Unions 2000). Some studies have found that young people, especially those under the age of 24 years, are more at risk of workplace harassment than older employees (Hoel & Cooper, 2000). Einarsen (2000) has suggested that youth are more likely to be both aggressors and targets of bullying. In contrast, Leymann (1996) found that age was of little significance. It may be, as Einarsen (2000) observes, a life cycle issue, that while younger employees may be targeted more, they are less likely to perceive the behaviour as workplace harassment (as they may be more eager to please in their early careers), whereas older employees are more likely to report such behaviours as they may have expectations of being treated with respect and dignity that comes with age. In relation to gender, Einarsen (2000) goes on to suggest that males are more likely to instigate bullying type behaviours, though the research is not unequivocal here, due to differences in occupations and industry characteristics (Leymann, 1996).

Are Human Services a Special Case?

Human services and high person contact occupations are often cited as representing high risk industries due to the close proximity of person-to-person contacts (Jones & May 1992). According to the ILO there is a growing body of national and international governmental research pointing to an association between workplace violence, bullying and occupational stress in human service industries (ILO 2002a, 2002b). At a national level, the Australian National Occupational Health and Safety Commission (NOHSC) has identified occupational violence and bullying in the health sector and human services sectors as a significant area of concern. According to the Queensland Bullying Task Force (2002: 16) the health industry accounted for 43 per cent of all workers compensation claims relating to workplace harassment and bullying in 2001–2002. A study by Rylance (2001) of social workers found that 12.1 per cent of respondents had experienced frequent workplace harassment from clients and 24.4 per cent of respondents who indicated that they were bullied by managers or co-workers. Williams (2000) in a survey of flight attendants reported finding that over 50 per cent of flight attendants had to deal with angry passengers ‘sometimes’ and 28 per cent dealt with them ‘frequently’.

Overseas surveys suggest similar experiences. For example, a recent unpublished Report on workplace stress by the U.S. National Institute for Occupational Safety and Health (July, 2004) found that 24.5 per cent of companies surveyed reported that some degree of bullying had occurred during the preceding 12 months and that 39.2 per cent involved an employee as the aggressor, 24.5 per cent involved customers or clients and 14.7 per cent involved a manager or supervisor. Recently, the Report on ‘Violence, Bullying and Harassment in the Workplace’ by the European Foundation for the Improvement of Living and Working Conditions (2004) detailed the findings of a survey of European Union member countries suggesting that 11.0 per cent of employees

employed in health and education industries had experienced some form of occupational violence and bullying over the past 12 months. The Report (2004) found that 1.5 per cent of employees had experienced some forms of workplace violence and bullying from fellow work colleagues with 4.1 percent experiencing these behaviours from people outside of the workplace. Whilst these are small percentages, they take on considerable significance considering the tens of thousands of employees employed in these industries throughout European Union member states. Whilst studies on bullying in Asian workplaces remain rare, there is increasing awareness of the impact of bullying as a social issue (such as school bullying) and workplace violence directed towards women and young people (ILO, 2002a). In relation to nursing, some researchers suggest that occupational violence and bullying emergence as an accepted cultural component of a disciplined managerial style in hierarchical occupations (Duffy, 1995). Others see the issue as more likely rising to the surface during periods of major tension, cost cutting and restructuring (Quine, 1999) leading to higher levels of absenteeism and sickness (Kivimaki et al. 2000) adversely impacting on nursing recruitment and retention (Jackson et al. 2002). Bullying has also become an industrial issue, with a number of Australian unions incorporating workplace violence and bullying as part of union workplace health and safety activities (see Queensland Nurses Union of Employees', 2002). Internationally, nursing organisations are also increasingly directing their attention to the problem of occupational violence and workplace bullying. At a recent meeting of the International Council of Nurses (Asia Workforce Forum) discussion included violence, bullying, harassment and verbal abuse (International Council of Nurses – Asia Workforce Forum 2003 Minutes, November 27-28).

Risk Management and Human Services: Too Little Too Late?

Risk management or risk prevention strategies in human services are more difficult to implement due to the uncertainty inherent in the management and control of different categories of persons using human services. In the health sector, production and consumption of services occur in close proximity of one another involving many groups and sub groups involving a full range of different behavioural and group dynamics: health professionals, para or technical professionals; nursing and care staff, operational, patients/resident, visitors, family, friends, clients, consumers, general public and so forth (Jones & May, 1992). When people are working in close proximity to one another, unacceptable behaviours are always a potential risk. According to Bowie "...workplace violence has always been present in one form or another wherever people work together..." (2002: 1). Health care service delivery necessarily involves shift work encompassing working unsocial hours and many health care workers work alone or in small groups. Managerial observability of the health care task is low with supervision porous. The health care sector is typically dominated by a labour market with high levels of female employment, many migrant and a considerable portion in precarious atypical and low paid employment (ILO, 2002a). Particular occupational groups such as nurses can be more susceptible to horizontal and vertical bullying (ACIRRT, 2002). As Farrell (1997) observes, workplace violence and bullying can seriously undermine the safety and well being of workers high touch occupations such as health where there is a high proportion of vulnerable workers. The health care sector as many other parts of the economy, have been extensively restructured and rationalised according to economic policies that require public sector activities to generate efficiency dividends placing greater stress on staffing levels, work intensity, longer hours, faster pace of work, more subcontracting, and atypical employment (ILO, 2002a).

Workplaces undergoing rapid structural change are more likely to generate work environment have a greater propensity for occupational violence and workplace bullying (Lee, 1999; Einarsen 2000; Hoel & Cooper 2000; Bone 2002). It has also been suggested by research findings that workplaces undergoing rapid structural change are more likely to generate greater dysfunctional behaviour (Lee, 1999; Bone, 2002). High turnover, absenteeism, declining productivity, low morale, interpersonal conflict, stress, alcoholism, drug abuse, workplace violence and bullying are cited as some of the outcomes of rapid structural change (Lee, 1999). Furthermore, it is suggested that

work environments that foster competition, job insecurity, work intensification, casualisation, stress and job dissatisfaction have a greater propensity for occupational violence and workplace bullying (Einarsen 2000; ACCIRT, 2002; Hoel & Cooper, 2001). Occupational violence and bullying is a significant organisational wellness issue (Mayhew & Chappell, 2001). For example, McCarthy et al. (1995) found that 60 per cent of respondents had experienced workplace harassment behaviours in organisations undergoing restructuring. Issues here included unreasonable workloads, poorly developed or dysfunctional organisational culture, ineffectual managerial practices, marginalization, alienation and results oriented individualist managerial styles. Einarsen and Matthieson (2002) contend there is a strong correlation between workplace bullying and ineffective leadership and inadequate work control. Weak managerial communication skills and a failure to 'follow up' complaints contributes to bullying being seen as an accepted part of workplace culture especially where such behaviours are seen as going unchallenged. It is recognised that this has a corrosive effect ('corrosive leadership') by perpetuating and reinforcing dysfunctional relationships between individuals, occupational groups and management as suggested by Ishmael (1999). Employers that are active in communicating company bullying/grievance policies are seen as less likely to have employees reporting bullying experiences (Sweeny Report, 2003). The genie may well and truly be out of the bottle. If factors such as inter personal conflict, peer group pressure, occupational ranking, work intensification, cost minimization, competitive work environments and poor management skills contribute to workplace violence and bullying behaviours (Ishmael, 1999; Diamond & Adams, 1999), then solutions may be far more difficult to implement. A glimmer of hope may be found in increasing importance in management education, improved communication and inter-personal skills, and better policies and investigative methods. This review points to the difficulty for tribunals to determine fault and responsibility in workplace bullying and harassment cases.

Legal and Ethical Issues and Regulation of Workplace Violence and Bullying

Under most Westminster style legislation, overt workplace violence is generally treated under the criminal code and at common law if the act involves 'physical assault'. Emotional and mental abuse is much more difficult with policing authorities very reluctant to pursue investigations that do not have a basis in common law assault where 'harm' is clearly discernible. Underpinning the legal concept of bullying as a legally cognisable harm has a convoluted history. Historically, the common law has clearly spelt of the inalienable rights of a 'master to run his affairs' and labour law has emphasised this individualist approach 'underscoring the social ambivalence about regulating workplaces that were long accepted as private spaces where employer prerogative prevailed' (Thornton, 2004: 22). The master and servant relationship reflected this 'hands-off approach'. Despite the a-symmetrical power in this legal relationship, the common law has nevertheless historically recognised an implied term in the master-servant relationship that being a requirement on the master to 'keep his servant from harm whilst in the master's employ'. Whilst managerial prerogative is and remains a mainstay of our legal approach to regulating the employment relationship, the inchoate concept that bullying is a form of workplace violence is based on the notion that every person should have the right to be free from abusive treatment (or harm) in the workplace. Damages actions at common law have been rare, because of the difficulty of proving fault. In addition, a tort action grounded in negligence are often unsuccessful as a plaintiff must generally prove that a risk was reasonably foreseeable and that risk could reasonably be controlled and that the defendant's actions thereby contributed to the plaintiff's injury (from which loss can be calculated!). The common law has slowly turned on the issue of what constitute 'harm' in the workplace, with many legal jurisdictions in the 1980's and onwards, more readily finding a legal relationship between cause and effect connecting 'working relationships' and 'harm' and employer becoming vicariously liable for the actions of other in the employer's workplace. The publication of the Robens Report (UK) in 1972 recommended self regulation in workplace health and safety regulation by means of spelling out the common law obligation on an employer as a safety obligation to provide a safe workplace that is free from the risk of illness, injury or disease. Managing workplace bullying and violence as a workplace health and safety issue is now much clearer with many jurisdictions defining the safety obligation to include

managing and controlling risks. Westminster style safety legislation have imported the common law notion of a duty of care into occupational health and safety legislation placing an onus on employers to maintain safe workplaces through adopting risk management strategies as part of broader human resource management and compliance strategies. The role of risk management under Australian statute has existed for several decades. For example, Section 85(c) of the Trades Practices Act 1974 (Commonwealth) and Division 12.3(c) and (d) of the Criminal Code 1995 (Commonwealth) enshrine a statutory duty on employers to adopt compliance strategies that aim to reduce risk of civil or criminal liability at either company or individual manager level or where liability is found, to reduce the penalties on the company or individual managers. In the past two years, public liability and indemnity insurance premiums have increased substantially worldwide. In addition, there is greater media focus highlighting perceived vexatious claims giving rise to excessive court awarded damages. Increasingly alarmed, community groups and professions have demanded that governments take action to curb excessive damages claims in what McCarthy and Rylance (2001) describe as a 'crisis like' response.

At the heart of an employment relationship, employers must ensure a safe workplace. This includes taking practical steps to identify, assess and control reasonably foreseeable risks. For example, Section 28 of Workplace Health and Safety Act 1995 (Queensland) places specific obligations on employers to ensure the workplace health and safety of employees. Courts have increasingly adopted a broader view as to what constitutes injury. A psychological injury is a personal injury having both mental (e.g., post traumatic stress disorder) as well as a physical (e.g., weight loss or gain, high blood pressure, heart disease) manifestations. Common law courts also are increasingly being called upon to arbitrate compensation claims and in some celebrated cases finding employers vicariously liable for stress and personal injury arising from workplace bullying (see New Zealand Court of Appeal. (2002). *Attorney-General v Christopher John Gilbert* [2002] NZCA 55, 14 March 2002; Australian Equal Opportunity Commission. (1999). *Arnold v Midwestern Radio Limited*. EOC, 92-970; Law Reform Commission, *Vicarious Liability*, QLRC Report No. 56, QLRC, Brisbane, 2001). A psychological injury does not need to actually occur for an employer to be found in breach of occupational health and safety law. Indeed, a failure to provide a safe system of work is enough to be charged and prosecuted (NSW Court of Appeal, *State of NSW v Coffey*, NSWCA 361, 7th November 200; NZ Court of Appeal, *Attorney-General v Gilbert*, NZCA 141/00, March 2002).

The Commonwealth of Australia and Australian states have OHS jurisdictions and safety legislation. These do not define the terms 'workplace violence or bullying'. Rather, these terms are encompassed under a 'catch all' safety obligation of 'ensuring a workplace that is free from the risk of illness, injury or disease' to be achieved through the implementation of risk management strategies. Many States have now issued OHS guidelines on workplace violence and bullying (Victoria Worksafe Victoria 'Guidance Note on Prevention of Bullying and Violence at Work' 2003; Western Australia, Worksafe Commission 'Guidance Note on Workplace Bullying' 2003; and Queensland Division of Workplace Health and Safety 'Advisory Standard on Prevention of Workplace Harassment' 2004) and these codes of practice set out steps to manage the risk of workplace bullying and harassment. OHS legislation also sets penalties for breaches of OHS obligations (see for example, Section 24 of the Workplace Health and Safety Act 1995 – Queensland) that range from tens of thousands of dollars to potentially six months jail! However, it is at common law that damages are mostly awarded in rare cases depending upon the extent of the psychological and/or physical injuries.

In Australia, specialist industrial tribunals have been established since the 1900's to regulate the relations between employers and employees and as an independent third party regulator, mediate and arbitrate grievances and disputes between employers and employees. Keashly (1989) sets out a number of factors that summarise the way in which workplace violence and bullying is approached: (i) the nature of the conduct involved (ii) repeated vs single acts (iii) degree of

unwanted or unsolicited behaviour (iv) the perception of violation of a person's rights (v) the degree of harm (vi) the intention or controllability the actions (vii) power differences between offender and victim. Tribunals are generally obliged to follow law, that is, cases involving workplace violence and bullying require that where an alleged perpetrator is to be terminated, the decision to do so must be 'sound, defensible and well founded' (Australian Industrial Relations Court, *Selvachandran v Peteron Plastics*, 62, Industrial Reports 371). Tribunals, though not formally bound by the rules of evidence, follow established precedent. Tribunals have generally adopted the approach of 'a fair go all round' requiring tribunals to weight evidence having regard to the unique facts and circumstances surrounding the case (*Loty and Holloway v Australian Workers Union*, Arbitration Reports, (NSW) 95, 1971). Under the Workplace Relations Act 1996, the Australian Industrial Relations Commission in determining, for the purposes of the arbitration, whether a termination was harsh, unjust or unreasonable, the Commission must under section 652 of the Act have regard to: (a) whether there was a valid reason for the termination related to the employee's capacity or conduct (including its effect on the safety and welfare of other employees); (b) whether the employee was notified of that reason; and (c) whether the employee was given an opportunity to respond to any reason related to the capacity or conduct of the employee; and (d) if the termination related to unsatisfactory performance by the employee -- whether the employee had been warned about that unsatisfactory performance before the termination. Other factors include whether the employer had access to professional HRM advice, employment size and other factor the Commission considers relevant.

A review of cases illustrate the factors relevant to determining workplace violence and bullying cases and these include: (i) extent to which the employer conducted an adequate investigation, (ii) the extent to which the alleged perpetrator had access to all the allegations against them (iii) the extent of the act (s) (iv) impact on victim (v) extent to which the employer has developed and communicated within the workplace violence and bullying policy (vi) the extent to which the policy has been reiterated and (vii) the extent to which punishment fitted the crime. There is therefore no single determining factor. The process adopted entails a number of ethical dilemmas (i) considering the definitional difficulties, how should one-off or marginal behaviours be treated? (ii) due to the often personal nature of the allegations, to what extent should a perpetrator have access to all allegations? (iii) when is retraining appropriate? (iv) can the perpetrator and victim be reunited in the workplace? In larger workplaces, redeployment is more readily an option (v) how does one prevent employees 'ganging up' on an employee by making false allegations? (vi) are managers sufficiently trained to conduct the investigation in a fair and transparent way? and (vii) how do we determine whether 'punishment fits the crime'?

A Workplace Bullying Prevention Strategy

According to Aretz and Aretz (2000), academic research in workplace violence and bullying must be capable of practical application. Compliance approaches to work place regulation that emphasis organisational wide risk management strategies are seen as better at coping with incidents workplace bullying (Mayhew and Chappell, 2003). Adopting a risk control/prevention strategy is now a feature of Australian OHS law that incorporates the following steps: (i) identify the risks; (ii) assess the risks (iii) develop controls (iv) implement these controls and (v) monitor and review. This would commence by implementing a 'zero tolerance' workplace violence and bullying' policy supported by senior management through out the organisational and articulated through on-going and regular training and induction in a supportive organisational climate. Simply having a policy is insufficient, reasonable steps must be taken to implement the policy and ensure that existing and new staff are aware of their obligations (NSW Administrative Tribunal, *Asnicar v Mondo Consulting Pty Ltd*, NSWADT, 143, 14th July, 2004). Prevention strategies should also include identification of risks and this may include employee consultation, implementation of incident recording system, reviewing previous incidents/reports, and creation of a data base of incidents. Developing a checklist of potential risks (emotional and organizational/work tasks related) and regular auditing can assist

with this process. Training is an important control and could include topics such as identifying sources, provide examples of unacceptable behaviours and impact of violence and bullying on employees, and identifying the appropriate ways for managers to deal with staff and staff to deal with one another and with residents and clients. In addition, ensuring victim support and performance managing perpetrators are important facets of such a policy. This may involve the appointment of a contact person in the workplace and/or use of external consultants to provide follow up counseling and emotional assistance, including counseling and mediation for both victim and perpetrator. In the case of the perpetrator, counseling may be followed by a disciplinary procedure that if un-heeded, may involve the ultimate penalty of termination. However, merely applying a disciplinary approach is insufficient especially as it can lead to a claim of unlawful termination. A key plank in management's action/response plan is to effectively performance manage the problem ensuring that proper HRM procedures and guidelines are applied (*B. Hill v Minister for Local Government, Territories and Roads, Australian Industrial Relations Commission, Matter no. U2004/2354, 26th April 2004*). Finally, management should monitor and review the adequacy of controls on a regular basis and if necessary, conduct further risk assessment and implement further controls to prevent reoccurrence. This should involve consultation with all stake holders such as employees (or their representatives), clients, users, customers, and so forth.

Conclusion

Academic and human resource management (HRM) research on workplace violence and bullying and harassment has attracted increasing attention from researchers and the material presented in this paper traverses some of the difficulties in approaching workplace violence and bullying. The role of tribunals has also been canvassed. The paper underlines the importance of clearly articulating HRM policies on bullying and following up with effective grievance handling procedures that enables employees to have confidence in the grievance process and outcomes. The implications of the paper for management are that inaction and poorly articulated HRM policies and practices have a corrosive effect on employee wellbeing allowing a bullying work culture to be created or to persist. In addition, this is a compliance matter as failure to take effective managerial action can lead to statutory penalties under OHS legislation and compensation payments arising from common claims. At a public policy level, the study highlights the problem of using statute to regulate workplace behaviours that may have a differential effect, that is, behaviours that adversely impact on some employees but not others. Despite these limitations, the paper sets out a bullying prevention strategy that when linked to wider organisational HRM and OHS strategies, may effectively prevent a bullying culture from taking hold at the workplace.

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Providing court ordered assessments for individuals convicted of crimes in a forensic hospital setting

Poster

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Abstract

Unit 3-7 of the Alberta hospital Edmonton is an intensive care program, provided in a maximum-security setting. Most patients admitted to the program are between the ages of 25-35 years with a history of violent behavior. In conjunction with the Criminal Justice System, clients are sent to our unit with court ordered assessments for the following:

- 1) Fitness to stand trial.
- 2) Criminal responsibility.
- 3) Degree of Dangerousness to the public.

Fitness for trial - legally a person cannot be prosecuted before a court of law if the individual does not understand the proceedings of the court and the role of its major players i.e. Judge, jury, defendant, crown prosecutor, etc. This assessment will determine if the individual is 'Fit' for trial or 'Unfit' for trial. If a patient is found to be fit for trial, they are returned to the criminal justice system to face sentencing. Individuals found to be unfit are kept in hospital indefinitely to receive treatment until eventual reintegration into the community can be achieved.

Criminal responsibility - this assessment will determine whether or not the individual at the time the offense was suffering from a mental disorder which led them to believe that their actions were not of a criminal nature. This assessment is more complex as it requires the assessment team to go back an indefinite period of time into the mindset of the individual, when the offense was committed. As in the case of fitness assessments, individuals found criminally responsible are returned to the criminal justice system and individuals found NCR (not criminally responsible) are treated in hospital.

Dangerous Offender assessments - In severe cases, the crown prosecution may make an application for finding a person to be a 'Dangerous Offender'. This can happen where an offender shows a pattern of persistent aggressive and repetitive behavior, showing failure to restrain his behavior with a likelihood of causing death or injury to persons. If this application is to succeed, an offender may be locked up indefinitely. This application must also accompany the testimony of two psychiatrists, thereby putting nursing staff on the frontline as contributors to the assessment. Dangerous offender assessments are often lengthy and upon completion, the offender can be returned to the criminal justice system. Due to the violent nature of the individuals involved in these assessments, nursing staff must constantly be aware of their surroundings and take diligence in ensuring their safety when interacting with these individuals. Clients have a wide range of mental impairments such as: schizophrenia, bipolar, antisocial personality, poly-substance abuse, drug induced psychosis, mental retardation, FAS, and pedophilia to name the more common. Charges can be very severe and of a brutal nature, i.e. 1st degree murder, manslaughter, kidnapping, sexual assault, aggravated assault.

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Virtue Ethics and the Relational Approach: Violence and the Response on Psychiatry Units

Paper

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Keywords:

Aggression, inpatient psychiatric units, virtue ethics, relational approach

This paper introduces an approach that draws upon both virtue ethics and an ecological framework to better understand the multiple influences on behavior in the inpatient psychiatric setting. Within this perspective, a relational approach is suggested as a primary virtue for psychiatric nursing with the focus for preventing, understanding, and intervening with violent behavior. In the psychiatric setting, virtue ethics is applied as a paradigm to create environments that foster the virtue of being therapeutic within relationships. An ecologic focus acknowledges the many layers that influence individual nurse-patient encounters including the local or unit, the organizational culture, and social influences (Bronfenbrenner, 2004). Inpatient psychiatric unit aggression has a negative effect in multiple interacting levels including patients, staff and the milieu. Both physical and emotional harm can result from violence (Menkel & Viitasara, 2002). Both patients and staff can feel demoralized, traumatized, angry and helpless after the occurrence of a violent event.

Health care professionals, especially inpatient psychiatric nurses are among those at highest risk of being engaged in a violent encounter at work. Mental disorder predisposes behavioral problems, often in the form of poorly controlled impulses. The therapeutic work of inpatient psychiatric nursing requires helping patients control their behavior through modeling, guidance, limit-setting, verbal interaction, and reduction of psychiatric symptoms in a therapeutically structured milieu. Violence and related antecedent behaviors, such as verbal and physical intimidation, present one of nursing's most challenging situations. Violence on inpatient units is influenced by the larger US culture which has among the developed world's highest rates of violent behavior, including homicide which is higher in 15 to 24 year olds than in any other country (Peden, World Health Organization, 2002).

Virtue ethics implies two related approaches, first is to seek ways to expand the virtues of individuals and second, to create environments, in this case, local and institutional cultures where the virtues can flourish. Virtuous action is the presence of both ethical rigor for intention as well as action. Factors leading to virtuous action include perception, moral development, integrity, and courage. Relational effectiveness is posited to be a primary virtue of psychiatric nurses on the assumption that influence is inherent in clinical relations, decisions are subjective, and factors relevant are continuous not dichotomous. A relational approach stands in contrast to an approach grounded only in human rights to justify clinical decision making in response to patient violence. Rights based decisions are characterized by a series of dichotomous decisions used to justify coercive treatment of violent or potentially violent patients but offer little guidance for gauging the ethical use of other lesser methods for influencing such patients. This difference in approach and suggestion of movement to a relational approach, more accurately reflects the human condition. For example not all individuals with particular risk factors for involvement in violent episodes actually end up in a violent interaction. There is a continuum of individual factors, behaviors, interactions, and contextual factors which are important to prevention and

intervention efforts, most of which fall short of actual use of force—whereas a rights based approach accounts only for the use of force. Similarly, there is a continuum of actions that might be taken in a high risk situation.

An ecological approach is used to organize the multiple levels of factors associated with the occurrence of violence in the psychiatric inpatient setting (Bronfenbrenner, 2004). There is not just one factor that leads to violent behavior on inpatient psychiatric units. Violence results from a multitude of factors, including individual patient factors, staff factors, the interaction between the patient and staff, as well as the interactions with the unit and organizational culture. Inpatient unit staff need to be aware of patient demographic factors such as patients who are younger in age and have a previous history of violence and assault are more likely to become violent (Flannery, 2006; Grassi et al., 2006). Patients with psychiatric problems such as schizophrenia and mania with active psychosis who may be responding to internal command hallucinations can be at higher risk for violent behavior due to the fact they may misinterpret communication or have command hallucinations to harm others that they respond to (Omerov et al., 2004; Mellesdal., 2003; Chou et al., 2002). Patients with substance abuse and personality disorders are also at more risk for being involved in a violent encounter (Flannery & Walker, 2001; Barlow et al, 2000). However knowledge of these risk factors alone has been available for many years, and does not by itself prevent violent events.

Staff factors and attitudes can contribute to violence on inpatient units. Researchers have found that demographic factors (Omerov et al., 2002), staff demoralization and job dissatisfaction (Morrison, 1998; Arnetz et al., 1996), greater external locus of control, and greater anxiety in staff members (Ray, 1998) predict increased violence. Units where staff did not develop therapeutic rapport or did not know the patients had more violent encounters (Carlsson et al., 2004). Less experienced nurses and nurses with greater authority were also at greater risk for violent interactions. Also, staff with less formal training in de-escalation procedures may be at greater risk for violent encounters (Owen et al., 1998).

Staff attitudes and behavior towards patients play a vital role in patient-staff interaction that decrease violence on inpatient units. Patient and staff power struggles were an emerging theme throughout the literature review as a precipitant of violent encounters (Chou et al., 2002; Secker et al., 2004). Specifically staff perceived as neglectful, confrontational or controlling with patients (Carlsson et al., 2004), asked too much of the patient, failed to keep appointments with patients (Finnema et al., 1994; Carlsson et al., 2004, 2006), and were hierarchical had more violent encounters with patients. Also, staff detachment or fear of patients resulted in more violent patient interactions (Carlsson et al., 2004; Spokes et al., 2002). Whereas staff who engaged the patients in early intervention, were psychologically available to patients, understood the patient's perspective, and demonstrated compassionate attitudes by listening, being respectful and comforting to patients resulted in fewer violent encounters (Johnson & Delaney, 2006; Carlsson et al., 2006).

Patients described staff that prevented violence as authentically relating to the patients (Carlsson et al., 2006; Johnson & Delaney 2006; Meehan, et al., 2006). Staff who managed their fear and remained involved with patients who were escalating had better outcomes (Carlsson et al., 2006, Olfsson, 2001). Respect for the patients boundaries and being observant of physical contact can decrease inpatient unit violence (Flannery, 2007). Each of these factors reflects the relational nature of violence.

Creation of unit culture that promotes meaningful and predictable activities and predictable staff are valued. Developmentally appropriate structure should include individualized treatment, including flexible unit rules for some patients as well as behavioral expectations and behavior management programs for younger patients (Dean et al., 2007) or patients with more severe

pathology who function more optimally with increased structure. Staff training in verbal de-escalation skills and excellent rapport with patients, separation of aggressive patients on the milieu, involvement of the patient in their treatment plan, positive unit leadership, increased staffing during times of increased admissions, and patient education are all factors identified to help decrease violence in the unit culture (Carmel & Hunter, 1990; Chou et al., 2002; Flannery et al., 1998). In addition Quintal (2002) suggests that nurses receive emotional support from the unit staff and management, including formalized support systems such as the Assaulted Staff Action Program (ASAP), developed by Flannery (2001). Quintal (2002) also recommends the development of violence workplace policies for reporting violent incidents, exploration of legal options for the victim and referrals for medical care and psychological support.

Unit cultural factors are also associated with violent encounters. Some of these factors include limited space and overcrowding or lack of privacy (Meehan, 2006; Chou et al., 2002). Lack of interesting ward activities (Meehan, 2006; Johnson & Delaney, 2006), shift changes, providing unwanted medications, changing medications without patient consent, the mix of patients, and making demands of patients or denying patients privileges can also cause patients to become agitated and can contribute to violence. Patients felt that restraint and seclusion escalated rather than decreased violence. Overall themes of unit culture that increased violence were forced patient compliance, denial of privileges, and loss of personal power and control (Foster et al., 2007; Chou et al., 2002). Unit culture plays a role in creating a climate that influences violence. Patients reported that unpredictable activities and staff (Katz et al., 1990; Olfsson, 2001), inflexible unit rules (Ilkiw et al., 2003) and staff that were unavailable emotionally or physically (Secker, 2004; Meehan, 2006) contributed to escalating situations of violence. Understaffing in the milieu and lack of teamwork among the staff can be problematic when patients become agitated and potentially violent (Bowers, 2007). A unit culture with unclear boundaries also appeared to be a precipitant of unit violence.

Important in considering unit culture is to understand how that culture, whose purpose is to meet the psychiatrically ill person's needs, responds to those needs. A reoccurring theme in the research was the presence of some need not being met. Areas of need that are clearly present in prior research include needs for: transition; structure; safety; autonomy; stimulation; and basic living needs. The need for transition included findings that shift change, high numbers of admission, time of day transitions and meal times were often times of greater violence. The need for structure included a need for predictability of schedule, rules, and roles, as well as this being thought of on a continuum rather than a dichotomy such that flexibility in structure was also possible. The need for safety recognizes that at times violence is prevented by having adequate staff to patient ratios, and the use of forced containment (seclusion and restraint) to prevent imminent harm. The need for autonomy was clear in the high rates of violence associated with restrictiveness, and denial of privileges and requests. The need for stimulation refers to difficulties present due to both lack of available activity and over stimulation. Finally the need for seriously ill persons to have assistance with basic functions such as meals, dressing and bathing were also times of higher risk of violence. How a particular context assists individuals in meeting their needs is important, and a relational approach within a virtue ethics approach offers a framework for preventing, understanding and intervening in violence.

This review of the literature on violence in the inpatient psychiatric setting identifies a multitude of factors important to violence prevention efforts. They include factors related to the patients as well as staff in inpatient settings, but knowledge of these factors alone is not enough. Violent events do not occur in a vacuum. Thus approaches that seek to identify only those at greatest risk often miss the point. A virtue ethics perspective moves away from focus on rules or principles that must be adhered to and refocuses on relational competence within a cultural context that fosters a value of relational ethics. Applying virtue ethics means creating environments that enhance the ability

to be therapeutic within relationships. The use of an ecologic approach in identifying the multi-factorial nature of how individuals interact within environments is important to understanding the context and to successful violence prevention and intervention. A perspective that incorporates the way a particular environmental context or culture responds to individual's needs has the potential to be a powerful point of intervention, and this perspective has not been adequately researched. An understanding of the interaction of individuals in a cultural and organizational context and of how to intervene using a relational approach to influence this context is an important area for future research and prevention efforts.

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What Is Workplace Bullying Supposed To Be? A case study based on court judgments

Paper

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Abstract

Background

A key question raised at previous conferences is what workplace bullying actually is. As research in this field is not yet based on generally accepted definitions or models, it is been suggested that focus at this stage should rather be placed on case studies (Rayner 2004). The main source of this kind so far tends to be anecdotal evidence from the victims, which contains a certain risk of bias.

Purpose and method

This paper aims to illustrate how the vaguely defined concept of harassment (or mobbing/bullying) is understood and modeled by a non-expert authority, which is expected to be neutral. Additionally it aims to suggest alternative approaches. This paper is based on text analyses of all judgments from the Norwegian Appeal Court in period 1994-2003 where “workplace harassment” is the main issue. Nine such cases were found. In seven of those the victims had in some way gained support from court or experts appointed by court. These are the source of the present analysis. The theoretical approach is based on the research field labeled “organisational behaviour” (Robbins 2005). (Results will be presented during session).

Conclusion

The Norwegian Working Environment Law of 1977 made employers liable for mental or physical damage caused by the workplace. Harassment (or mobbing) was especially added in legislation in 1995, but without a precise clarification of what can be construed as harassment. The present cases indicate that courts place little emphasis on defining harassment. However, their method of interpreting the phenomenon is reflected in how they evaluate the facts. The allegations related to “behaviour of the perpetrators” and “mental or physical damage inflicted” appear to be fragmented. Only those elements, which are considered as “relevant” and “proved”, are taken into consideration when the final correlation between harassment and damage is judged. Furthermore, these judgments only take the perpetrators’ specified actions against their targets into consideration. Other aspects of “organisational behaviour” - such as motives, behavioural patterns, machiavellianism, neuroticism, organisational culture/structure and likewise - seem to be ignored. This narrow way of proceeding is probably very disadvantageous to the sufferers who also bear the burden of proof. No known satisfactory formal definition has yet been drawn up. The problem here is that if it is too narrow, this could further reduce the victims’ rights.

Suggestions

So far the legal protection of workplace victims of harassment is primarily based on their rights to sue somebody for damages. These present examples indicate that their chances of winning are bad. As legal fees are high and compensation low, raising such a lawsuit is very risky. Thus the present legislation seems much too weak to be an incentive to counteract bullying in the workplace. Suggested improvements: 1. As legislative precision is missing, the interpretation of workplace harassment is left to the authorities. The present study confirms that such cases tend to be highly

subtle and intricate. Consequently applicable definitions for authoritative purposes may never be found. Thus this paper suggests that emphasis should rather be put on improving decision-makers' insight in how workplace harassment actually works. 2. Other concepts in legislation could be introduced as suggested by the ILO (Chappell & di Martino 2006). That is firstly "constructive dismissal", which implies the victims' right to raise additional claims. Secondly, there may be reason to regard cases, which include serious mental damage, as "violence" and thus open to public prosecution. Then the offenders would risk meeting a much stronger and more professional counterpart.

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Chapter 5 - Nature, epidemiology, patterns and trends of workplace violence

A study investigating the discrepancy between actual and reported incidents of violence and aggression perpetrated by service users against nursing staff in one NHS learning disability service

Paper

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Abstract

This poster presentation reports on research carried out within the Learning Disability Division of a major Mental Health NHS Trust in the North of England and relates to the violence and aggression directed towards staff by service users. It sought to identify the extent of the discrepancy between the actual and reported number of incidents of violence and aggression. A further aim of the research concerned the reasons given for such under-reporting, particularly whether these accorded with the literature.

The literature review demonstrated that violence is a particular issue for nurses, especially those working in the areas of mental health and learning disability services, where studies have indicated that as many as 1 in 5 may be affected. The population selected were nursing staff currently working with people with learning disabilities in a variety of NHS settings. These settings comprised respite, assessment & treatment, medium secure, residential and community areas of care. A questionnaire was subsequently distributed to all learning disability nurses currently employed in the Trust, a total of 411, with a response rate in excess of 40%.

The study revealed that a discrepancy does exist between actual and reported incidents of violence and aggression within the learning disability service. It also clearly differentiated between the reasons attributed to the prevalence of such under-reporting. It confirmed previous claims that the predominant difficulty is cultural, violence being regarded as part of the job and non-reporting primarily revolving around perceptions of incidents being considered 'minor', not worth the time to complete the paperwork.

The study concludes that more work is needed to achieve a united, consistent approach across the NHS, in order that a high quality, accessible service for people with learning disabilities and complex needs can be delivered without violence being considered an acceptable part of the job; it needs to be acknowledged, though, that the systems are already in place to achieve this, they need to be utilized more effectively. It also suggests that services should re-think the notion of 'minor', which is misleading at best, when applied to the issue of violence and aggression.

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Examination of Incidents of Workplace Verbal Abuse against Nurses

Poster

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Abstract

Purpose

The purpose of this research was to examine the incidents of verbal abuse faced by nurses in the workplace in the last year, by whom they were abused and what feelings they experienced after the abuse.

Design and sample

This research was planned as a descriptive study in Adana, Turkey Data were collected from 290 nurses who worked on various hospital wards and there was a 64.4% rate of participation.

Method

Data were collected using a questionnaire and analyzed using percentages and Chi square test.

Findings

The mean age of the nurses was 31.15 ± 5.57 years, all of the nurses were female. At the conclusion of the research it was found that the majority of nurses had faced verbal abuse in the last year (80.3%). The nurses with the highest percentage of verbal abuse experiences worked in the intensive care units (87.5%), The majority of the abuse came from patients' relatives (57.2%), and majority of the nurses responded with feelings of anger to the verbal abuse they faced (50.6%). After verbal abuse most (76.6%) stated, 'inspite of everything, I continued doing my job,' More than three fourths of the nurses (87.6%) indicated that the experience of verbal abuse negatively affected their morale, 91,0% that it caused emotional exhaustion, (68,3%) that it decreased their productivity, and 63,1% that it negatively affected their nursing care.

Conclusion

The findings from the research confirm the need for urgent and continually updated plans for dealing with workplace verbal abuse and that the principle of zero tolerance for verbal abuse should be adopted in Turkey and other countries.

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Experience of workplace violence during medical school in Nepal

Poster

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Keywords:

Health care workers; occupation; workplace violence

Abstract

Aims

To determine the type, extent and effects of workplace violence among graduate students during medical school.

Methods

During 4 years data, medical schools representing all geographical regions of Nepal. Random selected new students in the selected medical schools were asked to complete a semi-structured 'violence questionnaire' addressing the type (emotional, physical and sexual) and extent of violence experienced, the perpetrators of the violence and the victim's reactions to the experience during the time of early career.

Results

A total of 482 residents out of 431 completed the questionnaire. In all, 68% indicated they had experienced some form of workplace violence, 67% had experienced verbal violence, 16% had experienced physical violence and 3% had experienced sexual abuse violence. The victims' most prevalent reactions to violence included being deeply disturbed but feeling they had to cope with it for the sake of their career (39%), being distressed (26%) but considering that such events are common in all occupations and discounting it and being confused and bewildered and unsure how to respond (19%). The most frequently named perpetrators of verbal violence were relatives/friends of patients (36%) and academic staff (36%), followed by other students (21%), patients (20%), heads of department (13%) and non-medical hospital staff (6%).

Conclusions

Students new in medical schools in Nepal are subject to significant verbal, physical or sexual violence during the first year of programs. Precautions, psychosocial counseling to prevent such exposure are urgently needed.

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How violence at home impacts the workplace: Concerns for safety, financial security, and job attainment

Poster

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Abstract

Domestic Violence is a serious issue that impacts all areas of the victim's life. While much research has been done to examine the physical and psychological consequences of this issue, less attention has been paid to the effects of domestic violence on the work place.

This study examined the economic and employment effects of domestic violence in women participating in the SafeNet program of Hillsborough County Florida between October 2003 and March of 2008 (N=231). The Safenet program is designed to provide coordinated legal and social services for victims of domestic violence and their families through effective use of case management services. Data collection included measures of client goals and program outcomes in the domains of employment, finances, education, transportation, housing, childcare, child health, client health, and client safety. Data were collected via in person interview and mailed questionnaire at 3 time periods: program start, 6 months, and program completion.

Women in the program ranged in age from 18-7320(Mean age 36 + 9) and were predominately Caucasian (85%). Reported impacts of domestic violence on occupational health and safety were experienced by a large number of women in the program and included difficulties in obtaining employment (38%), difficulty maintaining present employment (20%), and problems securing adequate/higher pay (30%).

Difficulties securing employment included the need to hide from their abuser as a result of safety concerns, the need for child care once separated from abuser, abuse induced disability which impeded ability to get work, and positive criminal background checks as a result of involvement in domestic violence incidents.

Ability to feel safe in the work place, a large number of sick days due to injury, altercations with abuser at work, poor workplace performance due to heightened personal stress, and a need to work flexible hours as a result of concern for children's safety and mental health were reported as concerns for maintaining present work. Implications of these findings will be discussed in terms of policy and practice, and necessary workplace accommodations suggested for the health care sector.

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Mental Health in Prison Population: Israel Ambulatory Psychiatric Care

Poster

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Abstract

The number of prisoners in the Israeli correctional facilities stands on well over 24,000 inmates, in 28 different facilities. Amongst the inmates 10-15% needs the care of the legal psychiatry division. The population of psychiatric patients inside the prison walls is slightly different from the population on the outside. Cases of co-morbidity, personality disorders, sexual perversions, and mental disorders caused by difficulty to adapt to prison life – all are prevalent amongst inmates. In addition to that, the number of individuals suffering from mental disorders such as schizophrenia and bi-polar disorder is much higher inside the prisons than in the rest of society.

General care of inmates suffering from mental disorders is given by a multi professional team that includes psychiatrics, nurses, occupational therapists, social workers, clinical criminologists, psychologists, paramedics, education officers and occupation workers. Services given by the division of legal psychiatry include hospitalization services, ambulatory clinics where counseling is given to inmates according to prison location, risk assessment and following sex offenders law. Treating prisoners and detainee's serves without any shadow of a doubt a professional challenge for the caregivers, and yet not lacking risks. Those risks assemble mostly in verbal violence and threats, which characterize situations in which the prisoner 'disagrees' with neither decisions nor recommendations given by the caregivers. In extreme cases, the prisoner's behavior manifests itself as physical violence.

An important and significant reference to ambulatory clinics requires identification and treatment of prisoners who suffer from psychotic or major affective disorders, which might be of danger to themselves or their surroundings.

In the present survey we will present the population characteristics of the prisoners, which are required for ambulatory psychiatric intervention during their incarceration. The survey was conducted in one of the central and representative detention centers in Israel. In those detentions centers imprisoned on average of 650 detainees' of criminal nature simultaneously. All of them are men above 18 years of age, which are detained on the basis of varied criminal offenses, from murder and sex crimes to white collar and traffic violations.

In the process of the research, 92 prisoners were treated in a clinic, all men between the ages of 19 to 69, with an average age of 39.2(SD-11.1). 44 (47.8%) reported living with a spouse prior to their arrest, year range of education 4-16 averaging of 10 years of education. 42 (45.6%) prisoners reported having drug abuse and 32 (34.8%) reported alcohol abuse. 35 (38%) prisoners possess a background of self injury and suicide attempts.

The most common complaints were about sleep disorders, stress and mood swings, interventions relating to psychiatric medication balance, guidance and treating side effects of medication. In the course of the research 9 (9.8%) prisoners were diagnosed as suffering from psychotic or major affective disorders which required treatment by means of hospital admission.

The number of prisoners and detainees in Israel hold an increased orientation. It is of utmost importance to be familiar with the characteristics of the prisoner and detainee population, to be able to identify its unique needs in order to conduct effective assistance of a high standard.

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Mental health staff perceptions of safety in the work environment

Paper, Poster

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The Department of Psychiatry at the University of Rochester's clinical services consists of a large acute hospital, two partial programs, and a large clinic with numerous subspecialties, a full psychiatric emergency department, and a mobile crisis team. Our Department of Psychiatry Inpatient and Outpatient Services has the highest number (84) of workplace violence incidents per year among sixty-one hospital subdivisions evaluated at the University of Rochester Medical Center. The next highest ranking division was the Medical/Surgical Emergency Department at 42.

Objective

Due to the incidence of violent events in the Department of Psychiatry a Workplace Violence Committee of clinicians, security personnel, administrators, and educators was convened to develop strategies to address the problem.

Methods

Based on multidisciplinary input, a workplace violence survey instrument was designed that queried basic demographic information of age, sex, discipline, years in the field, treatment setting etc., Payroll and Employee Records was able to provide the names and intramural addresses of all employees in the Department of Psychiatry. Mailing Services sent the survey in a large envelope, enclosed with a self-addressed return envelope with no markings to delineate the source of the returned survey, for confidentiality. Definitions used in the survey:

- A Threat is an expression of intent to inflict pain, injury, or other harm. The expression may be verbal or non verbal. The threat of harm may be explicit or implied.
- An Assault is a physical contact that results in injury. The injury may be major or minor: e.g. mild soreness, scratches or bruises would be included.
- A weapon is any inanimate object used in a threatening manner or to inflict harm.

The frequency of experiences of feeling in danger, or having had threats or assaults was assessed. The tendency to press charges when threatened or assaulted as a function of whether the perpetrator is the patient, friend, relative etc, was ascertained as were other items more internally useful, but not presented here. Survey response data was entered in database using SAS for data analysis, Programs to analyze results were written by our senior data analyst, with statistical interpretation by our biostatistician.

To compare the distributions of events reported in the four time periods, we fitted a Poisson regression model to the data from all people surveyed in this study within a clustered data setting. The four clusters, one for each time period, were created by the fact that each individual surveyed could report multiple events in any of the time periods, resulting in correlated responses.

We introduced a normal latent variable to account for the correlations among the responses across the four time periods. Linear contrasts were used to test for difference in mean response across the four time periods as well as for differences between any two of the time periods. The Poisson regression was implemented in SAS using Proc NLMIXED.

Results

Out of 742 surveys sent out to all members of the Department of Psychiatry at the University of Rochester Medical Center, 380 were returned response rate of 51.2 %. Threats of physical harm occurred in 163 (42.89% of) respondents (56.58 % of clinicians, 14.29 % of non clinicians). 73.24 % of the time a patient was the source of the threat, with a weapon used 11.27 % of the time. Assaults occurred in 94 (24.74 % of) respondents (30.42 % of clinicians, and 7.55 % of non clinicians). 91.49 % of the time the assaults came from a patient, a weapon used 5.32 % of the time. Violent events have been increasing. In the last twelve months period of time surveyed, experience did have a protective effect from experiencing threats or assaults; however experienced clinicians still were threatened and assaulted. Among clinicians surveyed, 30.42 % have experienced being assaulted at work, as have 7.55 % of the non-clinicians. MD's RN's and Advanced Practice Nurses (APN's) were threatened and assaulted out of proportion to their respondent distribution. In looking at violent events in the last twelve months, the projection of violent events (threats and assaults) expected to occur in the 5 year interval 2002-2006, was calculated to be significantly increased over the period of the previous 5 year interval. In the Non-Clinical group, inpatient and outpatient secretaries (who have patient contact) appeared to have more assaults than their representative distribution in the survey sample.

In fifty percent of the events, no report at all was filed, and in only 16.3 % of the incidents had a police report been filed. Of the 30 police reports filed, 7 lead to incarceration, 4 released, 3 psychiatric hospitalizations, 5 an order of protection, and in 14 (46.7 % of the time) staff did not pursue charges. Eleven of those pressing charges had difficulties in the following areas: communication with the DA's office or police department, lack of institutional support and other responses. Forty-one respondents considered pressing charges but did not for the following reasons: fear of retribution, fear of disapproval of other staff or administration, not know they could do so, too injured, fear of complexity of the legal system, not think assailant responsible, not enough time to pursue, believed futile; or not believe the legal system would follow through, as well as others.

Discussion

This survey was able to uncover a number of surprising facts of the frequency of threat and assault experiences among staff in a psychiatric work setting. We have come to realize that both non clinicians and clinicians are at risk, and we plan to increase team (clinicians + non clinicians) interaction to help awareness and enhance communication. Our hope is that such team interaction would reduce future violent events in a population that appears to be increasingly violent. We have rolled out two training sessions on Personal Safety Training thus far in our Adult Ambulatory Psychiatry division, with feedback from those who took the course that it was helpful and should be regularly taught. This curriculum was designed by our local experts in combination with OSHA recommendations. Ambulatory Division was chosen as the first division to pilot this program as 1) patients walk in off the street, without the same availability of mutual staff support that occurs in emergency room or inpatient settings and 2) second to the ED staff, they have the least sense of safety at work. We also plan to do a follow up survey on the staff in the Ambulatory Division to see if our interventions may impact sense of safety and reduce patient complaints and turnover of staff. Post event interventions have been standardized to better assist staff victims and the administration attempting to help them

navigate through the complexities of intramural and extramural agencies that become involved, with this unfortunately increasing common problem.

Despite prevention efforts, incidents of threats or assaults will occur. Steps are also being taken to standardize post event protocols for immediate relief of duty of the staff victim as well as assistance with interaction with police, legal affairs, Security and the District Attorney's office, Security and Police, as well as Employee Assistance, Health Services and Worker's Compensation issues. As resources diminish, State Hospitals close, substance abuse more prevalent, health care workers are experiencing increasingly acute patients in the setting of continued staff cutbacks to care for them.

Conclusion

Violent Events towards staff are increasing in our Psychiatric population, and appear to predominate in RN's APN's and MD's, (predicted by increased exposure). However certain non-clinical patient contact groups are also at risk. Work experience alone does protect staff from experiencing threats or assaults; however experienced clinicians still experience threats and assaults. The need for Personal Safety Training of both clinicians and non-clinicians was uncovered by means of this survey. As a result of the findings of this survey, personal safety training and de-escalation techniques for clinicians and non clinician support staff has been deemed to be a critical missing element for staff doing work with patients in Psychiatry. We are in the process of designing and implementing a program that would develop a comprehensive Personal Safety Training Curriculum, based on local experts existing educational programs and OSHA recommendations, but with specific training models for clinicians, and non clinicians. Standardization of post event protocols is appropriate, as violent events towards staff are unfortunately on the rise. Violent incidents when they occur need to be systematically and routinely dealt with for better support to staff and with resultant smoother operations of the entire psychiatric system of care.

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Mobbing Behaviors Encountered by Academic Staff in University and their Responses to them

Paper

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Keywords:

mobbing, academic staff, work abuse, workplace trauma, physiological stress response

Introduction

Mobbing defined as antagonistic behaviors with unethical communication directed systematically at one individual by one or more individuals in the workplace. The mobbing process begins by attacking the honor, honesty, reliability and professional ability of an employee. Then mobbing victims are exposed to attitudes and behaviors that can be the cause of psychological violence such as frightening, exasperating, excluding, putting parentheses around, belittling, being excluded from some organization resources, isolating, injustice in the use of organizational resources, delaying or interfering with benefiting from rights (Einarsen, 2000; Cowie et al. 2002 ; Leymann, 1990). These behaviors can be done to the individual by the facility manager, supervisors, co-workers in the same position or subordinates (Leymann, 1996; Einarsen, 2000; Fox & Stalloworth, 2004). Psychological violence that continues for a long period of time has negative psychological, physiological and social effects on the victim (Salin 2003, Björkqvist 2001, Einarsen 2000). It has been reported in the literature that individuals who are exposed to long-term and continuous mobbing in the work place have decreased self-respect (Randle 2003, Einarsen 2000), and experience anxiety, depression and aggression (Quine 1999).

The common point shared in the results of international studies is that there are more mobbing victims than victims of other violence and harassment (Chappell & Di Martino 1999). Mobbing behaviors that are present in almost every academic area in different dimensions but that are not discussed out loud create the foundation of our study in closing the gap. This cross-sectional and descriptive study was conducted to determine the psychological stress that is experienced by academic personnel at universities in Turkey and to determine its emotional, social, physiologic and organizational effect on the personnel.

Method

Participants

Because of the sensitive nature of the topic related to work and being exposed to mobbing behaviors themselves, research data were collected from personnel using the internet, as done by Stebbing et al. (2004) and Fox and Stallworth (2005). The survey with the research questions was published as a link on a website. In addition an e-mail was sent to 3,800 personnel who are members of the site about the study. Individuals who did not respond after three weeks were sent another e-mail to remind them. The internet site that was used (www.forumakademi.com) is only used by academic personnel who work in Turkey of whom the majority are members, and is a site where academic questions and requests are discussed. To prevent the participants from sending in a second survey an electronic code was used. On the data collection tool the participants were explained the purpose of the study, informed that participation was completely voluntary, and

that data would only be used for research purposes and kept completely confidential, and the participants were told not to write their name, institution or city on the survey. Research data were collected between April and June 2006. The answers from a total of 606 individuals were evaluated for appropriate to research criteria, incompletely or incorrectly completed forms were eliminated which left the answers from 580 individuals included in the research. A four-part questionnaire was used in the data collection. In the first section the participants' demographic information was requested (gender, age, education, academic title, experience and area of specialty). In the second section the participants were asked about mobbing behaviors (Dilek & Aytolan 2008), in the third section about the emotional, physiologic and organization behaviors they experienced in response to mobbing, and in the fourth section about what the participants did to escape from mobbing.

Results

The gender distribution of the national university academic personnel in our study was 307 women (53%) and 273 men (47%), their mean age was 35.34 ± 7.89 (min:20, max: 62) years, the mean number of years of employment was 8.20 ± 6.65 years. The majority of the participants had a doctoral degree (64%) and was employed as research assistants (43%). Many of the participants (70%) worked in the health care field (37% at a medical faculty, 30% at a university nursing school, 3% as physiotherapists, pharmacists and dieticians), and the remaining 30% worked in various departments including engineering, agriculture, history, literature, business, mathematics, religion.

Mobbing Behaviors

The most frequent mobbing behavior to be experienced by the participants was "To have untrue things said about you" (65%). In response to the question of from whom they experienced this behavior the most, 47% of the participants reported that it can from their supervisors, 46% from their own co-workers. The second most frequently experienced mobbing behavior was "To talk about you in a degrading manner in front of others" (62%). Majority of this behavior came from supervisors by 73% of the participants. The third most frequently experienced mobbing behavior was "To have decisions and recommendations that you made criticized and rejected" (61%). This behavior primarily came from supervisors (81%). The percentage of academic staff who stated that they had never or almost never been exposed to mobbing in the last 12 months was 27% and the percentage for academic staff directly exposed to mobbing was 17%. There was no statistically significant difference between the women (Mean: 0.69 ± 0.72) and men (Mean: 0.61 ± 0.66) for being exposed to mobbing behaviors ($t: -1.499$, $p > 0.05$). In addition there was no statistically significant difference found according to educational level ($F: 0.95$; $p > 0.05$), title ($F: 1.01$; $p > 0.05$), or work area ($F: 1.069$; $p > 0.05$) for being exposed to mobbing behaviors in the multiple comparison analysis (ANOVA).

Response to Mobbing

The responses given by academic personnel participating in the research to mobbing behaviors frequently had psychosocial content. It can be seen that they felt tired and stressed (74%), replayed and relived the behavior over and over (71%), did not trust anyone at work (65%), and were negatively affected in their lives outside of work (their marriage and family) (64%). Other responses that were frequently experienced included having a headache (63%), feeling less attached to work (61%), having difficulty concentrating on a job (58%), feeling like they were betrayed (52%), experiencing conflict with co-workers at work (52%), sometimes thinking about taking revenge on the person who showed this behavior, (50%) and thinking that they are depressed (49%).

What did you do to escape mobbing?

The most frequent response given by academic personnel to escape from mobbing behaviors was "I am working harder and better organized" (78%) and "I am being a lot more careful with my

work to avoid criticism” (76%). In addition the academic staff used methods of resolution for the injustice they faced by talking face to face with the person (66%) and reporting the negative behaviors to their superiors (51%). In addition half of the participants seriously considered resigning from the institution and 32% thought about changing their work area within the institution. Only 7% (41 people) of the participants reported that they occasionally think about committing suicide because of the mobbing behaviors.

Discussion

It has been reported in the literature that some professional groups in the academic world are at risk for violence in the workplace (Leymann 1992; Chappell & Di Martino 1999). A significant percentage (90%) of the academic personnel in this study had encountered mobbing behaviors one or more times in the last 12 months and 17% of the participants had been directly exposed to mobbing, the majority of which came from their own supervisors. The presence and frequency of mobbing behaviors encountered in the academic area, is an indicator, unfortunately, of the lack of awareness that the most valuable resource in institutions are their human resources. The findings in our research show that, no matter what your gender, title or educational level, that in every academic work area you may face mobbing behavior. It is very important for both employees and institutions to prevent these destructive behaviors, that can be seen in every workplace in the world and that are carried out, sometimes violently, sometimes with special tactics. In recent years in many countries there have been both legal and institutional efforts to prevent mobbing that is experienced in the workplace and in treating its victims. However in our country even though mobbing is widespread in the work environment and continues as an unnamed battle, there are no legal and institutional foundations on the subject of workplace mobbing and very little research has been conducted.

Because workplace psychological violence has a negative effect on both the employees and on the institution it is an undesirable situation. To be able to eliminate and prevent workplace psychological violence it is important for it to first be well defined. If a situation is perceived or a complaint is received about workplace bullying being experienced the manager can make a good diagnosis of this situation, can determine the factors causing the psychological violence in the workplace and the people involved, the problem can be well analyzed and an appropriate solution can accordingly be recommended. In addition as a result of possible solutions who will experience what and loss of power also needed to be evaluated.

To prevent the development of psychologically violent behaviors in the workplace it is recommended that workers be made aware of psychologically violent behaviors in the workplace, that an atmosphere be created in which a bully and victim are always noticed in the workplace, that places to register complaints about workplace bullying and receive support be created in the workplace, that institutional practices be made humanitarian, the workers’ job satisfaction be checked regularly, and that organizational sensitivity be shown in situations where there is any misunderstanding between individuals or groups to prevent the problem from growing.

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New Emergency Nurses Descriptions of Transitioning to an Experienced Emergency Nurse: The Impact of Workplace Factors

Paper

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Abstract

Introduction

Currently there is a shortage of emergency nurses and the problem is likely to expand if new nurses are not retained. The workplace environment may play a key role in the experience of violence, job satisfaction and subsequent retention of nurses. The purpose of this study was to describe the experiences of new emergency nurses and the intent to leave their current position.

Design

The analytical, qualitative research approach of interpretive description was used.

Setting/Sample: Using theoretical sampling, eight new emergency nurses were recruited from British Columbia, Canada. They had completed the core courses of an emergency specialty program and had three years or less of emergency nursing experience in community and urban emergency departments.

Methodology

Ten in-depth, semi structured, audio taped, face-to-face interviews were conducted with the nurses. Two participants were interviewed twice to further explore, verify, and check emerging themes.

Results

All of the new emergency nurses felt overwhelmed and unprepared as they started their practice. Hospital overcrowding created an environment where the nurses experienced occupational stress, mental and physical fatigue, and abuse from patients, their families, and emergency personnel. Participants described the need to endure the abuse and that they could not change the situation. All the nurses described experiencing horizontal violence from nursing colleagues. Examples of the horizontal violence behaviours that the participants described included: bullying; being tested to see if they'd fail; having people refuse to help when they were busy; having people "impose their ideas" even when these weren't consulted; having people embarrass them in front of others; the questioning or undermining of their decisions; or people not speaking to them. They described working in an environment which consisted of fear and intimidation and that they were not comfortable confronting their colleagues. Six of the eight nurses anticipated leaving the emergency department or changing their status in a year. These changes included: working in a different hospital, becoming a charge nurse, going on maternity leave, practicing in another area of nursing, or leaving the nursing profession.

Conclusions

It is imperative that governments, health care institutions, and nursing organizations develop initiatives to retain emergency nurses. The impact of hospital overcrowding on the nurses' experience of violence needs further exploration. Creative initiatives to assist nurses in coping

with workplace violence, to address workplace violence and to feel empowered must be explored. A brief overview of some preliminary initiatives undertaken to address workplace violence, developed from a workplace violence study the presenter is currently engaged in, will be introduced and audience discussion invited.

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Nurses Association of Botswana (NAB): The Extent and Impact of Workplace Violence in the Health Sector in Botswana

Paper

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Abstract

Very limited evidence on workplace violence in the health sector in Botswana is available. No research in this field has been carried out. However, several reports of incidences of workplace related violence have reached the offices of the Nurses Association of Botswana (NAB), including violence between health workers and health workers and their clients. As part of a three year Workplace Violence Project (WVP), NAB has implemented a research project to determine the perceived risk, nature, incidence and impact of workplace violence in the health sector. Results of the study will be used to guide the WVP in the implementation of risk reduction strategies.

The research protocol, instruments, methods and sample design were adapted from the ILO/ICN/WHO/PSI (2003) documents on Workplace Violence in the Health Sector. The study used an explorative and descriptive design. Sampling, done by convenience, was limited to the districts where the WVP team members are working, but covered most parts of the country representing all existing type of health facilities and different cadres of health workers.

A total of 836 questionnaires were collected. Currently, data of 243 questionnaires have been entered. Preliminary outcomes indicate that the majority of respondents were nurses (58%) and female (68%). More than 90% indicated that violence was of concern and that they are worried about it; and 80% of respondents perceive their place of work as not being safe or secure. In the last 12 months preceding the research, 80% had experienced some form of workplace violence, of whom 42% more than three times. Of those who had experienced violence, 8% was given time off from work and 56% indicated that the violence could have been prevented. The majority of incidences of violence reported are verbal abuse (53%), followed by threats (16%), physical abuse (13%) and various others (18%). Of the reported violence, 78% took place during the day shift and 30% of the violated health workers did not report incidences. The highest ranking in terms of most identified risk factors include: Shortage of staff, shortage of equipment, lack of security staff, long waiting time at facilities and dissatisfaction with services provided. Only 5% of respondents indicated that policies and procedures regarding workplace violence were in place.

Preliminary conclusions indicate that workplace violence is much more common in Botswana's health facilities than previously anticipated. It has often been seen as a normal occurring component of the provision of health services. Both health workers and the public engage in violence. So far, little has been done in the country to address workplace violence and cases are rarely followed up. Open ended questions have not yet been analyzed. Final data and recommendations will be provided at the conference.

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Nursing Student Abuse: What do we know?

Paper

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Abstract

Workplace abuse in the health sector is on the rise (International Council of Nurses (ICN), 2000) and sustained exposure to abusive behaviours has serious physical and psychological consequences (MacIntosh, 2005). The literature on workplace abuse has grown in the last decade, yet nursing students' experiences with abuse have remained virtually invisible. While nursing associations such as the ICN (2000), the Canadian Nurses Association (CNA), (1996), and provincial nursing associations have position statements on abuse that advocate strongly for "zero tolerance" in the workplace, reports of abuse against nurses and nursing students continue, seemingly unchecked. Internationally, Celik and Bayraktar's (2004) study of nursing student abuse in Turkey, Bronner, Peretz, and Ehrenfeld's (2003) study of sexual harassment of nurses and nursing students in Israel, and Randle's (2003) three year study of bullying among nursing students in the United Kingdom (UK), are notable exceptions. Apart from Theriault, Landry, Merritt-Gray, McLean, and Erickson's (1999) exploratory research project conducted by nursing students exploring Canadian nursing students' perceptions and experiences with abuse in schools of nursing across the country, no Canadian research on this troubling phenomenon has been reported.

We formed a research team to study this issue in three Canadian provinces, sparked by actions of professional bodies in Ontario. Our team proposes research to moves beyond describing experiences of workplace abuse by delivering evidence to support fundamental changes in workplace cultures within healthcare work and learning sectors and to develop and implement appropriate strategies for promoting healthier workplaces. The purpose of this research is to explore the nature and consequences of abuse experienced by Canadian nursing students and to explore their constructed meaning of, and responses to, those abusive experiences. The research will focus on psychological or emotional abuse which involves "the intentional use of power, including threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, or social development" (ICN, 2003, p. 3). We will use interviews and focus groups with nursing students to gather data. From interpretative data analyses, we hope to uncover systemic factors that support, contribute to, and reproduce abusive behaviours towards nursing students in clinical and educational settings, identify those factors which mitigate against such behaviours, and address prevention and intervention strategies to "break the cycle of abuse" so deeply embedded in the nursing profession.

In this presentation, we discuss the current relevant literature on nursing student abuse and we place it in the context of the more general area of workplace abuse in health care. We discuss the nature of nursing student abuse, its impact on students and the profession of nursing in general, and how our proposed work will contribute to the transformation of nursing education curricula, form the basis for research-based policies for challenging harmful workplace cultures, and guide educational programs to manage abuse effectively in the workplace.

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Occupational Violence in Mental Health Nursing an Australian Perspective

Paper

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Abstract

A Victorian based Mental health service was studied to ascertain the prevalence of occupational assault against nurses in both the inpatient and community settings. The results of the study assisted in developing strategies to minimise the occurrence of occupational assault and more importantly, its impact for nursing staff. A survey methodology was used with all nurses employed within the service invited to participate. A 70% response rate was achieved. High levels of Occupational Violence against nurses overall and in the past year, under reporting of incidents and high levels of staff fear are all prominent findings of this study. The results indicated that there needed to be a total review of all policy relating to occupational violence with special focus given to the results of this study. The areas of risk management, training, sanctioning and incident reporting along with staff culture were deemed important to address. Universally adopting a zero tolerance approach to occupational violence suggests that it is far from being part of the job. Further, management should consider a comprehensive orientation package that informs patients and their significant others about the role of the treating team. Communicating adequately with patients and their significant others is needed to clarify expectations and to avoid frustrations of and angry outbursts.

This research paper was published in the Feb 2008 edition of the International Journal of Mental Health Nursing as a feature article and was titled 'Occupational violence and assault in mental health nursing: A scoping project for a Victorian Mental Health Service.

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Patient aggression in mental health care settings: Staff and patient perspectives on causes and management

Paper

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Abstract

Introduction

Aggression directed toward health care workers is frequently studied during the last decades, still the occurrence of aggression and violence in the psychiatric inpatient population is reported to be on an increase and little seems to be achieved in reducing the scale of the problem (Whittington, 2000). According to Meehan (2006), research has shown several interpersonal and environmental factors associated with aggressive behaviour, the majority of these studies are based on quantitative methodology and the focus has been on the staff's perceptions and reactions to aggressive behaviour. Most of the qualitative interview studies have also focused on the views of staff (Duxbury, 2005). The patient perspective on the cause and management of aggression is rarely emphasized, and patients have up to now usually been the objects of research rather than participants (Duxbury, 2002; Whittington, 2000). According to a recent literature review on violence and aggression among psychiatric inpatients, future research needs to focus on the interactive variables between staff, patient and environment in order to deepen the understanding of how and why aggression occur and the effects of preventive interventions (Woods, 2007).

Objective

The aims of the study will be two folded. Firstly, to examine to which the extent there are differences in the views of patients and staff about causes and management of patient aggression in various mental health inpatient settings. Secondly, to explore how patients and staff conceptualize aggressive behaviour and how they experience and explain patient aggression.

Method

Participants: The sample will be comprised of all patients and nursing staff from a selection of forensic and acute wards in Norway. A representative sub-sample of participants will be asked to participate in qualitative semi-structured interviews.

Data collection

Data will be collected by using the Management of Aggression and Violent Attitude Scale (MAVAS), developed by Duxbury (2003). MAVAS is a 27 item self-report questionnaire with statements about causes and management of patient violence and aggression. The scale has four sub-scales, three reflecting explanatory models for aggression (situational, external and internal) and one reflecting views about management approaches. The reliability of the MAVAS was .89 and the item loading on the four subscales was $\geq .80$, which demonstrates acceptable construct validity (Jansen, 2005; Duxbury, 2005; 2003). The reliability of MAVAS for the Norwegian population will be determined through a test-retest procedure in a pilot test toward staff and patients. In order to get the best possible response rate, the postal method of enquiry will be chosen for staff and one-to-one delivery through staff for patients. The questionnaire will be

linguistically validated by a process through translation into Norwegian and back translation. A subsample of the respondents will be asked to participate in semi-structured interviews, and the responses given in MAVAS will be further explored.

Results

Data will be collected during Spring/Summer 2008; preliminary results will be presented and discussed.

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Patient and visitor aggression toward health care staff in nursing home and general hospital settings: An Austrian study about healthcare staff perceptions and attitudes regarding aggressive behavior

Paper

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Keywords:

health care workers, aggression, violence, general hospital, nursing home

Abstract

Introduction

Aggression towards health care staff has become the focus of the management in the Vienna hospital group over recent years in an attempt to change attitudes and responses to such aggression and violence. The problem of aggression towards health care workers has been a subject of research, although much of the existing evidence relates only psychiatric settings. Patient aggression is a long-standing problem in nursing (Hansen 1996) especially in psychiatric nursing, in accident and emergency nursing, and in the care of the elderly. Research on physical injuries inflicted on health care staff by patients is common. The NEXT study conducted by the EU revealed that 22% of the nurses reported exposure to frequent violent events from patients or relatives. Rates range from 9% (Norway) to 39% (France). Nurses exposed to aggression show symptoms of posttraumatic stress disorder, higher levels of burnout and reported more intentions to either leave nursing or change their employer. In Austria we had no data of the occurrence and the perception of aggression in nursing homes and general hospitals.

Aim

The aim of this study was to identify and categorize differences in the perception of patient aggression and aggression among health care workers in nursing homes, general hospitals and the different areas (emergency, surgery, psychiatry etc.).

Methods

The study was conducted in nursing homes and general hospitals in Vienna, Austria from November 2006 till March 2007. Nurses (registered Nurses, nursing aids and nursing students), physician, therapists and social workers answered to a questionnaire form. A retrospective survey was conducted to investigate the experiences of aggression in the preceding 12 months. Data were also gathered by the POPAS - Perception of Prevalence of Aggression Scale (developed by Oud, 1997, 2001; Nijman, Bowers, Oud, & Jansen 2005). This questionnaire was developed to assist in identifying the frequency with which health care workers experience aggressive or violent behaviors in the course of their work in the preceding 12 months. There are 16 questions to be completed in total. The POPAS rates experiences with 15 types of aggressive behavior, namely: verbal aggression, threatening verbal aggression, humiliating aggressive behavior, provocative aggressive behavior, passive aggressive behavior, threatening physical aggression, destructive

aggressive behavior, mild physical violence, severe physical violence, mild violence against self, severe violence against self, suicide attempts, completed suicides, sexual intimidation/harassment, and sexual assault/rape. Approval was given by the Ethics Committee of the Vienna hospital group.

Results

A total of 3991 healthcare workers from the different areas of nursing homes and general hospitals responded to the questionnaire (59,4% response rate). Workers on emergency wards carry the highest risk for aggression (95% assaulted, 70% attacked). Even Management has experienced aggression and violence by patients and visitors (29%). Sexual harassment was highest in the nursing student group (13%).

Discussion and relevance to clinical practice: Institutional averages actually obscure the much higher levels of aggression experience by the health care workers in particular departments. This study helps to localize the problem and identify persons with the highest risk. POPAS is also applicable in general hospital and nursing home setting. However, research is needed on the etiology of aggression and on vulnerability factors associated with victimization.

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Physical Violence Against Health Care Providers at Jordanian Hospital

Poster and Paper

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Abstract

One could ask the question, of how it is possible that the hospital, a place of skilled care and compassion, can also be a home to physical violence and abuse against the health care providers. Work place violence is one of the major problems facing health care providers with global and international dimension. This problem is more acute among developing countries.

According to the Jordanian policy authority and news media forty five incidents of physical abuse and violence were reported against doctors and nursing in the last six months. Of those, 26 cases were against nurses, and the other 19 incidents were reported against doctors. Knives, weapons, and physical assault were used by patients and their families against nurses and doctors. At least 16 of these cases required admission to the hospital whereas two cases required admission to the ICU.

The purpose of this study is to describe and investigate the causes of this unhealthy phenomenon of physical violence against health care worker at the Jordanian hospital, and to find out its impact on nurses and doctors moral, productivity, quality of work, turnover, retention, and sense of safety.

Furthermore, this study will provide specific recommendations to the Jordanian authorities, hospital and health care providers on how to reduce the incidence of physical, verbal, and emotional violence and abuse against health care worker in order to provide a safe working environment.

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Positive working environment: Violence against nurses in Turkey

Paper

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Abstract

There are ongoing discussions indicating that violence against healthcare workers, especially nurses, is increasing. According to Nova Scotia Association of Health Organizations, violence is defined as any behaviour that results in injury whether real or perceived by an individual, including but not limited to verbal abuse, threats of physical harm, physical harm and sexual harassment. Among health personnel, nursing staff are often at the most risk of all kinds of violence. Nurses act as the 'public face' and 'intermediaries' of the hospital, between patients and desk staff, technicians and doctors. They, especially in the emergency rooms, are usually the first persons that patients and their families meet. Therefore, nurses are often blamed for late or inadequate health services as most patients are afraid that a physician may refuse to care for and treat them properly if they blame the doctors. In effect, nurses become the scapegoat. In addition, nursing has long been viewed as an acceptable profession for women because it has been traditionally associated with feminine qualities, such as care giving, warmth, and empathy. This image might result in nurses being particularly vulnerable to violence.

In the studies, the prevalence verbal and physical abuse reported by nurses in Turkey was found to be high. The available studies on sexual harassment among nurses in Turkey have indicated different findings about sexual harassment. These studies on sexual harassment against nurses have reported wide prevalence rates ranging from 37% to 72%. In addition, the largest proportion of less serious events goes unreported. There are many reasons of under-reporting violence behaviours in different studies.

Investigators in Turkey found that the most frequent sources of violence against nurses were patients, patients' family members, visitors, physicians, other healthcare personnel and even other nurses. When all the sources of violence are considered, physicians and patients are discussed or found as the most important sources of violence.

The negative effects of violence behaviours in Turkey were found as follows: 1) The nurse was affected their mental and physical health negatively. 2) The nurse decided to relocate within a facility or to another healthcare facility, or to leave nursing altogether. 3) Working life included decreased work time, decreased productivity, increased medical cost, decreased job performance and job satisfaction, difficulty returning to work, changes in relationships with co-workers.

Investigators found that the most frequent coping methods of nurses experienced violence were "did nothing" or "report abuse to a manager" or "pretended not to see the violence." The necessary attempts that should be taken to protect the nurses against abusers and to decrease the negative effects of violence behaviours on the nurses might be as follows:

- Hospital-wide administrative measures should be developed to discourage the abusers from showing violence behaviours.
- Hospital and nurse administrators should provide clear policies and procedures regarding violence.
- Nurses should know their rights, including regulations prohibiting violence, the established procedures for reporting violence.

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Preparing the Future Nursing Workforce: A 4-Year Study Examining Stressors and Nursing Student Stress

Poster

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Abstract

The current nursing shortage challenges nursing schools and the nursing profession to examine potential stressors that impact retention and attrition of students and practicing nurses. The main objective of this repeated measures 4-year study is to identify the type, extent, and temporal sequencing of various stressors, such as depression and verbal abuse, associated with nursing student academic success (Years 1 & 2) and then transition into professional practice (Years 3 & 4). In the fall of 2006, baccalaureate junior nursing students (N=132) were recruited from 2 separate campuses to participate in this longitudinal cohort study. Research participants have completed 5 interviews as of May 2008: 1st 2 weeks of the program, and then at the end of each of the 4 semesters. Preliminary results indicate upon entry into nursing school (Fall 2006), 24% of the students reported experiencing verbal abuse during their preparation to become a nurse. The abuser tended to be male (74%) and the top 3 sources of the abuse were: peer/classmate (32%), non-nursing professor (29%), and a school staff member (23%). By the end of the first year of nursing school (May 2007), 15% of the students reported verbal abuse. The abuser tended to be female (72%) and the top 3 sources of the abuse were: nursing professor (44%), peer/classmate (22%), and intimate partner (17%). This study is significant to nursing as it will follow a cohort of baccalaureate nursing students, from the beginning of their nursing program into professional practice and will examine verbal abuse and then workplace violence. Results will assist nursing education to develop programs that address verbal abuse and violence and its impact on students and professionals.

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Psychological Violence and Nursing

Poster

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Abstract

Nursing, due to the specificities of its activities and due to the target subjects of care, is an occupation subject to professional risks. Psychological violence at work is one of the identified stressors, with significant consequences upon the nurse's quality of life, upon his / her family, upon the organizations and upon societies. Nurses represents a type of population that fits well into the types of places where this phenomenon is seen, namely in those institutions where there are large numbers of workers and where there are underlying interpersonal relationships.

The Nurse, socially recognized for his / her role, with expectations, privileges and responsibilities, is also a person, with feelings and with emotions, which are not just restricted to those at work. The nurse is simultaneously, a professional from whom one expects help, but is also someone who may become vulnerable.

The growing scale of psychological violence at work, at worldwide level, and the little investment on this topic which has been made in Portugal, encouraged us to carry out this research which is part of the PhD Nursing Program, and which, among others, has the purpose of identifying the presence, or not, of psychological violence at work in nursing and the relationship between psycho-social variables and the presence, or not, of psychological violence at work in nursing.

It is an exploratory and descriptive type of study, integrated within the paradigm of quantitative research. It is also a prospective and longitudinal study, as it will make an intra-subjects approach, at two different points in time. The sample is made up of nurses / students of the Post-Graduation Course of the Porto Nursing School (N=109). The instrument for collecting data in order to study the phenomenon of psychological violence was the NAQ-R, (Einarsen & Raknes, 1997), adapted by (Araújo, McIntyre & McIntyre, 2004). The data was collected between February and March 2008.

From the preliminary results we would highlight that in a sample of 109 nurses 88.1% were female, and 11.5% males. The minimum age was 24 years and the maximum age 54 years, and the average age was 32.9 years (SD= 5.242). As far as the civil state, 55% of nurses were married, and 64.4% had no children. The average length of time working in this occupation was 10.4% years, and the respondents were working about 43.6 hours per week; in average. 69.7% were registered nurses, 75.2% belonged to the permanent staff of the institution, 81.5% were performing their professional activity at a hospital and 16.7% in Primary Health Care. Only 21.1% of the respondents had leadership responsibilities, and 31.7% of the nurses have ever thought of asking to be transferred from the service where they are performing.

Analysis of the internal consistency of the NAC-R (23 items), through the Cronbach Alfa coefficient, was between 0.849 and 0.862. As far as the main NAC-R results, we found a positive response in 15 of the 23 items, and those with a higher frequency were: "Someone conceals information which affects ones performance"; "To be forced to carry out functions below ones level of competencies", "Withdrawing or replacing certain key responsibilities in ones position, by other ones less important and / or unpleasant" and "To be exposed to an excessive amount of work, impossible to carry out".

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Stress, violence and well being in nursing in Vojvodina

Poster

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Abstract

Introduction

According to the Karasek model the nursing in Vojvodina is characterized by high psychological demands and low decision latitude (control) which places them in high-strain quadrant which is at greatest risk level. The level of stress in nursing workplace has been on the increase for the last fifteen years in Vojvodina particularly because of impact of local circumstances such as sanctions, bombarding, and transition period of society. It is also considered insecure, low paid and socially underestimated workplace in our country.

Materials and Methods

The sample included nurses (n=197) divided into subsample. The research was conducted as a cross-sectional study. As a means of research Expanded Nursing Stress Scale was used apart from additional survey designed particularly for the needs of this research in order to obtain socio-demographic data, workplace related data, personal habits and health condition related data. The data were processed with suitable mathematical statistics methods such as multivariate analysis of variance (MANOVA), discriminative and other parametric procedures and methods. Roy's test, Pearson's coefficient contingency, multiple correlation coefficients (R) were conducted amongst other univariate procedures.

Results

As a group, the nurses were predominately female 96,59% with average age of 35.8 (SD=7.99) and were married 60%. Only 5,37% nurses in this study were graduates of diploma programs. The difference was established between the subsample workplace (.004) in relation to stress situation of psychological environment, (.053) in relation to stress situation of physical environment and (.002) in relation to social environment. The characteristic of each subsample in relation to the workplace is defined by stress situation from the group and problems with nurse supervisors and managers with 40.31%, then discrimination as group stress situation (27.91%), conflicts with physicians (16,28%), patient and his family (10,08%) and problem with coworkers (5,43%). Supervision and manager related stress in nursing compared to well being causes anxiety, restlessness and headache, while discrimination, conflicts with physicians and patient and his family related stress causes also lethargy, and disпноea. Coworker related stress causes insomnia in 19.12% while musculoskeletal pain in 21,10% characterizes work overload. All surveyed nursing staff have on average 3.16 cups of coffee daily (SD=1.5), and more than a half of them are smokers.

Conclusion and actions to be taken

The results of this study show that the nursing staff from the sample group is exposed to all potential stress sources of social environment causing physical and psychological violence in that way. Thus we suggest education of nursing staff through stress management program for implementing anti-stress strategies, especially in hospital nursing, and improving their self-esteem and communication abilities with doctors, supervisor sisters and other coworkers as well as team work.

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The Analysis of Violence Against the Nurses in Mugla State Hospital

Poster

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Abstract

In this research, socio-demographic characteristics of nurses who work in Muğla government hospital were studied. The relationship between their working conditions and violence exposure while working was determined using an intersectional, analytical survey. The study contacted all 310 nurses working in the hospital. Of the 310, 268 nurses participated, yielding a response rate of 86.5%. After explaining the purpose of the research, in-person interviews were used to collect data. This data was analyzed through the use of the 15.0 SPSS package program. The data was examined by using Fisher's Exact Test and Pearson Chi-Square Test.

When the data was evaluated, it was found that 85.8% of the nurses were exposed to violence, with 70.4% of the violence coming from the relatives of patients. 87.2% of the nurses were exposed to verbal abuse while 71.4% were physically assaulted. Unfortunately, 98.4% of the abused did not report the physical abuse. 83.3% of the nurses always felt violence anxiety, while 92.9% of them thought that their institutions do not make an effort for the security systems.

In this research, we found that the nurses were exposed to multiple forms of violence. This was correlated with their monthly average income, marital status, parental status, work status, night shifts, overtime, rotational shifts, total and daily work hours.

Keywords: Violence, workplace violence, nurse

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The caregivers also suffer: Pediatric nurses' suffering

Poster and Paper

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Keywords:

Nurse, pediatrics, suffering, end of life, stress

Background

Suffering as an unavoidable event can occur on different life moments of each person and under differing conditions. In periods of suffering the person reflects, questions, and gathering many moments which may lead to internal growth. The scientific and technological progress associated with the amelioration of life conditions, advanced diagnosis procedures and new therapeutic possibilities change the course of several diseases that affect the children. However, although these developments help to control some illnesses (e.g. contagious diseases) and contribute to the decrease of the mortality rate, consequences with a new dimension in pediatrics have emerged that currently constitute new challenges. Acknowledging that suffering is a part of life, should suffering be simply accepted as something negative? Nursing is in essence to take care of others as unique human and relational beings and therefore requires nurse to reflect their behavior from an ethical point of view. In pediatric services nurses face the problem of each child's hospitalization on a daily basis. However, our society believes that health professionals are protected from diseases due to their knowledge in the health area. In this context, the nurse is at the same time not only someone from whom you expect encouragement and support, but also someone who can become vulnerable. The nurse is a caregiver, but occasionally, the nurse may need help and support. But who takes care of these caregivers?

Conceptualization of the study

The nurses' suffering resulting from the perception of the child's suffering, was the object of this study – conducted within the scope of Master's Degree in Philosophy in Bioethics, Faculty of Philosophy of Braga under the guidance of Professor Doctor Silveira de Brito. The purpose of the study was to investigate nurses' perceptions of their suffering when they render nursing services to children with chronic diseases or in end of life. The exploratory and descriptive study employed a qualitative approach following phenomenological guidance. For the investigation of stress situations we also used quantitative methods.

Research aims

The research objectives were: a) to find out whether nurses suffer when they take care of children with chronic diseases or in end of life; b) to quantify the perception of the nurse's suffering on a 10 point Likert scale; c) to analyze elements of nurses' suffering, using descriptions of their experiences during health care practice; d) to identify the adopted coping strategies; e) to identify opinions about the way the Health Care Institution/Service could help the nurses to decrease stress related to suffering, and f) to identify relations between social-demographic variables, personal answers, coping resources and critical indexes.

Sample

The studied population is composed of nurses working in a pediatric hospital and excludes nurses working in the operating theatre, as we consider that these have very reduced contact time with the children and their parents. The population consisted of 103 nurses and the following inclusion criteria for participation of the nurses were applied:

- Nurses with more than five years of professional experience.
- Nurses having taken care of children with chronic diseases.
- Nurses having cared for children in end of life or dying situations.
- Nurses having agreed to participation in the study.

For the qualitative part of the study we took a convenience sample (sample 1) of 20 nurses – based on the criterion of saturation - meeting the inclusion criteria and conducted interviews to capture the participants' descriptions. For the quantitative part of the study we selected a sample (sample 2) from the same population. All the nurses from the Pediatric Hospital were invited to complete the questionnaire "Answers and Personal Resources Inventory" (IRRP of McIntyre, McIntyre and Silvério (1995), except the nurses from the operating theater.

Results of the qualitative investigation

The nurses were mostly female and the average age was 37.5 years. Sixteen nurses (80%) were married, 6 (30%) nurses had no children, 8 (40%) had one child, 5 (25%) had two children and 1 (5%) had three children. Ten nurses (50%) nurses were graduated, 6 (30%) were specialists and 4 (20%) were nursing directors or supervisors. The average nursing experience is around 15.4 years. Eleven (55%) participants had specialized education in pediatrics.

The nurse's suffering resulting from the perception of the suffering of the childrens' and parents' suffering is the most representative concept. However, when we asked what does suffering mean to you the nurses responded: It is something that affects people a lot and causes stress, it's inherent to each nurse's individuality, disturbing his communication skills, rest - since it causes mental pain and can disturb sleep". The nurses announce aspects that contribute to the increase of that suffering, that interfere in its management and make it bearable. The nurses also still attributed a transcendent value to this feeling, which is part of the human care essence and that has a meaning. We asked the nurses to state a value that corresponded to the subjectively perceived level of their suffering on a scale between 0 (it doesn't affect me) and 10 (it affects me a lot). The average score of the group was of 7.65 with a minimum of 5 and a maximum of 10.

Content analysis regarding nurses suffering experiences resulted in the appearance of sub-categories. The following situations which can aggravate nurses' suffering were identified: The child's clinical situation, deflecting of the nurses' experience made worse by feelings of guilt, conditions of the child's death, the close relation with the child and parents, the behavior adopted by the parents, the day of the child's death and the circumstances that lead to the child's death. The nurses reported the following behaviors when facing situations of child's suffering: Getting closer to the child and parents, expressing feelings, or sometimes avoiding the situation. Regarding the strategies adopted by the nurses aiming to overcome their feelings of suffering the results indicate that the nurses used predominantly coping strategies to handle their emotions (for example, the interviewed nurses referred to escape strategies fifteen times, rationalization fourteen times and self-control three times). The participating nurses indicate that emotional management can be developed at an individual or organizational level. At the organizational level they identified the following possibilities: Psychological support, restructuring of the service, education, valorization of the nurse's work, and job rotation.

Results of the quantitative investigation

Of the 103 eligible nurses 78 completed the Answers and Personal Resources Inventory (IRRP) and 18 of those 78 also participated in the qualitative part of the study. The respondents in sample 2 were predominately women ($n = 72$, 92.3%) with an average age of 34.6 years, 31 (39.7%) nurses were bachelors, 45 (57.7%) married and 2 (2.6%) had another civil status. Fifty percent of the nurses (39) had children. Regarding the professional category 22 (28.2 %) nurses were of level 1-nurse, 36 (46.2 %) graduated, 14 (17.9 %) specialists, and 6 (7.7 %) were nursing directors or supervisors. The nurses had between 10 and 14 years working experience. From these 78 nurses, only 11 (14.1%) had undergone specific pediatric education.

The IRRP showed that Philosophical Mind (Personal Existential Resources) is the most predominant personal resource of the nurses. The most prevalent responses to stress are denial; anger and frustration, distress and health, guilt, physiological response and dysphoric emotionality.

Conclusion

It is obvious that the contact with the parents and relatives of suffering children is also a suffering source to the nurses themselves. It seems important to us that nurses dealing with hospitalized children with chronic diseases or at end of life must have already developed a minimum set of personal and relational skills, in order to respond to the situations effectively. The institutions must pay attention to the physical infra-structure, to the human and material resources, and must encourage education programs to cater for the needs felt and expressed by the nurses, namely in the area of human suffering, occupational stress and dying. Reflection on suffering situations and the sharing of feelings by the nurses must be instigated in order to promote the development of the nurse's skills and practice. Finally, it is necessary for the nurses to develop programs of emotional management within the institution and to disclose their work inside and outside the institution.

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The frequency of violence toward nurses, doctors and the impact among employees in the Nazareth hospital

Poster

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Abstract

Background

Violence in the health care system is increasing in recent years. In the U.S.A 85% of un-lethal violence occurs in places offering services such as health care system. Health care providers are 16 times more at risk to endure violence than in other systems. Violence is not only physical contact, but can be verbal and psychological and may be as tough as physical violence. Hostile and sharp words hurt individuals and make them very frustrated.

Methods

A questionnaire was given to all staff (nurses and doctors) working in the following wards: Medical, surgical, orthopedic, labor, maternity, intensive care, pediatrics, dialysis, day care and emergency department. The study population (nurses and doctors) number 195 and 173 (89%) responded.

Results

About half of the respondents answered that shouting and intense argument with the staff was common. Two thirds of the respondents said that physical contact and imprecation occurred to a moderate or low degree. About 75% of the interviewed complained of fear at moderate and low levels. 80% of the interviewed reported having experienced verbal violence throughout their career. The majority of the study sample reported that violence has a bad impact on them and marked violence affects their satisfaction. Most of those interviewed reported about fear of violent patients, nervousness, practice performance disruption, and insomnia due to violent behavior against them. About half of the interviewed noted that they do not identify themselves to violent clients. 81.5% reported about serious worries from violence related phenomena. Males reported violence more than females, academics reported being confronted with more with physical violence than non-academics. Emergency staff reported more physical and verbal violence confrontation than workers on other wards.

Discussion

Univariate analysis revealed a statistical correlation between the physical violence and the variables sex and education. There is correlation between verbal violence threatening professional care disruption and thoughts of professional retention. A correlation also exists between profession and the degree of agreement on violence causes (long waiting time, inconvenient waiting conditions, treatment dissatisfaction, patient worries, staff behavior making clients angry, staff work over-load, and disease). Further correlations were found between the professions and their non-identification of client depression, and violence and departments. Logistic regression revealed significant statistical correlations between the variables profession and trying to hide their identity toward the violent client with nurses endeavoring to hide their identification more than doctors.

Conclusion

Verbal violence is more frequent than physical violence and most staff experienced verbal violence. Experiencing violence is not related to socio-demographic data. There is place to promote activities helping to deal with this phenomenon by demanding from the hospital executive or priority agenda. Further research is needed to examine the impact of violence on the care given to client

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UK Nurses' Perceptions of Violence: A Case Study within an Accident and Emergency Department

Paper

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Abstract

This research was designed to explore nurses' perceptions of workplace violence and aggression, and how nurses define and report such acts. The research further sought to determine if there is a disjuncture between official definitions of workplace violence & aggression offered by U.K Government bodies and the unofficial definitions held by Accident and Emergency (A&E) (Emergency Room) nurses working in the UK National Health Service (NHS).

The literature on violence and aggression in the workplace reports little evidence relating to nurses' perceptions of violence and aggression in the workplace. The large available body of literature on workplace violence fails to address 'frontline nurses' views about the nature and extent of aggression in the clinical setting. This research aimed to expand and enhance the understanding of A&E nurses' perceptions of workplace violence and aggression within a U.K hospital. It explored 'to what extent is there a disjuncture between nurses' definitions and understandings of violence in relation to the official definitions of violence and aggression defined by the Official Government departments in the UK.'

This research was designed to document nurses' perceptions of violence, how nurses define violence and aggression within the A&E department, staff attitudes towards violence and when and why incidents are officially reported. Other studies tend to ignore nurses perceptions of workplace violence and aggression this project utilised an in-depth approach to the study, which allowed for nurses opinions and feelings to be recorded, evaluated and interpreted. The interviews were semi-structured in nature, with questions relating to nurses experiences of incidents, reporting of incidents, defining workplace violence, and the nature of the problem and influencing factors relating to violence and aggression.

The research demonstrated that violence and aggression within the NHS is a significant problem, and that all staff interviewed had been subjected to an aggressive or violent incident at work. When looking specifically at the official definition offered by the Department of Health initially staff believed that it was an accurate and useful definition, however on further reflection the majority finally concluded that it needed to be expanded to incorporate aspects such as bullying and harassment by colleagues and the hospital authority. This demonstrates a disjuncture between official definitions of violence and aggression and those acts of violence and aggression experienced by staff.

This research has also highlighted the limitations of the feasibility of the Zero Tolerance approaches employed by the health authorities. All staff interviewed gave various examples of when they would justify and tolerate certain levels and acts of aggression and violence.

Finally, it demonstrated that violence and aggression is a significant problem in the NHS and that further research needs to be undertaken to further explore what behaviours nurses view as

violent and aggressive. From the research it can be concluded that a comprehensive definition of workplace violence and a more explicit classification of various acts of violence and aggression would help in the development of further strategies to combat the problem of workplace violence in health settings.

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Verbal Aggression - What is the impact on student nurses?

Workshop

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Abstract

Background

Violence and aggression in many organisations including healthcare settings is a persistent problem. The majority of the violence and aggression that occurs within nursing is nonphysical (RCN 2005) with verbal aggression being the most common form (Lanza et al 2006). Separating verbal events from those that are physical or sexual is unusual in nursing research on violence and aggression and these behaviours are generally examined concurrently. Whilst this approach has utility because verbal and non-verbal aggression often co-occur, it can also result in a less in-depth examination of verbal aggression. Few studies have focused specifically on non-physical violence in nursing literature and there is a paucity of research on verbal aggression and the implications of this for nurses.

Objective

The goal of this study was to investigate the experience of student nurses through documenting the situational forces, perpetrator and victim characteristics, victim orientated factors and the psychological effects of victimisation along with victim coping mechanisms.

Methods

A prospective study was undertaken. Student nurses completed a diary to record their experiences of verbal aggression in their clinical practice and were also given measures of self-esteem. Students who experienced verbal aggression were asked to complete the Impact of Events Scale (Revised Version) (Weiss & Marmar, 1996). The diary method allowed the researchers unobtrusive access to information that may have otherwise been closed to them. The investigation of verbal aggression is sensitive and can be intimate in nature; the diary allowed participants to disclose these feelings without having to come face to face with the researcher. Questionnaire items within the researcher designed diary were developed on the basis of issues identified in the literature and also those that arose from the vignette study. 154 diaries were issued to a convenience sample of pre registration mental health nursing students who were in clinical placements between Sept 2006 and July 2007. A total of 74 (48%) diaries were returned of which 73 returned diaries contained useable data.

Results

Analysis of this material is currently underway but preliminary results are as follows:

- Environmental context alters the cognitive appraisal or interpretation of patient communication.
- Verbal aggression is normative in healthcare; it is viewed as 'part of the job'.
- Verbal aggression from a colleague is the most distressing form.
- The most frequently utilised intervention for dealing with verbal aggression from patients in this study was to give medication.
- Females in this study were less tolerant of verbal aggression than males.
- Tolerance for verbal aggression is associated with psychological impact - a zero tolerance approach resulted in higher scores on the Impact of Event Scale-Revised (Weiss & Marmar 1997) following an episode of verbal aggression.

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Violence against Emergency Department Workers

Paper

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Abstract

Purpose

Emergency Department (ED) workers are at risk of violence because of the increased numbers of patients and visitors under the influence of drugs and/or alcohol or with psychiatric disorders or dementia. In addition, a presence of weapons in the emergency department, a stressful ED environment, and a flow of violence from the community may contribute to violence in the emergency department. The purpose of this study was to survey ED workers about the violence they experienced from patients and visitors.

Methods

This was a descriptive survey study. The study took place at 5 hospitals in the Midwest. Two were located in urban areas, and 3 were suburban hospitals. One of the urban hospitals was a teaching, level I trauma center. The study population included 600 ED workers who worked at least 8 hours per month and interacted with patients and/or visitors. The population included nurses, physicians, paramedics, physician assistants, social workers, patient care assistants, unit and registration clerks, schedulers, and patient representatives. A 31-item survey that included multiple-choice, open-ended and Likert-type items was developed by the researchers. Study variables included frequency of assaults, verbal and sexual harassments, and verbal threats during the previous 6 months; reporting frequency; worker injuries; lost workdays; prevention training; and assault risk factors. After obtaining approval from each hospital's institutional review board, anonymous surveys and consent letters were distributed to employee mailboxes. ED workers were instructed to place completed surveys in data collection boxes that were located in each emergency department. A reminder flyer was posted in ED break rooms at each facility to increase response rate.

Results

Two hundred forty-two surveys were returned (response rate = 40%). In relation to violence from patients, 94% of respondents reported being verbally harassed, 66% reported being verbally threatened, 48% reported being assaulted, and 39% reported being sexually harassed. Sixty-five percent of those assaulted never formally reported the incident. Sixty-three percent of respondents had no violence prevention training within the previous year. Alcohol and drug use by patients were the most frequently cited risk factors for assault as perceived by respondents.

Conclusions

Results of this study confirm that the ED workplace poses a risk for violence to ED workers. Prevention efforts need to include education, security, environmental controls, and violence prevention policies. Reporting is needed to document risk factors and plan appropriate interventions. An experimental study is currently being planned to test an intervention aimed at reducing the incidence of violence in EDs.

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Violence against health care staff in general hospitals: An underestimated problem?

Paper

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Keywords:

Aggressive behavior, violence, patient, visitor, health care staff, general hospital

Introduction and Background

The most important work-related violence in the health care system is patient and visitor violence (PVV) [1], which is a complex and dangerous occupational hazard for health care staff. According to international research staff and patient attributes, interaction, and environmental characteristics are important factors related to the occurrence of PVV. However, these factors are rarely investigated in general hospital settings. To date no information is available on this topic for Switzerland and only few studies exist in the European context [2].

Aim

The aim of this study is to explore health care staffs' experience with PVV in general hospital settings and to investigate related factors. The research questions were:

1. How often do the different forms of PVV occur and in which environments?
2. What are the characteristics of patients/visitors and health care staff involved in PVV?
3. What are the characteristics of patient/visitor-health care staff-interactions leading to PVV?
4. What are the environmental characteristics influencing the occurrence of PVV?
5. What are the reactions or interventions against PVV practised by health care staff?

The presentation will focus on persons involved in violent situations and how health care staff handles these situations.

Method

A retrospective cross-sectional survey was conducted between May and July 2007. A total of 4845 health care staff working in different clinical departments in a Swiss university hospital were invited to participate in the study. The instrument was an adapted German version of the Survey of Workplace Violence. The criteria for inclusion were contacts with patients and visitors and adequate knowledge of the German language.

Results

Two thousand and ninety five health care staff working on different general hospital units participated in the study giving rise to a response rate of 51%. The participating staff did not differ in gender, professional experiences, degree of employment, and workplace from the non participating staff, but were slightly younger and had accordingly less professional experiences.

Almost all health care staff (85%) had experienced PVV during their career. The findings revealed that 59% had experienced verbal and 22% physical PVV in the past 12 months, 9.4% were physically injured and 3% took one or more days of sick leave. In the week prior to data collection 10% experienced verbal PVV and 3.6% were physically attacked.

Considering workplace characteristics and different forms of PVV in the past 12 months the descriptive analysis showed that health care staff working on mother and child wards and operation rooms experienced the lowest levels of PVV with ca. 30%. PVV was most often experienced by health care staff working in emergency rooms (74%) and in intensive and intermediate care (58%). In outpatient care, surgical and rehabilitation units 53% of staff experienced PVV. Long waiting time and noise were most often cited as environmental sources of PVV.

In the past year 55% of nursing staff and 48% medical doctors reported having experienced PVV. Of the nurse assistants, medical assistants, radiographers, occupational therapists, nutritional therapists and physiotherapists 43% experienced PVV. Much less PVV (12%) was experienced by ward clerks. Multiple regression analysis revealed a higher risk to experience PVV for staff having more than 30% of patient contact during working time, for those working with elderly patients over 65 years, and those having less than four years of work experience. Only 16% of all health care staff have attended an aggression management training course. These staff experienced PVV more often.

Analysis of aggressive incidents in the week prior to data collection revealed that aggressive patients were most often male, between 50 and 74 years old (50%), and had a diagnosis of drug and alcohol abuse (31%) or depression (14%) or delirium (25%) or dementia (17%). According to the reports by staff these patients suffered anxiety or confusion, felt that excessive demands were being made on them, or were unable to understand their situation. Furthermore, aggressive patients were subjected to numerous examinations and tests and were enforced by health care staff to hospital rules. Violent visitors were most often males between 35 and 49 years old. They experienced anxiety, excessive demands in the situation, did not understand the situation involved and/or showed cultural diversity.

The intervention strategies health care staff used included informative and calming conversation, no intervention or sedative medication. For most health care staff, the emotional impact of PVV was moderate and they seldom sought support to cope with PVV.

Conclusion

The results indicate that PVV in general hospitals in the German-speaking part of Switzerland is a serious workplace problem for all health care staff and show the same levels as in international studies, with highest levels against nursing staff and staff working on emergency rooms. In accordance with international studies it seems that organisational characteristics like long waiting times, numerous medical examinations and tests patients have to undergo, enforcing patients to comply with hospital rules must be treated with more caution as they play an important role in the development of PVV [3-5]. Switzerland has one of the most expensive health care systems in the world, paid by patients' private insurance of [6, 7]. We therefore assume that given the high cost, patients and relatives expect a well functioning system with effective procedures. We suggest a quality improvement approach to analyse organisational processes and scrutinise diagnostic procedures or hospital rules an interdisciplinary in order to help to eradicate or reduce certain sources of PVV.

Younger or less experienced health care staff often seems to have difficulties in coping with the complex interactions leading to PVV. However, perhaps this staff group is more sensitive toward PVV and therefore experiences it more often. Staff having undergone a training course in aggression management seems more frequently to find themselves in difficult situations

leading to PVV. These circumstances could also have a connection with a higher attention toward PVV. Nevertheless, our results suggest that it is time to consider the use of interdisciplinary prevention programmes in Swiss general health settings. Even in nursing education there is a lack of attention to PVV. Most of the specific training programmes include strategies useful in psychiatric or geriatric care such as diffusing the aggression or breakaway techniques to promote personal safety but do not focus on problems in general hospitals. Therefore it is not astonishing that only 16% of health care staff had attended such trainings.

Concordant with other studies PVV is mainly caused by patients [3, 8, 9]. The results indicate that male patients between 50 and 74 years old and medical diagnosis which lead to cognitive impairment seem to be important risk factors health care staff need to consider in preventing aggressive behaviour. Diagnoses of drug and alcohol abuse, delirium and dementia leading to considerable difficulties in correct comprehension of situations are more common in older age and may therefore render interaction difficult. The results also reveal that anxiety, problems to comprehend a situation and excessive demands may trigger aggressive behaviour. Therefore it is important for health care staff to have knowledge to assess such situations for prevention activities and to intervene in an appropriate way [10]. In order to prevent PVV general hospitals should consider formal procedures toward PVV and guidelines on how to prevent and handle these complex situations. Clear patient information regarding for hospital rules and long waiting time, and comprehensible information and explanations on examinations and tests patients have to undergo are important prevention strategies against PVV.

Future research should investigate risk factors more closely to gain specific knowledge of aggressive situations. This could include qualitative analysis to discover a more detailed view of these complex interactional situations in order to develop adequate prevention or intervention strategies.

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Violence amongst nurses in eight Cape Town public hospitals - South Africa

Paper

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Keywords:

Levels of violence; psychological; covert; vertical; public hospitals; South Africa

Introduction

Positive nurse-nurse relationships foster constructive teamwork that uplift health care consumers (Taylor 2001; Duddle and Boughton 2007; Rich 2007). Nevertheless, there is a silent phenomenon-eroding moral within the profession, i.e. violence among nurses (Glass 1997; Woelfle and McCaffrey 2007). The paper presents part of the findings from a larger study examining the extent that violence exists within the nursing profession.

The primary aim of the study is to examine all dimensions of violence in nursing. A specific section of the study explores levels of interactions that nurses are capable of violating their nursing colleagues and this ranged from psychological to overt negative interactions. Psychological violence consisted of all forms behaviours that cause distress, e.g. verbal abuse, shouting, isolation, marginalisation, and labelling. Vertical violence is negative behaviour towards senior or junior nursing colleagues. Horizontal violence occurs among nurses of the same rank. Covert violence is any form of behaviour conducted in secret against other nurses (McCall 1996; and Leap 1997).

Methods

Ethno-phenomenological approach was selected to study the culture of nursing and the phenomenon of violence in the profession (Polit and Hungler 1999). Population were nurses registered with the South African Nursing Council (SANC 1984) and working within the Cape Town. Human ethics clearance enabled non-probability sampling of registered nurses from eight large public hospitals providing general, maternity, psychiatric, and paediatric services (www.wma.net/e/policy/).

The first stage of data collection was confidential questionnaires distribution. Although rich quantitative data were generated from the responses, most participants did not elaborate on their selection of responses. The quantitative data indicated that 202 general nurses, 148 psychiatric nurses, 90 midwives, and 31 paediatric nurses participated in the study.

Despite the good response, some participants responded to specific sets of questions relating to violence among nurses. For example, 213 (45%) provided information on psychological violence, 155 (33%) vertical violence, 143 (30%) on covert violence, 137 (29%) on horizontal violence, 124 (26%) on overt violence, and only 95 (20%) on physical violence among nurses (Table 1).

Table 1: Types of violence amongst nurses per specialist practice area

	Psychological	Vertical	Covert	Horizontal	Overt	Physical
General	92 (46%)	66 (33%)	64 (27%)	64 (32%)	55 (27%)	33 (16%)
Psychiatric	66 (45%)	35 (24%)	36 (24%)	29 (20%)	28 (19%)	36 (24%)
Midwifery	45 (50%)	44 (49%)	38 (42%)	36 (40%)	34 (38%)	22 (24%)
Paediatric	10 (32%)	10 (32%)	5 (16%)	8 (25%)	7 (23%)	4 (13%)
Total	213 (45%)	155 (33%)	143 (30%)	137 (29%)	124 (26%)	95 (20%)

Results

Results indicated that psychological violence is more prevalent among nurses (Table 2). Humiliation a form of psychological violence is much more common amongst nurses working in the general and maternity hospitals (Table 2). Within three of the specialist practice areas, professional nurses (RNs) have the propensity to resort to humiliating other nurses than any other category of nurses. Whereas, within the midwifery settings it is senior nurse managers that tend to humiliate other nurses (Table 2)

Table 2: Psychological violence amongst nurses, e.g. humiliation

	General	Psychiatric	Midwifery	Paediatric
Professional	63 (31.2%)	37 (25%)	28 (31.1%)	9 (29%)
Enrolled	44 (21.8%)	19 (12.8%)	6 (6.7%)	6 (19%)
Auxiliary	37 (18.3%)	19 (12.8%)	6 (6.7%)	4 (13%)
Senior managers	49 (24.3%)	23 (15.5%)	33 (36.7%)	6 (19%)
Nurse learners	22 (10.9%)	13 (8.8%)	11 (12.2%)	4 (13%)

Examining the extent of vertical violence within the eight hospitals, it was evident that shouting a form of vertical violence is more prevalent within the general hospital settings than in the other three specialist practice areas (Table 3). However, as Professional nurses are usually in-charge of wards/clinics in all specialist practice areas, they were identified as the main culprits that frequently resort to shouting at other nurses, i.e. general (14%), psychiatric (6%), midwifery (4%) and paediatric (1%).

Table 3: Vertical violence among nurse, e.g. shouting

	General	Psychiatric	Midwifery	Paediatric
Professional	64 (31.7%)	26 (17.6%)	20 (22.2%)	7 (23%)
Enrolled	28 (13.9%)	20 (13.5%)	7 (7.8%)	8 (26%)
Auxiliary	37 (18.3%)	26 (17.6%)	12 (13.3%)	6 (19%)
Senior managers	38 (18.8%)	22 (14.9%)	11 (5.6%)	7 (23%)
Nurse learners	14 (6.9%)	14 (9.5%)	5 (5.6%)	4 (13%)

Discrimination as example of covert violence is high among all categories of nurses working in the general hospitals than in other three specialist hospitals (Table 4). Within the general hospital, professional nurses, enrolled nurses, and senior nurse managers tend to discriminate against other nurses. In the psychiatric hospitals, professional nurses, nurse managers and auxiliary nurses discriminate against other nurses. On the other hand, within the maternity hospitals, only professional nurses resort to this mode of behaviour towards their colleagues (Table 4). In the paediatric hospitals, discrimination is common across all categories of nursing staff except nurse learners (student nurses).

Table 4: Covert violence among nurses, e.g. discrimination

	General	Psychiatric	Midwifery	Paediatric
Professional	49 (24.3%)	19 (12.8%)	16 (17.8%)	3 (10%)
Enrolled	45 (22.3%)	13 (8.8%)	5 (5.6%)	3 (10%)
Auxiliary	34 (16.8%)	15 (10.1%)	8 (8.9%)	3 (10%)
Senior managers	41 (20.3%)	18 (12.2%)	9 (10%)	3 (10%)
Nurse learners	21 (10.4%)	11 (7.4%)	4 (4.4%)	2 (6%)

The limited qualitative data collated was utilised to identify some of the factors contributing to violence amongst nurses. The primary factor contributing to the unpleasant interpersonal relationships amongst nurses within the clinical settings was 'lack of effective communication'. The second factor was 'lack of mutual respect amongst nurses of all categories' within the participating hospitals. Despite the South African Constitution (1996) which guarantees equal rights for all, some nurses continue to violate their colleagues. In all the six levels of violence studied, it was evident that professional nurses (RNs) and senior nurse managers have the propensity to violate other than any other category. Each participating hospitals provides counseling services for nurses traumatised from either health care consumers or colleagues. Although the service is available to all staff members, some nurses preferred to utilise other community support systems to manage their work-related traumatic experiences.

Conclusion

The results of the study indicated that violence in society has permeated the nursing profession. If violence amongst nurses were not adequately managed, the exodus of nurse from Cape Town would increase. Furthermore, negative personal experiences from professional colleagues are sometimes related at social functions and such information could deter potential recruits into the profession.

Acknowledgement

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Violence and aggression in haemodialysis units in general hospitals

Paper

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Keywords:

Workplace violence; healthcare setting; haemodialysis; incident recording; mixed methods research

Abstract

Introduction

Disruptive, abusive and violent behaviour by patients and occasionally their family members is becoming a significant problem in some Haemodialysis Units, with literature suggesting that this is an emerging problem both nationally and internationally (King & Moss, 2004; Sedgewick, 2005). This phenomenon is occurring within a context of an increase of violence & aggression reported in workplaces as a whole, including the NHS in the UK.

Violence and aggression in healthcare settings

Violence and aggression in general hospitals in the UK is an increasing problem; the number of violent incidents has been increasing significantly over time (DH, 2003) with NHS staff, particularly nurses, at greater risk of physical assault or verbal abuse than many other professional groups (HSAC, 1997; British Crime Survey, 2002). There have been a number of national programmes to tackle the problem and also local policies in individual NHS Trusts (Barts & The London NHS Trust, 2006). However, a big problem with these initiatives is the widespread under-reporting of violent incidents by NHS staff; it is estimated that 39% of incidents are not reported (National Audit Office, 2003).

Existing research studies from general health care settings suggests that potential predictors of violent incidents may include:

- Staff factors – younger age and shorter health service experience;
- Patient characteristics – mental state of patient, the presence of associated ill-health; patients living in deprived areas;
- Nature of interactions between staff and patients during the delivery of care and treatment, both verbal and physical;
- Work environment - delays in receiving treatment
- Physical environment - A study by the Royal College of Psychiatrists (1998) found that certain features of mental health settings, such as poor design of waiting areas, poor lighting, excessive noise and overcrowding also contribute to violent situations.

Disruptive behaviours in Haemodialysis Units

Different terminology has been used in the literature to describe dialysis patients whose behaviour is deemed unacceptable, including: 'abusive', 'difficult', 'disruptive' and 'noncompliant' (Johnson et al, 1996; King & Moss, 2004). These different terms demonstrate the complexity of the problem; it is not simply about aggressive behaviour, but also patients' non-adherence to treatment regimes. Little is known about what precipitates disruptive behaviour by dialysis

patients and visitors, although there are a handful of publications that highlight the existence of the phenomenon, predominantly from a North American perspective (Johnson et al, 1996; Rau-Foster, 2001). A study by King and Moss (2004) set out to establish the extent of the problem in the USA, with a survey of 203 dialysis facilities staff at a national Nephrology meeting in 2000. The majority of respondents (69%) reported that their dialysis facilities had witnessed an increase in disruptive patient situations in the previous 5 years and most (71%) reported that they were frequently or always engaged in attempting to resolve difficult/disruptive patient situations. These findings are supported by a recent UK-based survey of 89 nurses working in Nephrology services (Sedgewick, 2005) that found that four out of five respondents (80%) had personal experience of violence and aggression in the workplace in the previous 12 months and in the majority of cases (77%), renal patients were identified as being the perpetrators.

King and Moss (2004) have provided a more comprehensive definition of 'disruptive patient behaviours', specific to haemodialysis settings, encompassing:

- Verbal abuse.
- Physical abuse.
- Non-adherence to treatment: not adhering to one's medication, diet or fluid restrictions, missing or shortening dialysis treatment).
- Substance use.

Aims of study

There are two aims of this study:

- a) To identify factors that predict disruptive behaviour in Haemodialysis Units;
- b) To identify effective strategies for the management of future disruptive behaviours.

Design and methods

The study is using an exploratory, mixed methods design, using both quantitative and qualitative research methods. Data collection methods include: Collection of incidences of aggressive behaviour (physical and verbal) using the SOAS-R (renal version) over a 12 month period; staff and patient questionnaires; staff and patient interviews. The research team is being advised by a Project Advisory Group, composed of patients, carers, clinical staff, managers, and 'experts' in the Nephrology field.

Results

Preliminary analysis of the incident data demonstrates that incidents of aggression have been instigated by a very small minority of haemodialysis patients and relatives. The data analysis has revealed interesting temporal patterns to incidents of violence, with more incidents occurring on particular days of the week and at certain times of the day. The themes of 'waiting' and 'staff-patient communication' are emerging as themes from the qualitative data.

Discussion

It is clear from the limited research evidence and anecdotal evidence from Nephrology clinicians, that the problem of disruptive patient behaviours in Haemodialysis Units is increasing and requires urgent attention. To our knowledge, this research study is the first empirical study of its kind in the nephrology field. We anticipate that the findings of this study will be useful for clinicians, managers and policymakers involved in the provision of renal care in the UK and beyond.

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Violence and Post Traumatic Stress Disorder (PTSD) in Nursing Staff

Poster

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Abstract

Introduction

Post-traumatic stress disorder (PTSD) was mentioned for the first time in the WHO International Classification of Diseases in 1992. Initially it was connected almost exclusively to the military personnel as the psychological aftermath of combat. It is realized today that, among others, this syndrome develops in victims of disasters, and violence (sexual and social) and that it may also affect the health professionals who care for such individuals.

Purpose

The aim of this study is the exploration of the psychological aftermath that the exposure to, or the experience of traumatic events (violence included) could have on the health-care professionals and more specifically on the nursing staff.

Methodology

The search had three sections. The first explored the threatening incidents of assault, verbal threats, and injuries by which the personnel working in psychiatric departments are faced with. The second explores the psychological impact of being working under a potentially self-harming occupation, and /or caring for people with urgent medical needs. The third section explores the emotional sequence of being exposed to traumatic material, suffering, or death in the everyday practice of the profession.

Results

The review of the literature, documented the development of PTSD or PTSD-related reactions in the nursing staff, in all three sections of the search.

Conclusion

The literature describing these symptoms is not vast, however it is indicative of a problem that - among other - has been blamed to lead to job turnover, negative impact on the nurse-patient relationship, and loss of money by the health institutions (due to sick leaves). Although to prevent the confrontation of traumatic incidents in an environment connected with human pain and sickness by the care-workers is impossible, it is however clear that more consideration to prevent possible development of occupation-related traumatic reactions should be given in the future.

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Violence Assessment and Intervention in the Veterans Health Administration 2001 - 2008

Paper

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Keywords:

Violence, health care, surveys, intervention, patient assaults, coworker hostility

Introduction and background

Employees in the Veterans Health Administration [VHA] experience assaults and verbal abuse at twice the rate of US Postal Service employees [figural 1]. Several clustering, adverse events, with major media exposure, led VHA to undertake a national review of existing programs, implementation, and strategies. Although VHA has had a violence prevention program since the late 1970s, the magnitude of this hazard and the state of programs in 2001 led to a systematic set of interventions over seven years, culminating in a formal reassessment. The initial 2001 survey suggested that patients represented 85% of assault perpetrators at clinicians but only 65% of the perpetrators for other staff. An initial set of interventions and therefore focused on patient assaults prevention; subsequent efforts focused on coworkers, supervisors, and subordinates. This report will summarize briefly both the interventions, and the assessment of violence prevention programs and their consequences in a second national survey.

Intervention

The intervention steps as, after the 2001 review included the following. As with its 1997, safety reform, VHA initiated steps to achieve top management commitment, using an approach used for other program rollouts. A half-day session at one of the regular National Leadership Board meetings presented the results of the national review, existing data, economic consequences, and a strategy. One in the following year, each facility reviewed its policy for adequacy and conducted a stand down, where employees participated in a one hour session with a facilitator [91.5% participation].

The following year facilities trained to new trainers, for hands-on skills including de-escalation, personal safety skills such as breaking holds, event reporting, and therapeutic containment. Over the next several years all high-risk employees, including nurses, emergency room, geriatrics, and mental-health workers were to complete a 16 hour training program. Subsequently, a Disruptive Behavior Committee (DBC) was established in each hospital, under senior clinical leadership, to assess disruptive and assaultive patients; to identify underlying clinical conditions, that might be treated differently, and to assess environmental triggers; and to maintain an electronic flag in the patient record that provided guidance on patient management. A threat assessment curriculum was developed, and a monthly telephone call led national discussions on the threat assessment and management. The minutes of those DBC meetings were rolled up in a quality improvement program.

Methods

Violence prevention program assessment

Together with the National Institute for Occupational Safety and Health, VHA initiated a set of evaluation steps. By 2006 an instrument with 110 criteria statements on violence program quality had been developed and piloted. A three person team visited each hospital, completed the assessment, reported the results, and led the development of a local abatement plan. Domains included DBC performance, culture environment as it affected reporting, evidence of top leadership commitment, use of patient record flags, the use of banning and barring patients, formal threat assessment procedures, adequacy of environmental safety rounds, incident reporting procedures, and front-line worker training.

Follow up survey

The follow-up survey used the questions from the 2001 survey on assault and verbal abuse from the 1999, US Postal Service survey on violence. That instrument assault and verbal abuse. The former consisted of six forms, including throwing something; pushing, kicking, grabbing, slapping, or hitting; hitting with an object; beating up; threatening the with a gun, knife, or other weapon; using a gun, knife, or other weapon; or rape or attempted rape. Verbal abuse included starting or provoking an argument; calling names or putting down in front of others; making someone feel inadequate; shouting or swearing; frightening; and making intimidating or threatening gestures. A range of response frequencies was offered, [one, 2, 3, 4, 5, 6 to 10, and more than 10]. Satisfaction with follow up included a five point ordinal scale from very dissatisfied, dissatisfied, and neutral to satisfied and very satisfying. Perpetrator status was characterized as patient; supervisor, subordinate, or coworker; and other. The more detailed exploration of "other" in 2001 suggested that fewer than 3% of all assaults occurred from criminal intent, family members, or non-employees. In addition, based on a separate National Science Foundation -funded Stress and Aggression project, these authors selected five frequent, widely disparate, and, in the organizational folk culture, important items. They included failure to include appropriate staff in decision-making; experiencing unreasonable slowness in response [telephone and e-mail]; failure to provide necessary information; and excluding from meetings. The same frequency choices, perpetrators of the most recent incident and reporting and satisfaction questions were included. The survey was conducted using the same methods as VHA's All Employee Survey, used for a leadership performance measure evaluation. The survey was anonymous, with only categorical demographic data; administered through the way that; and completed on work time. A detailed marketing campaign included posters, announcements, and e-mails beforehand and reminders, including daily cumulative response rates, during the three weeks of the survey. A designated coordinator, vested in violence prevention was included in the marketing campaign, either, generally, the chair of the Disruptive Behavior Committee or one of the two hands on trainers. Data were entered through the Perseus software, cleaned at VHA's data center, and made available in SAS and SPSS files. Where records appeared duplicated, i.e., appeared from the same facility, functional group, and identical demographics, and and identical responses, the second record was excluded. No reports are made available for groups of individuals consistent of fewer than 10 employees. Results were available through a national website on a Proclarity data cube, with training sessions support frontline supervisor, and employee, use of data.

Results

Evaluation results were available from 143 of 144 hospitals. In general, between 70 and 80% of facilities completely met any given criteria statement, although few hospitals met even 90% of those statements. The overall response rate was 36.0%, compared with the response rate in 2001 of 36.5%. Slightly more women and slightly fewer men responded than in 2001. A

slightly greater percent of respondents was below the age of 30, and a substantially greater proportion above the age of 50 than in 2001. Slightly fewer individuals of Hispanic descent responded in 2008; strikingly, a substantially greater proportion of individuals responded “unknown” possibly because individuals were forced to make a single choice. Respondents in 2008 were more likely to have worked in VHA for less than a year war for greater than 20 years in 2001. Figure 2 presents the relationship between the average proportion of facility employees [by hospital] who experienced at least one assault in 2008 and the change in assault rate by facility between 2001 and 2008. Changes in assault rates were examined for subgroups. Table 1 presents those changes by subgroups of violence and their relationship to program evaluation factors.

Discussion

The lower the assault rate in 2001, the greater the decline between 2001 and 2008 suggesting that less safe facilities improved far less with this approach than better facilities. Factors associated with improvement included primarily the degree of top leadership commitment. Interestingly, the factors widely assumed to be of most importance, DBCs, and their functioning, did not appear to influence the results. Although violence is clearly a problem in healthcare, sustained interventions may in fact reduce the frequency. Of paramount importance are infrastructure tools and, not surprisingly as in all safety programs, top management commitment. Given that the facilities with higher assault rates improved less than better facilities, some other form of intervention may be necessary.

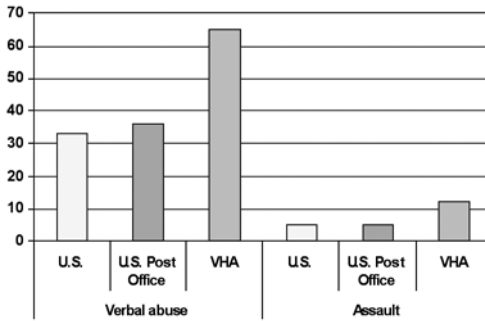


Figure 1: Relationship between Changes in Assault Rates and program evaluation factors

- Assaults on all employees
 - Leadership
- Assaults on Mental Health employees
 - Leadership
 - Environmental safety and management
- Assaults on Geriatric/LTC employees
 - Banning
- Assaults on Nursing employees
 - Leadership

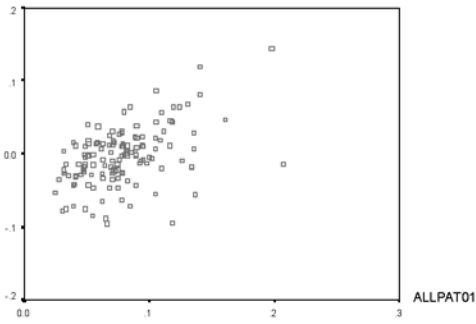


Figure 2: Change in assault rate from 2001 - 2008 by initial assault rate in 2001

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Violence by Patients and Visitors Leads to Physical and Psychological Responses for Pediatric Emergency Department Workers

Paper

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Abstract

Purpose

The purpose of the study was to identify the presence of physical and psychological responses for healthcare workers in a pediatric emergency department (ED) following violence by patients and visitors.

Methods

Semi-structured interviews with 31 healthcare workers from an urban pediatric were audio taped and transcribed. Data were analyzed using constant comparative analysis.

Results

Participants reported both physical and psychological responses following physical and verbal violence. Violence was most likely to occur from patients being seen for mental health complaints, from the parents of a chronically ill child, and from the parent after a child's death. Physical responses included increased heart rate, flushed face, insomnia, shakiness, adrenaline rush, and the need to pace. Psychological responses included being afraid, embarrassed, irritated, and offended. Responses included the avoidance of patient perpetrators or the child of a family perpetrator. Participants believed they have few, if any, alternatives, other than to accept the violence. Participants reported a greater degree of emotional and physical support from colleagues with events of physical violence compared to verbal violence.

Discussion

Healthcare workers in a pediatric ED were recipients of both verbal and physical violence. The negative consequences experienced were similar to those reported by ED workers providing care for adult patients. Interventions need to be developed to prevent violence when possible and prevent the negative consequences when violence does occur.

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Violence in Emergency Departments in Palestine: Prevalence and Prevention

Poster and Paper

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Abstract

Many research studies show that violence and aggression in the workplace have increased in recent years. Moreover, they show that the prevalence of violence is six times higher in health sectors. Personnel in the front line as in the emergency department (ED) are more susceptible to violence and assault. The true incidence of violence is difficult to determine, due to different definitions of violence. There is evidence of under-reporting of violent behaviors and lack of formal education and training in relation to dealing with violent patients. There is also lack of support for victims in the health care sectors.

A quantitative approach was adopted to investigate the prevalence of violence in emergency departments and measures used by ED staff to prevent such violence. Cross-sectional non-experimental description design was used. A non-probability sample of all registered and licensed practical nurses working in EDs in Palestinian hospitals located within an area of 80 km square were selected. An instrument developed by the International Council of Nurses (ICN) was used to collect the data. A total of 99 questionnaires were distributed between 9 research sites and 92 were returned (a 92.9% response rate). Descriptive statistic methods were used and the findings were statistically interpreted using the statistical package for Social Science (SPSS). Results show that the prevalence of verbal abuse was reported by the majority of the respondents and one-third had experienced physical attack in the last 12 months. The main perpetrators of violence were relatives, followed by patients. The most frequent time of physical attack happened between 7.00 am and 1.00 pm.

The most common type of support given by the employer was the opportunity to speak about and report the incident in cases of both physical and verbal violence. In general, the victims were dissatisfied with the way the incident was handled in the workplace. Reporting of violent incidents by victims was low, as they think it is useless and not important. Respondents think that restricted public access, improved surroundings, restricted exchange of money at the workplace, patient screening, training, investment in human resource development and reduced periods of working alone could be helpful in minimizing workplace violence.

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Violence in the workplace, the experience of nurses in Isfahan, Iran

Paper

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Keywords:

Violence, workplace, nurses, health sector, quantitative data, verbal aggression

Introduction

All health care professionals including nurses have the right to work in an environment that is free from harassment and threat. This research was conducted in Isfahan, Iran, aiming to explore the situation, contributing factors and management of workplace violence among the nurses in the health sector of Isfahan, Iran.

The issue of violence against nurses at work is a serious one which must be addressed urgently. Despite strong measures introduced to combat violence and abuse in the workplace, recent media reports of incidents against nurses show that violence in the workplace continues and recent evidence suggests that the incidence of violence and abuse towards the medical profession remains a real threat.

Method

A total sample of 250 nurses was recruited from all the health care services available in Isfahan, representing all branches of practice. Data were collected between January and March 2007. The research setting in this study is the city of Isfahan in centre part of Iran. In Isfahan, there is a wide variety of health care services, including all the types of services and levels of health care available in Iran. The subjects were recruited from all health care levels and all professions by cluster random sampling techniques. Health posts/centers, community hospitals, and private hospitals were randomly selected. The specific number of subjects recruited from each health setting was estimated from the number of patient beds available in the setting.

Thirty percent were recruited from hospitals equipped with more than 30 beds but less than 100 beds and 15 % from those with more than 100 beds. For small hospitals equipped with less than 30 beds, the number of subjects varied from 5 to 10. If there were no patient beds, the number recruited was approximately 10-15 % of the number of total nurses. For the quantitative data, the researchers and/or the research assistants contacted the relevant authorities for permission to collect data. The purpose of the research project as well as the techniques and procedures for questionnaire survey were explained. After that the researchers and/or research assistants distributed the questionnaires through accidental random sampling techniques. That is, the nurses who were available and accessible during that period were invited to participate in the study. To reduce biases, the accidental sampling techniques were explained in detail and justified. In the setting where the personnel were difficult to access, a person working there was invited to assist in distributing and collecting questionnaires. The procedures were explained to that person. For small workplaces in remote areas, the questionnaires were distributed and returned by mail. Nurses were asked a series of questions about their personal experience of workplace violence

in addition to their views and perceptions of violence in the workplace more generally. This can include verbal aggression or abuse, threat or harassment as well as physical violence.

For the purposes of this study, the definition of violence follows has been accepted. "Any incident where nurses are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health ". In the qualitative part aiming to verify the definition of workplace violence and other aspects, six groups were included (Registered nurses/midwives, technical nurses, practical nurses, nurse aids, and health workers). Data from these groups were mostly obtained through 15 interviews consisting of 90 nurses recruited according to availability. The number of participants in each group varied from 3 to 9. Almost all of the groups consisted of same-sex nurses from the same levels. The time spent in each group interview varied from 60 to 180 minutes. Interviews were stopped when the obtained data became redundant. For the rest of the groups, data were obtained through formal individual interviews and occasionally informal interviews from 25 persons. A few interviews were conducted via telephone. Qualitative data were collected through interviews, with audiotape recording if permission was granted. Field-notes were taken as well. Since workplace violence is a sensitive issue, the privacy, confidentiality, and safety of the subjects were protected throughout the processes of qualitative data collection. Most of the individual interviews were conducted at the participants' workplaces. Prior to data collection, the researchers asked for written permission from each workplace. All subjects participating in interviews were requested to give oral consent after the explanation of the research project's objectives, procedures, confidentiality, as well as the benefits and possible risks.

Data Analysis

Quantitative data were analyzed by the SPSS 9.0 software program. Descriptive Statistics was employed to illustrate the demographic characteristics of the sample. The differences of the incidences of violence across various factors were analyzed by the Chi-square statistic. Qualitative data were analyzed by content analysis.

Results

The sample size was 250. Majority of the sample were female (65.7 %) and had up to 5 years' working experience. Most of the samples were single. There were non-significant differences in the age and years of working experience between males and females. More than a half the sample (52%) had reported that they were victimized at least once in the previous year. Verbal abuse, the expression through words or verbal behaviors was found to be the most common type of workplace violence. Qualitative data supported this finding. Verbal abuse was found to be the most common type of workplace violence. Among hospital nurses, those working in Psychiatry, Drug abuse and Screening units are more likely to report violence as a problem in their workplace. A third or nurses who reported experience of workplace violence experienced physical violence or abuse. These incidents ranged from being kicked, bitten, punched, knifed and hit.

Sexual harassment was the least common type of workplace violence. Females, younger nurses, working in night shifts, having physical contacts with patients, working in crowded units and poor working experience nurses were more likely to experience violence. The subjects with fewer years of working experience were more likely to experience violence, especially verbal abuse, than those with more experience. The personnel whose working experience was less than 5 years experienced violence greater than did the personnel who had over 10 years of working experience. The subjects working in private organizations experienced violence significantly less than those working in the government health sectors. It was found that the violence incidents were more prevalent among the nurses who reported that there had been a reduction in staff numbers in their workplaces. It was found that there was no statistically significant difference

in the experience of each type of violence across marital status, and ethnicity ($p > .05$). Most respondents who experienced violence or abuse in the last year, reported patients as being the main perpetrators, followed by patient's family and/or relatives. Other perpetrators included managers, other medical staff, nurses and the general public. The psychological backgrounds of perpetrators, especially of managers and other medical staff are: Lack of emotional and moral maturity and control, anger management skills, stress releasing skills and communication skills, psychological stress caused by working, as well as personal, economic, and family matters. A few subjects suggested that violence was a learned behavior. If nothing happened or perpetrators did not receive any punishment for their violent acts, they would repeat them and increase their severity. Dissatisfaction of service provided includes patients' frustration for long waiting times, refused to admit for treatment or prescribe medications and dissatisfaction with diagnosis or planned treatment was the most frequently stated reason for work place violence. Psychological backgrounds, inability to pay for hospital bill, low social security conditions, the rise in prices due to economical inflation and rapid political changes were the indirect factors. Around a quarter of nurses said that their experience of violence had affected their work. And less than 2 percent reported that their experience had made them consider changing their career.

Discussion

Improved working systems were recommended in order to reduce conflicts and stress and increase quality of services and patients' satisfactions. This would solve the problems of work-overload and staff insufficiency. Improving the workplace atmosphere and cultivating a non-violence tradition were suggested. Improved relationships between employers, and or senior and subordinated staffs and staff members was also worth working for, recommended the respondents. Reporting the incidents should be encouraged. Procedures for reporting should be practical and feasible. More importantly, positive attitudes toward reporting must be developed among health personnel. The procedures for investigation and management, including punishment for perpetrators and support for victims, should be developed in concrete ways. Existing regulations in the Civil Service Act as well as existing labor laws and criminal laws should be applied as punishment guidelines. Health services for both victims and perpetrators are essential. Measures adopted for prevention is another issue. They should include direct measures for violence prevention and control, and measures for reducing contributing factors, as mentioned before. The institution of prevention programs in each health setting should be encouraged and supported. The program target groups should include both male and female staff, especially juniors and those who have few years of working experience.

Conclusions

Improved training, better security measures, including provision of a safe environment to treat known or potentially violent patients were seen as crucial to reducing the incidence of violence against nursing staff. Prevention programs and health services for both nurses and patients should be provided.

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Violent behaviour and threats in Norwegian Reception Centers for asylum seekers – frequency, nature and consequences for staff and co-residents

Paper

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Abstract

Background

Aggression and violent behaviour in reception centres for asylum seekers is a challenge for staff and co-residents. Reports from staff working in reception centres in Norway indicates a relatively sparse experience and knowledge of how to understand and handle violent incidents, a need of improved risk assessment and a request for a common recording system for violent incidents. There is a lack of empirical research on the magnitude of violence in reception centres in Norway, consequences for staff and co-residents, and how aggressive behaviour is managed. As a consequence, the Norwegian health authorities allocated funds to a descriptive study of the frequency and nature of violent incidents.

Objective

The purpose of the present study was to explore the frequency and nature of violent incidents in Norwegian reception centres for asylum seekers in terms of provoking factors, type and severity of incidents, and measures taken to stop the aggression.

Method

During a twelve month period in 2007, residents in all reception centres in Norway were monitored using the Staff Observation Aggression Scale Revised Asylum version (SOAS-RA). SOAS-RA is developed from SOAS-R (Palmstierna and Wisted, 1987; Nijman et al., 1999). Severity of the incidents was calculated with the built-in severity scoring system in SOAS-RA.

Results

Preliminary results will be presented and discussed.

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Violent Events against Physicians and Nurses in a Greek Paediatric Hospital

Poster

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Abstract

Study objectives

To describe the nature and frequency of violent events in a paediatric hospital.

Methods

Physicians, nurses and nursing assistants (n=352) working in a Greek paediatric hospital reported on workplace violence. An anonymous self-administered survey questionnaire was used. One factor and multi-factorial logarithmic regressions were conducted.

Results

The most violent events were coming from patients' relatives. Psychological (35.8% & 20.2% respectively) and verbal (56.5% & 34.4% respectively) incidents were the most frequent types of violence. Healthcare professional, also reported that a) 88.4% of them faced a violent incident by themselves, b) 35.8% feel safe at work, and c) 21% were very satisfied (10.5% not at all satisfied) with the violent events' dealing ways. The most important factors influencing types and frequency of violent events were socio-cultural attributes of healthcare providers and patients, previous experience of violence, and seriousness and severity of the incident. Usually, nurses than other professionals were victims of workplace violence. Satisfaction with violent events' dealing ways was associated with presence of private security agents, their effectiveness, and the type of nursing unit employment.

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What is verbal aggression?

Workshop

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Abstract

Background

Verbal or non-physical aggression is encountered on a daily basis within healthcare (Cox 1987, Farrell 2006). Increasing attention has focused on the incidence and source of this in the nursing literature but a particular difficulty encountered when trying to understand verbal aggression is the lack of a clear definition used by researchers. The nursing literature on verbal aggression and indeed the wider literature on violence (RCN 2005, Farrell 2006, Lanza et al 2006) reveals a range of actions which could be interpreted as verbal aggression ranging from openly hostile remarks, use of profanities through more covert actions such as taking the credit for someone else's work to spreading malicious rumors.

Objective

Student nurses are thought to be a vulnerable group, exposed to repeated instances of verbal aggression because of their junior status and the aim of this study was to understand what a cohort of student nurses consider to be verbal aggression in their everyday clinical practice.

Methods

This study adopted a vignette approach (Gould, 1996) to mapping the boundaries of student nurses' views of verbal aggression. The use of brief vignettes is a flexible method, where in this instance, a series of short, realistic accounts of possible incidents of verbal aggression were given to participants. Part of the flexibility and subtlety of the vignette approach is that aspects of situations which the literature suggested might influence participants' perceptions of whether particular acts constitute verbal aggression can be systematically varied. In this study, the gender of the perpetrator in specific incidents, the level of offensiveness of language used and the clinical environment in which incidents were set were varied between different cohorts of participants completing the study.

The use of this methodology also allowed exploration of sensitive topics by distancing issues that might otherwise feel threatening or disturbing to respondents as they could complete the questions without the need for a face to face interaction. An initial set of fourteen vignettes were devised based on the literature, the experience of the researchers in their own professional practice and that of their supervisors, and clinical practice colleagues. Each vignette represented a possible situation of verbal aggression. Following a pilot study, two of the original vignettes were removed because respondents felt that they portrayed sexual harassment rather than possible verbal aggression. The scores analysed using SPSS and mean scores for each item were calculated. Vignettes which achieved mean scores of 4 or 5 were accepted as portraying verbal aggression.

Results

Length of training and ethnicity were found to affect the perception of verbal aggression portrayed in some of the vignettes. Environmental context also altered the cognitive appraisal of some of the vignettes of possible verbal aggression perpetrated by patients. Intent was an important factor.

This study confirmed the complexities of verbal aggression and the need to study this separately from physical violence and aggression so that greater attention can be paid to the finer details, especially in relation to individuals cognitive appraisals of the event and the coping mechanisms marshaled to deal with this.

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Workplace Abuse In Nursing: A Problem That Can't Be Ignored

Paper

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Keywords:

Workplace violence, nurses, interventions, legislation

Introduction

While it seems that workplace abuse and harassment of nurses would be uncommon, it is not. In fact, nurses frequently experience abuse and harassment in many workplace settings in which they practice, learn, teach, research, and lead. Abuse can take the form of behavior that humiliates, degrades or otherwise indicates a lack of respect for the dignity and worth of an individual to actions that can take the form of intimidating behaviors such as condescending language, angry outbursts and/or threatening body language and physical contact. The emotional impact of such abusiveness demoralizes nurses and can leave the victim feeling personally and/or professionally attacked, devalued, or humiliated. Victims of abusive behavior can also suffer physical consequences such as loss of sleep, anxiety attacks, hypertension and/or weight loss or gain to name a few. Abuse and harassment of any type is a serious issue and should never be tolerated. Unfortunately, we have become so used to it in the nursing profession that it is oftentimes ignored, avoided, or excused in some way as acceptable behavior. Many nurses feel helpless to confront abuse and harassment in the workplace, or they are persuaded to believe that no one really cares. Because a majority of acts of abuse and harassment are not reported, tolerance is likely contributing to the escalating problem. Sadly enough, the literature has demonstrated that inexperienced nurses are more likely to report workplace abuses than experienced nurses. Experienced nurses are more likely to perceive that policies and procedures for workplace abuse and harassment are ineffective.

Main Paper

Although there is a paucity of literature on abuse and harassment of nurses in healthcare organizations, there is some evidence of the origins of this disturbing behavior. Historically it was thought that physicians were the only perpetrators of such behaviors. However, we now know that such acts in the workplace also come from patients and much of the abuse comes from nurse co-workers and supervisors. Other factors contributing to workplace violence include stress, poor staffing levels, long hours worked, improper training of personnel, power/control issues and negative characteristics of perpetrators.

Finding ways to create workplace environments that discourage abuse and harassment of nurses is long overdue. With the worsening national nursing shortage, many professional organizations have examined factors that lead to satisfaction or dissatisfaction among nurses. In 2004, the American Association of Critical-Care Nurses (AACN) identified some of the more serious nursing concerns as cases of verbal abuse and disrespectful behavior from co-workers, peers and colleagues. AACN's policy position on 'Zero Tolerance for Abuse' indicates that abusive behaviors that occur in work environments in which nurses practice "threaten the delivery of

safe, quality care and have the potential to violate a nurse's rights to personal dignity, integrity and freedom from harm." Nursing experts in the area of workplace violence have reported that abuse in the workplace will continue unless programs are instituted to establish, enforce, and measure zero-tolerance policies are put into action. The Nursing Organizations Alliance (NOA) established principles and elements of a healthful practice/work environment in 2004. Since that time these principles have been fully endorsed by the American Association of Spinal Cord Injury Nurses (AASCIN) as well as other organizations including, but not limited to, the Association of peri-Operative Nurses (AORN); National League for Nursing (NLN); American Association of Nurse Anesthetists (AANA); Association of Women's Health, Obstetric & Neonatal Nurses (AWHONN), the American Academy of Ambulatory Care Nursing (AAACN) and the American Nurses Association (ANA). It is critical that nurses and nursing organizations continue to work on initiatives that help nurses create environments that discourage abuse and harassment. The American Nurses Association (ANA) made workplace rights one of its strategic imperatives in order to promote healthy work, practice and learning environments for all nurses and nursing students. In 1993, the ANA House of Delegates (HOD) supported a policy that identified making healthy and safe work environments for all nurses part of its strategic direction. At that time ANA suggested developing recommendations, programs and legislation that would be aimed at decreasing the incidence of violence in places where nurses work. Historically, the focus of ANA has been on sexual harassment and ensuring that there is recognition of, and adherence to, the Americans with Disabilities Act.

Research has established that such abuse and hostility considerably influences places in which nurses practice, learn, teach, research, and lead, significantly decreasing morale and diminishing job satisfaction. In 2006, the Federal Nurses Association (FedNA) submitted a resolution to the ANA HOD that extended the area of focus to include protecting nurses who work for individuals who abuse/misuse their positions of authority and whose actions foster hostile work environments. The resolution recommended adopting principles related to nursing practice and the promotion of healthy work and professional environments for all nurses where by all nurses have the right to work and practice in healthy environments free of abusive behavior and harassment. The resolution encourages all nurses to promptly report incidents of abuse and harassment as well as ensure that no nurse who experiences and reports workplace abuse faces retaliation. It was also resolved that ANA, through and/or along with the Constituent Member Associations, provide guidance for and support nurses who speak out about abuses and suffer reprisal for speaking out against such violence. FedNA also proposed that critical protections be instituted for nurses who speak out against workplace and academic environment abuses and hostile work environments. FedNA recommended that ANA support initiatives to ensure whistleblowers do not suffer reprisal actions as this is extremely important for nurses who are in positions with few avenues to seek protection or assistance. This includes active duty military nurses who have limited civil rights due to the Feres doctrine. Feres doctrine prevents military service members from suing the federal government. In fact, military nurses have little legal recourse currently if they experience harassment or intimidation as long as the harassment and intimidation do not result in narrowly defined adverse personnel actions. Other recommendations included advocating for the implementation of policies that support violence-free workplaces through comprehensive workplace violence prevention programs. The resolution proposed by FedNA was approved by 97.6% of the House of Delegates which consisted of over 600 nurses from across the United States.

As a profession we must be politically active to ensure that members of Congress are aware of the severity of the problem of workplace abuse and that they advocate for legislation to address this issue. In particular, ongoing work is needed to improve and support legislation addressing whistleblower protections. For example, current Congressional efforts are underway to improve whistleblower protections for Federal employees. The Paul Revere Freedom to Warn Act (H. R.

4925) was introduced in the House of Representatives in 2006. The purpose of this legislation is to afford greater protections for employees and/or members of the uniformed services who suffer reprisal for speaking out against wrongdoing. If passed, H.R. 4925 would provide individual reinstatement with the same seniority status and employment grade or pay level that the individual would have had, but for the reprisal. Individuals would also be eligible for compensatory damages sustained as a result of whistle blowing. While circumstances vary for why and how abuse and harassment in the workplace occur, there are some general guidelines to help nurses address the problem. Nurses should take every effort to familiarize themselves with organizational policies and procedures against abuse, harassment and hostile work environments. They should also be familiar with the mechanisms in place to report such abuses and what entitlements exist for nurses to be protected for reporting such incidents. In order to address the problem of underreporting, nurses need to become better at immediately reporting cases of abuse to immediate supervisors and the human resources department if needed. Concerns should be elevated to more senior leadership within the organization until the problem is appropriately addressed. It is also imperative that detailed documentation be kept surrounding the circumstances. For example, written reports should include the date and time of the incident, the name and title of the individuals involved, the nature of the abusive behaviors, witnesses, actions taken, results of actions taken, etc.

Conclusion

Abuse and harassment of nurses in the workplace has become a very serious matter. Ensuring this critical issue is brought to an end requires that all nurses advocate for initiatives that address factors that put nurses in harm's way.

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The views expressed in this proceeding are those of the author and do not reflect the official policy or position of the United States Air Force, Department of Defense, or the U.S. Government.

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Workplace bullying in the public service sector in Sweden: grounded theory studies on its origin, maintenance and consequences

Poster

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Abstract

Bullying, defined as demeaning and downgrading of humans through repeated negative acts, is a widespread problem in working life. The frequency of reported bullying cases has increased in the public service sector in Sweden. Research in Great Britain and Norway also report that health care staff are exposed to bullying. In a psychiatric ward in Norway about 10% of nurses reported that they were bullied or 'frozen out' by one or several of their co-workers. An English study showed that significantly more qualified nurses were bullied compared to other health-care staff. During the last decades the public service sector in Sweden has been subjected to repeated reorganizations and reductions in staff members. Has this fact contributed to an increase in workplace bullying and if so, in what way?

Aim

The aim of this research project was to investigate how bullying is initiated and maintained at the workplace in the public service sector and to explore health consequences experienced by bully victims. The study was done to gain a deeper understanding of workplace bullying and to gain knowledge to facilitate bullying prevention at workplaces in the public service sector.

Method

The grounded theory method was chosen because of its focus on meaning, action and social processes. The aim of such an inductive method is to generate theory from empirical data and to explain what the main problem is in the studied area. The 22 informants included in the study were recruited from advertisements in daily newspapers and participated voluntarily. They had all been exposed to bullying at their workplaces in the public service sector. Data was collected through open taped interviews lasting 1-2.5 hours. Collection and analysis of data was a simultaneous process and continued until saturation was met, i.e. when new data did not add new information.

Results

The results show that a long-standing struggle for power precedes systematic bullying. The power struggle emanated from conflicting values among the staff at the workplace. The interplay between poor organizational conditions, weak or indistinct leadership styles and the involved parties' work expectations seemed to contribute to the origin of the conflict. Individuals who described themselves as strong and competent persons were often targeted in these conflicts. If the conflict remained unsolved, it escalated and grew into systematic and persistent bullying. According to data, the aim of bullying seems to be resolution of a conflict through rejection and expulsion of a threatening workmate. Indirect aggressive behaviours in many subtle shapes were used and aimed at betraying, devaluing and violating a person. The bullying could be legitimized through the managers' unjust treatment, such as offering worse tasks and lower pay increase. The consequences of bullying were initially feelings of guilt, shame and diminishing self-esteem.

These feelings were followed by deteriorating psychic and physical health, e.g. sleep disturbances, stomach trouble, headache and depressed mood. Psychosomatic symptoms developed and medical treatment and sick listing followed. The longer the bullying continued the more limited was the bully victim's possibility to change the situation. Returning to a 'normal' life could be possible but presupposed that the bully victim had worked through the course of events and obtained some form of redress, e.g. monetary compensation or professional confirmation. Despite this, a bully victim is marked for life.

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Workplace Violence against Nursing Personnel: Prevalence and Risk Factors

Paper

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Abstract

The purpose of this longitudinal research is to determine the prevalence of and risk factors for physical and psychological workplace violence (WPV) against nurses and nursing personnel. The Haddon Matrix, a classic public health framework for addressing injury control, was adapted to guide the study. 2170 (52% response rate) nurses and nursing personnel from one large urban, one medium sized community and one small suburban hospital responded to an online confidential survey on workplace violence. At baseline, 30.3% of the participants reported experiencing physical (19.8%) and/or psychological (20%) WPV in the past 12 months. Approximately 10% of those physically assaulted were injured. A case control design was utilized to select 1695 participants for follow-up, including the population of nursing personnel who experienced WPV (cases; n=652) and a random sample of controls (n=1035). The response rate was 81.3% (n=1378). 37% of follow-up participants reported experiencing physical (23.9%) and/or psychological (24.5%) violence in the approximately 6 months between baseline and follow-up surveys. Of those who reported experiencing WPV at follow-up, 21.8% had not reported experiencing WPV at Baseline. Logistic regression was used to examine the risk factors for WPV at follow-up. Nurses were more likely than non-nursing personnel to be the victims of WPV, as were participants who identify as White. Variables regarding hospital unit had the highest adjusted odds ratios; significantly more WPV was reported by nursing personnel who work in the Emergency Department and the Psychiatric Unit. Childhood physical and sexual abuse also was risk factors for experiencing WPV. Those participants who reported being depressed (CESD-10) at baseline were significantly more likely to report WPV at follow-up. Burnout was measured using the Copenhagen Scales at Baseline. Personal Burnout at baseline predicted experiences of WPV at follow-up. However, Client Burnout shows the opposite effect, with nursing personnel who reported Client Burnout at baseline significantly less likely to report WPV at follow-up. Workplace violence is a common experience for both nurses and other nursing personnel. Violence is significantly associated with general physical health outcomes as well as injury. An understanding of the risk factors for WPV can help to inform prevention and intervention efforts.

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**Chapter 6 -
Policies and Operational
Strategies regarding workplace
violence: local, national,
international and global
guidelines, standards, reporting,
prediction, risk assessment,
prevention, management, after
care and rehabilitation**

A solution focused approach in a health care provider for mentally disabled people

Workshop

Leo Roelvink

AveleijnSDT, Borne, The Netherlands

Abstract

Management: In order to increase employee safety AveleijnSDT has implemented a full organizational approach. This is based on solution-focused working, which checks what works, then expands it until the desired target is achieved. Within this policy framework, Managers are expected to create a safe working environment for employees. This policy addresses both employees and clients. On one hand, measures are taken to increase the safety of the employees, while on the other hand the organization stimulates clients in behavioral adjustment.

This presentation focuses on three measures to increase employee safety.

1. AveleijnSDT has developed a Quickscan Risk Behavior methodology, which rapidly determines the risk profile of new clients before they accepted and placed in the organization. This methodology ensures correct placement so reducing risk, and can also be used when relocating clients is required.
2. AveleijnSDT has recently started a residential treatment location with 30 clients. Its objective is to reduce the psychic, psychiatric, and behavioral problems, particularly impulse control problems. The treatment is based on solution-focused therapy, as well as other forms of treatment. Hypotheses will be presented regarding the conditions that contribute to the prevention and reduction of client aggression. In addition a report on the first clinical results using a few N=1 cases studies will be given.
3. Since 2004 AveleijnSDT has registered all incidents of client aggression using the SOAS (Staff Observed Aggression Scale) system. From the analysis of results, a policy has been developed to reduce and prevent client aggression. Figures and analysis of aggression incidents will be given during the presentation as well as insight in the resultant policy measures.

Foundation

The AveleijnSDT Foundation is a health care provider in the East of the Netherlands, which offers support and development to some 2300 mentally disabled people. AveleijnSDT supports the mentally disabled people of all age groups, and also specific target groups such as non-congenital brain damage, autism and psychiatric problems. AveleijnSDT presently employees some 1500 people. The provision of care by AveleijnSDT is primarily based on the AWBZ (Dutch Law on extraordinary medical expenses). All clients have been given a care indication by the CIZ (Dutch bureau which determines need for care), which determines the budget.

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Acute management of disturbed, aggressive and violent behavior in inpatient psychiatric setting - A systematic review

Paper

Bindthu Nair, Govindasamy Arumugum, B. C. Ong, Raveen Dev, Samsuri Buang, H. C. Tan, H. C. Su, T. Yap, Institute of Mental Health, Singapore, Singapore

Abstract

Introduction

Violence is defined as severe verbal abuse, physical assault, touching or any form of unwanted physical contact, threatening behaviors or persistent harassment of any kind (Bedfordshire and Luton, NHS, September 2007). Violence is a common and imminent problem in the mental health setting. Disturbed, aggressive and violent behavior displayed by patients poses a serious risk to himself / herself, other patients and staff, causing harm to physical and psychological health. This threat has become increasingly recognized as a significant problem in a psychiatric setting. A review of the incidence rates of assaults in the Institute of Mental Health, a psychiatric hospital in Singapore, found 403 cases of assault incidents against patients and staff. 267 cases involved patients being assaulted and 136 involved staff being assault, highlighting the urgency and clinical important of this issue.

Aim

This paper aims to systematically appraise the best available evidence for management of aggression and violence in an inpatient psychiatric setting.

Methods

The databases MEDLINE, CINAHL, Embase, Cochrane and gateway Ovid were searched using keywords such as violence, aggressive and disturbed. The search was limited to English language. The inclusion criteria was adults 18 years and above. The setting was limited to the acute inpatient psychiatric setting.

Results

Findings from the literature search recommended the use of risk assessment tools and structured clinical judgment to assess disturbed, aggressive and violent behavior. Rapid tranquillisations involving the use of intramuscular injection was also recommended compared to oral medication administration in view of the faster onset of action. Other intervention included de-escalation and the provision of a calm, open, non-threatening and friendly environment. Restraint should be considered only after other strategies failed to calm the patient. However, debriefing had to be initiated within 24 hours from the termination of restraints. Alternatively, social interventions such as verbal interaction with staff member, provision of quiet time, physical / diversion activity (such as escorting patient for a walk or exercise, listening to music) and relaxation therapy were suggested to decrease the number of violent incidences in inpatient psychiatric setting.

Conclusion

The synthesis of evidence from the literature highlights the recommendations for practice with regards to reducing the incidences of disturbed, aggressive and violent behavior in psychiatric

settings. The findings suggest that the strategies to manage aggression in adult inpatient psychiatric setting are multi-faceted ranging from assessment to the use of injection, de-escalation, restraint or social interventions. It is imperative to introduce such interventions to bring about a reduction of violence incidences.

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An Integrated Approach to Preventing and Managing Aggression: Successful Strategies and Initiatives

Workshop

*Kathy Finch, Riola Crawford, Alison Jones
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Abstract

Riverview Hospital is part of the British Columbia Mental Health and Addiction Services (BCMHAS), an agency of the Provincial Health Services (PHSA). A tertiary care psychiatric hospital, Riverview continues to provide extensive inpatient services to the seriously mentally ill while working collaboratively, under the BCMHAS (and PHSA) to re-develop this level of service throughout the province. Tertiary care comes with an inherent risk of aggression from patients. By taking an integrated approach to violence prevention and management, we have been successful in significantly reducing staff injuries from patient assault.

We support and encourage an integrated approach to preventing and managing violence and aggression and it is through this lens that we wish to share the successful strategies which not only improves the quality of life for patients and staff but does so by managing risks effectively. This workshop focuses on our organizational model for Preventing and Managing Violence and Aggression and a Continuous Quality Improvement framework for addressing those elements essential for managing risks effectively, for monitoring and evaluating structure, process and outcome, and for continuously improving care and service from a patient, family, staff, and organizational perspective.

Central to it all will be our commitment to a culture of patient safety, to sustaining a respectful workplace, to promoting safe and satisfying work. This commitment has grown to include leadership education and numerous opportunities such as workshops, team and individual coaching and safety huddles, to fully engage in meaningful work at all levels.

The underpinning value of our comprehensive Nonviolent Crisis Intervention Training© program is that of providing a common language and singular awareness and focus on sustaining a safe working environment. In such circumstances, best practices become the norm.

Workshop Scope and Content:

1. Agency -based and Service-based organizational models for preventing and managing aggression and violence;
2. Links to federal and provincial standards such as hospital accreditation, violence prevention policies and joint occupational safety and health violence prevention programs
3. The Riverview Hospital experience: Violence Prevention Program and extensive Nonviolent Crisis Intervention Training program effective in significantly reducing staff injury; feedback from staff and patients; quality improvement initiatives to improve communications about escalating behaviour; and case study demonstrating impact of key initiatives on quality of life.

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An Urban Acute Care Hospital's Response to Workplace Violence

Paper

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Abstract

Health care professionals, especially point of care staff are experiencing and reporting greater incidents of workplace violence. An increase in the prevalence of societal violence, nature and proximity of the staff/patient relationship, health care consumer expectations, gender and trends towards increased incident reporting are factors. In response, hospitals require policies and procedures that reflect a zero tolerance for violence and address staff's needs for educational programs to aid in prevention, safe intervention and critical stress incident management.

In 2006, several University Health Network (UHN) departments recognized a common interest and obligation to address workplace violence. Specifically, UHN received an order from the provincial Ministry of Labour regarding unionized staff's complaint of repeated experiences of 'patient aggression'. Occupational Health Services also noted increased numbers of reported incidents prompted through the organization's emphasis on Workplace Wellness, Code of Conduct, Respect in the Workplace and 'a just culture' which supported a value for increasing incident reporting. In addition, hospitals perceived a heightened level of risk due to extensive media coverage of a sentinel event involving the murder of a nurse by a coworker in an acute care setting.

Prompted by these events, an inter-professional Workplace Violence Prevention Committee was formed to 1) revise current policies/procedures, 2) develop response training and innovative e-learning modules, which highlight verbal de-escalation, other prevention techniques and response strategies and 3) communicate and market resources available. Other recent initiatives involve reviewing and acting on the inquest recommendations related to the acute care sentinel event as well as developing a volunteer critical stress incident peer support team (PST). The PST provides defusing and debriefing for a wide continuum of events ranging from catastrophic tragedies to common daily experiences of staff moral distress and compassion fatigue.

Staff, while still experiencing incidents of workplace violence, feels a greater sense of individual confidence as well as more explicit manager and organizational support. Formal evaluations of the impact of the PST interventions are pending.

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Breaking the silence: lateral violence in the workplace, a path to cultural transformation

Poster and paper

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Keywords:

Workplace violence, healthcare, intensive care nursing, zero tolerance, lateral violence, horizontal violence

Introduction

Lateral violence, or nurse to nurse violence, has received increased attention in the past few years and is acknowledged to be a continued source of stress facing the profession. Silence surrounding this disturbing phenomenon endangers patient safety and increases the vulnerability of an already fragmented profession. The Joint Commission acknowledges that unresolved conflict and disruptive behavior adversely affects safety and quality of care [1]. Healthcare organizations face a continuing nursing shortage today which is projected to grow worse as nurses retire [2]. Breaking the silence of lateral violence and its effects is a priority for all nursing leaders.

Background

The International Council of Nurses, defines workplace violence as physical and psychological violence, abuse, mobbing or bullying, racial harassment and sexual harassment, and can include interactions between co-workers, supervisors, patients, families, visitors and others [3], lateral violence [4, 5, 6] horizontal violence [7, 8, 9, 10] and horizontal hostility [11, 12] are terms used to describe the physical, verbal or emotional abuse of an employee. Within nursing, lateral violence (LV) is defined as nurse to nurse aggression. This violence can be manifested in verbal or nonverbal behaviors. Common forms of LV in nursing include the following: non-verbal innuendo, verbal affront, undermining, withholding information, sabotage, infighting, scapegoating, backstabbing, disrespecting privacy, and broken confidences [4]. Lateral violence as a form of workplace aggression most commonly takes the form of psychological harassment, creating hostility [8]. There is a paucity of research regarding LV and its effects in NICU. Persistent conflict at work is detrimental to the work climate and negatively affects individuals physical and psychological well being [13], and results in increased turnover and absenteeism, reduced coordination and collaboration, and lower efficiency [14, 15]. Intimidating, abusive behaviors impact patient safety, according to a survey by the Institute for Safe Medication Practices, 49% of all respondents reported that experiences with intimidation altered the way they handle clarifications or questions about medication orders, increasing the risk of incorrect interpretation and occurrences of medication errors, while 7% reported that they had been involved in a medication error during the past year in which intimidation clearly played a role.16 And in a position statement from the American Association of Critical-Care Nurses, intimidating behaviors also endanger quality patient care [17]. Nurses have reported concern about the lack of action taken by supervisors in addressing horizontal violence in the workplace [8, 6].

The ramifications of LV in the workplace are many and powerful. Ongoing LV sets up a downward spiral that becomes costly to the staff and to the organization as a whole. LV results in low morale,

retaliation fears and lower levels of collaboration. The ultimate result is a negative impact on patient care and outcomes as nursing focus is moved away from patient care. Leadership interventions should include training in group dynamics, communication, employee assistance programs, and a team approach to change [18]. Managing inappropriate aggressive behavior needs to progress from crisis management to preventative programs that operate at an institutional level. One study examined horizontal violence amongst midwives and showed that senior management recognized a cultural, rather than individual issue of bullying, realizing that, in some respects, management were actually exacerbating the problem by maintaining a hostile environment [19]. A taken-for-granted phenomenon can result from many nurses and organizational cultures fostering an environment which supports violent behavior and protects perpetrators [20,21]. The literature suggests that LV may be multi-factorial. To this end, we proposed a tri-phasic intervention to examine its effects on LV among NICU staff.

Methods

This study used a descriptive mixed methods approach within a hospital-based cohort to examine a three phased leadership intervention initiative within a NICU to reduce LV. A convenience sample of 48 registered nurses employed at a community teaching hospital NICU within an academic system was obtained. Employing focus groups this study interviewed staff nurses to obtain concurrent and stimulated narratives of experiences with LV in the unit. Additional employee assistance time was allocated by the organization for all participants. A prospective mixed method quasi experimental design included pre and post-test examination of the degree of LV present in the unit. A nursing leadership team consisting of a maternal child health division director, clinical nurse specialist, and unit director was identified to offer a multi-layered intervention. A peer-reviewed questionnaire was developed to facilitate semi-structured interviews and focus groups on LV. Organizational climate assessment was embedded in this instrument. Descriptive information was gathered on a demographic tool.

Intervention

Phase 1: Voicing the Problem. During this phase we conducted staff nurse focus groups. Each focus group was offered for 60 minutes to all NICU nurses and allowed staff to openly share experiences of covert and overt violence, feelings, and barriers to change that revolved around their experiences. A full day off-site mandatory 'retreat' was designed for the staff with the consultation of the organization's employee assistance counselors for content focused on appreciation, teamwork, communication, conflict resolution and reflection. This educational retreat was facilitated by a licensed psychotherapist from the employee assistance program. Information was collected at retreats to build interventions. Follow-up meetings were conducted by the same psychotherapists. Management teams met with staff monthly. These steps were designed to understand unit culture, work values and beliefs. Goal setting was used to prioritize strategies to overcome barriers raised in the meetings and focus groups. Phase 2: Staff Education. Offsite and in-house seminars were facilitated by a counselor and the leadership team. Educational materials related to LV and bullying were provided to participants during follow-up sessions and strategically placed to be accessible during work hours. Educational sessions on conflict management were provided to charge nurses and a dedicated new graduate socialization program was initiated. Phase 3: Zero Tolerance. A zero tolerance policy against LV was established and enforced following education. Newly designed interpersonal and professional standards were disseminated. Leadership presence was made highly visible to demonstrate support.

Data analysis

Descriptive statistics were used to measure differences between staff outcomes measures (pre and post intervention) to examine retention, turnover, perceptions of teamwork, and staff satisfaction along with external agency staffing numbers. Evaluators used well-documented qualitative techniques to analyze focus group data based on systematic grounded theory coding procedures. Initial coding was descriptive and used participants own words. Throughout the process coding was an iterative process with emerging themes identified by a group consensus. Statistical analyses were performed with STATA 8. Continuous variables such as nurse retention, experience and perceptions of LV were analyzed using multivariate and univariate regression with post-hoc testing with Hosmer-Lemeshow goodness of fit test using a .05 significance level. Mantel-Haenszel odds ratios (ORs) were used for analyzing categorical data.

Results

The purpose of this study was to evaluate the effectiveness of a multifactor leadership pathway in transforming the culture of NICU with high levels of LV. Interviews were completed on 98% NICU staff with both shifts equally represented. Education varied between associate degrees (90%), bachelors (6%), and masters (4%) in nursing science. Post intervention, outside agency use dropped to zero as retention increased to 100% with new hires. Staff satisfaction increased as evidenced by a decrease in documentation of unprofessional behavior. Qualitative data revealed high levels of satisfaction with interpersonal relationships and collaboration between team members. Episodes of LV decreased, unit morale trending toward hopeful and positive. As bullying decreased, staff participation increased in precepting and unit projects.

Qualitative analysis of focus groups and interviews revealed five major themes: 1) LV creates a toxic environment; 2) LV varies in degree from day to day; 3) overwhelming lack of respect; 4) deleteriously effects teamwork and 5) fear of retaliation. For example, participants described difficult interpersonal behaviors which they experienced as personal attacks and harassment as a daily source of stress that coincided with escalating bullying. There was a reluctance to discuss somatic symptoms with concern it would be seen as a weakness lead to more bullying. Breaking the silence was seen as both therapeutic and threatening by participants. Bullies were identified as informal leaders that created complex power groups. Participants used individual coping strategies but did not feel safe in seeking organizational assistance to reduce LV secondary to fears of retaliation and retribution. This fear was linked to the concern of not receiving assistance in critical patient care situations. Among participants, LV was seen to be affecting teamwork, interdisciplinary collaboration, morale, and patient care. Pessimism regarding the potential for affecting the levels of LV in the unit was a recurrent theme. Patterns of silence, passivity, and fear were present in participant responses during the interview, retreats, and follow up sessions. Staff perceived a culture of safety existed to protect reporting of bullying and/or LV. A bully to victim attitude was identified in a few participants who reported higher levels of bullying. Participants described a higher level of confidence in the organization to protect them in the workplace and provided expressions of relief and optimism regarding the lower levels of LV.

The multivariate regression model (AdjR2= .56) tested for goodness of fit revealed negative associations between LV degree and RN satisfaction level ($p=.01$, CI-.53, -.07) and retention ($p=.01$, CI -.63, -.08) and a positive relationship with recognition of effect on teamwork ($p<.001$, CI .34, .96). Univariate regression showed a negative association between LV and retention ($p=.006$, CI -.47, -.08). Experienced nurses were four times more likely to report LV team effects (OR 3.75, CI 1.7, 8.2). Multivariate regression identified retention was linked to LV degree ($p=.015$, CI, - .66, -.07). Retention was 5 times more likely among experienced nurses than less experienced (OR 5.2, CI 1.9, 13.5). Nurses who identified a higher LV in NICU were 18 times

more likely to report LV had a strong effect on teamwork (OR 18, CI 4.3, 74). The odds of a nurse recognizing a high LV in NICU increased with years of experience (OR 6.6, CI 2.57, 16.9). Nurses dissatisfied with the unit climate were three times more likely to identify moderate to high levels of LV (OR 3.2, 1.2, 7.9).

Discussion

The purpose of the study was to evaluate the effect of a multi-faceted leadership intervention in a NICU with high LV which reportedly impacts mental and physical health. The Washington State Department of Labor produced a report identifying bullying in the workplace as repeated acts of aggression, creating an on-going pattern [22]. The report cites significant physical and mental problems experienced by the victim includes high stress, post-traumatic stress disorder, phobias, sleep disturbances, increased depression/self blame, reduced self esteem, musculoskeletal problems and digestive problems. It unearthed extreme levels of anxiety and feelings of disrespect being experienced. Similar symptoms were reported by participants and the literature (e.g. palpitations, nausea, headache, dizzy, suffocation, feeling attacked, embarrassment, belittlement, and fear) [22, 23]. This tri-phasic intervention was a crucial first step in affecting cultural change [24]. These findings are unique but not entirely incongruent with the Safer Services Model [25]. Historically, healthcare organizations tend to deny or ignore the problem of LV [25]. Our leadership retreat was successful in giving a voice to complaints related to communication, discussions regarding fear of retaliation as well as suggestions for environmental improvements. Victims of some of the most severe LV exhibited perception shifts regarding the violence perpetrators. The relationships between perpetrators and victims created complex circuits of power not unlike what is listed in Hutchinson.²⁷ Feelings of initial anger shifted to sympathy and questioning of their potential responsibility in eliciting the LV, a bully to victim transformation, requiring a dedicated multi-level approach from both leadership and employee assistance to affect growing empowerment abilities of the staff. The intervention led to improvements in communication, collaboration, congeniality, and feelings of safety that changed the climate. Nurse recognition of effect on teamwork was strongly associated with recognition of LV which is important as a stepping stone to speaking out. Nurses who identified higher LV were much more likely to report its strong effect on teamwork and this was more likely among experienced nurses. Interestingly, recognition of the effect did not translate into awareness of LV. A focus on staff education and research in this area is imperative. The negative association between LV and staff retention was statistically significant and clinically important as new hire training costs nearly 65,000 dollars. Retention was 5 times more likely among experienced nurses than new hires so methods to minimize LV leading to staff flight are needed. While nurses dissatisfied with the unit climate were more likely to recognize moderate to high levels of LV, recognition occurred more with experienced nurses. This leads us recommend that education on LV, how to recognize it and break the silence early on is critical for all new hires to enhance satisfaction and retention. Targeted education and training in conflict management and communication provided requisite skill sets to empower violence reduction at the time of occurrence. This enhanced education and training, in combination with an administrative infrastructure at both the unit and upper levels of management implanted and supported a culture of safety and zero tolerance for abuse resulted resulting in positive outcomes including reduced staff turnover, increased commitment, retention, and satisfaction. Limitations include small sample size and generalizability.

Conclusion

This paper has identified a multi level leadership pathway to reduce LV in a NICU. A multifaceted, multi-level, evidence based leadership pathway provided a transformation of a unit culture with high levels of toxic LV to a safe and empowering workplace for staff and

patients. Further research is needed to address the issue of sustaining the transformation as well as to replicate these findings in other settings. Breaking the silence of LV must be a priority for all nurses.

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Calming the Tigers: Addressing Violence in the Healthcare Workplace with a Theory-Based Systemwide Action Plan

Workshop

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Abstract

Experiencing and responding to episodes of physical, verbal, and emotional violence in healthcare settings has been reported world-wide as a critical safety issue. Violence in the healthcare workplace evokes fear, and may threaten the fragile power balance as the victim may become the aggressor and the aggressor becomes the victim. Patients, nurses, healthcare personnel, physicians, visitors, families, and intruders all participate in a complex web of relationships which are replete with the potential for conflict.

Conceptual frameworks for understanding violence include systems theory and the intersection of an extensive continuum of violence with a multi-level spiral of violence. Evidence-Based Interventional Strategies are focused through the lens of restorative justice, Caplan's concepts of primary, secondary, and tertiary prevention, and core bioethics principles. Addressing systematic issues of exclusion, harassment, and misuse of power imbalances are as critically important to reducing workplace violence as developing physical intervention policies and providing violence prevention / intervention training for all personnel based on their unique risk factors. Achieving congruence with action and intent requires interrupting the spiral of violence with nonviolent alternatives.

Development and implementation of a theory-based, system-wide plan to ensure both patient and personnel safety requires: engaging top-level administrative commitments, integrating the plan into the corporate culture, examining cost-benefit ratios, meeting regulatory standards, and including quality initiatives. Partnerships cultivated include: Risk Management, Security, Human Resources, Administration, Communities Served, College of Nursing, Physicians, Clinical and Non-clinical personnel, and Chaplains. This allows everyone to own a part of the problem and become a part of the solution.

During this highly-interactive, rapid-paced workshop, an experienced, U.S.-based, Psychiatric Clinical Nurse Specialist, baccalaureate nursing faculty member, and consultant will provide an integrated theoretical framework for addressing issues of healthcare violence, an overview of the scope of the issues, and concrete examples of a multidisciplinary implementation plan for an acute care, multi-hospital system with psychiatric services. Collaborative strategies and resources for addressing verbal, emotional, and physical violence in diverse healthcare settings will be shared, including how to meet and exceed regulatory requirements. Through extensive, structured, participant contributions, global and local resources, strategies, issues and concerns, will be discussed and shared.

Outcomes include:

- a. maximizing the impact of interventions to reduce violent behaviors and their consequent sequel in diverse healthcare settings,
- b. ensuring consistency and congruency in addressing issues of violence throughout the organization,
- c. securing long-term organizational commitment to violence reduction and response,
- d. meeting and exceeding regulatory requirements, and
- e. improving patient and personnel safety.

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Changing a culture: Reflecting on the contributing factors that helped shift the approach to managing workplace violence in an acute care facility in Winnipeg, Canada

Workshop

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Abstract

Violence in hospitals, particularly emergency, dialysis and mental health occurs so commonly that many health care workers, particularly nurses believe it is simply “part of the job” (Clarke, Griffith, & Brown, 2002). Increasing concern over the growing number of incidents and the seriousness of staff injuries has resulted in a new culture at the Health Sciences Centre. Upon reflection, the impetus for an alternate approach to managing workplace violence resulted from a variety of local, regional and provincial factors that created an environment ripe for change. The approach to workplace violence had been reactionary in nature and did not promote the development of proactive mechanisms. Individual incidents were responded to as they arose with the resources available at that time. In the early nineties an evolution began, and concern about workplace violence became part of the collective consciousness of staff at the Health Sciences Centre. Regional surveys conducted in 2000 with mental health staff on work life satisfaction, revealed a strong theme of fear and its impact on their quality of work life (Clarke et al., 2002). In 2001 the survey reported that nurses in mental health responded on average that “sometimes” fear of violence from patients affected the quality of care they could provide and “sometimes” to “often” their personal safety is jeopardized by violence from patients (Clarke, 2001). The survey findings provided the impetus to develop a number of quality improvement initiatives. Various strategies including the training of staff in programs such as Non Violent Crisis Intervention, paraprofessional competency training, policy development, revised occurrence reporting, quality improvement initiatives and research projects, took place. New policies such as ‘searching patient belongings’, and ‘managing aggressive incidents towards employees’ reflect the Centre’s philosophy and intent to provide a safe, non-threatening, quality environment. The development of policies related to workplace violence provided clear direction to the facility, and set the stage for greater involvement from the Occupational Environmental Safety and Health department who have recently developed a workplace violence prevention program proposal. Another initiative was the development of a Violence and Abuse Free poster initially displayed in all areas of the hospital, later adopted regionally and most recently supported by professional unions to be displayed in all provincial facilities. The poster was followed up with a corresponding pamphlet that is provided to all patients on admission, that makes explicit that patients, visitors and staff are to be respected and must feel safe at all times. Other process improvements include conducting risk analyses throughout the centre resulting in multiple recommendations, installing cameras, purchasing personal alarms for staff, and developing protocols for defining minimum safe staffing levels. These activities have been done collaboratively with various programs throughout the facility as well as external stakeholders. Patients report that our comprehensive efforts are noticed and have helped contribute to an increasing perception of overall safety.

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Collaborative Management of Aggression: Helping Us Help You

Poster

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Abstract

Purpose

In the acute adult psychiatric inpatient setting, how do the perceived causes of agitation compare between client and staff, and what are effective collaborative strategies to manage these incidences so as to reduce the use of seclusion and restraint procedures? We examined the effectiveness of a collaborative intervention between client and staff to promote client-involved care through insight and communication.

Background

Seclusion and restraint procedures are recognized formally in literature and anecdotally as physically and emotionally dangerous interventions for involved participants. Client and staff can more effectively cooperate together in determining a client-centered, plan of care. This initiative develops insight for client and staff, improves communication, and recognizes seclusion and restraint as a last resort.

Methods

San Francisco General Hospital Department of Psychiatry inpatient unit 7B is the setting. The project team is a clinical nurse specialist as the coach and a registered nurse of the designated unit as a fellow. We instructed all regular and non-regular unit staff and disciplines and encouraged participation as a per incident basis as a collaborative management form change agent tool. Evaluation strategies included a post-survey follow-up of staff considerations and an examination of efficacy of the change agent interventions.

Results

An approximate six-week trial period was allocated for implementation with six male clients with varying psychiatric diagnoses and established as cognitively functional. Behaviors included impatience, inappropriate sexual conduct, cases of self-harm behavior, and cases of homicidal threats. Perceived causes included attention seeking desires, unavailability of medications, altered perceptions, and needed consolation. Collaborative strategies included allotted attention, medication availability, and personal discussion of feelings. One of the six clients required continued revision of management. All six exhibited either elimination of behavior or at least, compliance with the collaborative plan following inappropriate exhibited behavior.

Discussion

Though behaviors repeated, earlier recognition and harm reduction initiatives did occur. Limitations include a limited trial period influencing a low data sample size, creating a less accurate reflection of project reliability and variation of outcomes, possible unclear understanding of instruction and design, along with the less than adequate formal follow-up measures, thus demoting usage.

Implication

Purposeful documentation with accessible communication aspects requires further investigation to facilitate intervention strategies. Implementation with a similar population may yield more convincing results without any unit-specific barriers. The healthcare field as a whole needs a system to achieve the mentioned issues and to aptly organize such information for convenience in access and follow-up.

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Combating Violence in the Community Care Environment

Seminar

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Abstract

Current English health policy is to shift the bulk of health care from the hospital into a community setting. The strategy is progressive and meets the issue of patient choice.

But the move out of institutions like hospitals and big health care facilities does have its challenges when addressing the health, safety and welfare of healthcare staff working in the community. There is no longer a centralised workplace with a management and clinical structure to work within. And the healthcare worker can find themselves working in isolation away from their employers and its dedicated workplaces.

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Crisis Intervention Care team in a Psychiatric University Hospital as a violence prevention tool in clinical psychiatry

Workshop

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Abstract

In spite of improvements in therapy, supervision, and care on in-patient psychiatric units, the acute unit in particular suffers from a considerable amount of violence (violent assaults) as well as various other disturbing incidents and suicides, all of which have traumatizing effects on the care team. Up until now, this area has been given little attention. In fact no systematic procedure and no institutional standards exist in the care and supervision of the staff working in the psychiatric acute care unit, whereas this exists for other professions. For this reason, a crisis intervention care team was set up at the Psychiatric University Hospital Zurich.

In 2000 the Psychiatric University Hospital crisis intervention care team was founded and put together by experienced people from the care department. The task was to accompany individual members of staff in traumatic situations by providing an initial debriefing, a triage and further procedures as necessary, on request and in a focused manner.

In this presentation and workshop we would like to present the concept and our experiences so far, in more detail. It has become clear that, independent of the current supervision, of care personnel, there is a considerable need for immediate intervention. We will present some data on the number of incidents and profiles of the cases dealt with, as well as feedback i.e. self-evaluation of the members of the supervision group and the traumatized carers themselves. Due to the highly qualified and extremely experienced members of this team, the methods they used could be applied on an individual basis. In addition regular meetings of this intervention care team were held to further members' knowledge and keep up to date with the latest research findings.

Over the past few years, at the same time as the intervention care team had been establishing itself, there has been a continual increase of violence in the hospital, for which there are various reasons. In the meantime, the crisis intervention care team of the Psychiatric University Hospital Zurich has become an indispensable part of the clinic's culture and an immediate preventative measure against burnout and the consequences of PTSD which may lead to the inability to work and subsequent absenteeism. The crisis intervention care team therefore plays an important role in prevention of violence.

The workshop will discuss the concept, the experience, and the results of an interdisciplinary crisis intervention care team in the Psychiatric University Hospital Zurich especially concerning the consequences and violence prevention strategies in clinical psychiatry. It will become obvious that, from our point of view, in the field of modern psychiatry such a team should be an integral part of professional practice. It is astonishing that there is a negligible amount of literature and research in this particular area, that such a care team is the exception rather than the rule, and that no quality management standards for such a back-up team exist.

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Determinants of domestic violence among women attending VCT in health center

Poster

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Abstract

Context

Violence against women is a global phenomenon that cuts across all social and economic classes. AIMS: This study was designed to measure the prevalence and correlates of domestic violence (DV) among women seeking services at a voluntary counseling and testing (VCT) center in developing country.

Settings and Design

A cross-sectional survey was conducted among women visiting an human immunodeficiency virus (HIV) VCT center between September and November 2007.

Materials and Methods: An interviewer-administered questionnaire was used to collect information about violence and other variables.

Statistical analysis used: Univariable associations with DV were made using Pearson Chi-squared test for categorical variables and Student t-test or the Mann-Whitney test for continuous variables.

Results

Forty-two percent of respondents reported DV, including physical abuse (29%), psychological abuse (69%) and sexual abuse (1%). Among the women who reported violence of any kind, 67% also reported that they were HIV sero-positive. The most common reasons reported for DV included financial problems (38%), husband's alcohol use (29%) and woman's HIV status (18%). Older women ($P < 0.001$) and those with low income levels were the most likely to have experienced DV ($P = 0.02$). Other factors included husband's education, HIV sero-positivity and alcohol or tobacco use ($P < 0.001$).

Conclusion

This study found DV levels comparable to other studies from around the world. The findings highlight the need for additional training among health care providers in VCT centers in screening for DV, detection of signs of physical abuse and provisions and referrals for women suffering from domestic partner violence.

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Development of a Comprehensive Working Alone Program for Community Care

Poster and Paper

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Keywords:

Community care, working alone, violence prevention

Introduction

Recently, there has been a growing awareness of the risks to community service workers who work alone. The term “working alone” has been defined by WorkSafe BC (formerly Workers’ Compensation Board of BC) as: “to work in circumstances where assistance would not be readily available to the worker in case of an emergency, in case the worker is injured or in ill health”. Most hazards associated with working alone are linked to acts of violence or aggression.

To address this concern, a project was launched by Fraser Health’s Workplace Health department to review best practices, develop a comprehensive Working Alone Program (WAP), pilot the program at selected sites in Fraser Health and evaluate the outcomes of the pilot. The purpose of the WAP Project was to improve the quality of the work environment in community care by reducing the risks of potential physical and emotional harm to staff associated with working alone.

Past approaches to managing risk of personal injury to staff working alone have employed various controls, including check-ins, use of technology or policies. It is clear that no Canadian healthcare organization has developed a comprehensive program to reduce risk of injury to healthcare workers who work alone while providing care to clients in the community. This organization faces the additional challenge of addressing both urban and rural settings.

Methods

A project steering committee comprised of senior management, union, Workplace Health and Protection & Emergency Management representatives was established to oversee the WAP project. The steering committee assisted with project development and evaluation of the project following a multistage process as detailed below.

Phase 1 – Background Review and Needs Assessment

Workplace Health, working in cooperation with the expertise of Healthcare Benefit Trust (HBT), conducted a current situation assessment to which included:

- Conducting a literature review of industry best practice
- Reviewing current policy and procedures within the various Fraser Health community health departments
- Reviewing records and statistics (e.g. injury and time loss data)
- Conducting focus groups with a representative sample of community health workers

Phase 2 – Development of the Program

Workplace Health, utilizing WorkWell Consulting, an external health & safety consultant with specific expertise in healthcare, developed the Working Alone Program. This included:

- Identifying those community staff that work alone and the frequency of how often they work alone.
- Identifying the tasks that community staff perform while working alone.
- Developing a draft Working Alone Program that included elements of policy, procedures, risk assessment, risk control measures – including training and technology and monitoring tools based on the Phase 1 report recommendations prepared by HBT.
- Conducting site reviews to determine client intake processes for opportunities to incorporate the Working Alone Program tools into existing department processes.
- Exploring various technology solutions such as automated check in systems that could be incorporated into the WAP.

Phase 3 – Piloting the WAP

A grant was received from the Healthcare Innovation Fund (HIF) in the amount of \$210,000.00 to assist with piloting the Working Alone Program over a period of 3 months within a representative sample of community health services organizations.

WAP Processes and Tools

The WAP consists of a three step process which must be completed and implemented prior to staff working alone:

Hazard Identification



Risk Assessment



Hazard Control

Hazard Identification

In order to identify and assess risks, a standard client “intake” or “pre-visit” Risk Assessment is performed for all clients requiring a home or site visit. The client will be contacted by phone prior to the visit and asked questions to better understand the safety hazards present in the home (e.g. animals, weapons, etc.). This information will be placed on the client record and shared with appropriate employees or groups/departments.

Risk Assessment

Information collected from the hazard identification process will be assessed through a risk assessment and a level of risk related to working alone will be assigned to that particular client. The level of risk will assist in selecting appropriate controls measures to minimize or eliminate the identified hazards. Identified actions or activities are qualitatively rated based on the Australia / New Zealand Standard AS/NZS 4360:2004 - Risk Assessment Matrix. This matrix provides an indicative level of risk based on the Likelihood and Consequences of performing the activity. The outcome results in a Risk Level of: Low, Medium, High or Extreme.

Hazard Control

Hazard control is based on the level of risk associated with the anticipated hazards. Basic Controls are also established which set the minimum standard which must be followed by all staff that work alone. These would be appropriate for most Low and Moderate risk levels. Risks identified to be considered High or Extreme require Additional Control Options.

Basic Controls

1. Employee Emergency Contact Information Sheet – Documents and maintains employee contact information that includes vehicle descriptions, license plate number, emergency contact name and number, and personal mobile phone numbers which may be necessary in case of an emergency.
2. High Risk Address Designation – A database of addresses maintained in which significant hazards have been identified that have not been corrected. Once this designation is applied, further risk controls must be considered to reduce or eliminate risk to employees should they need to visit this address.
3. Employee Itinerary – Employee’s planning to travel alone are required to complete an itinerary of activities (estimated) prior to departure.
4. Mobile Phone # Documented – Fraser Health owned cell phones which are shared amongst staff will be signed out and the phone number of the phone documented.
5. Check In/Out Protocol – New technology that provides a “check-in” system that employees can program like a voice mailbox has been introduced. The technology allows employees to enter a verbal description of where they will be working alone and set up the system to call them back on their cell phones at predetermined intervals throughout the course of their work day. During a “call back” by the automated system, employees need to answer the phone and enter a password to indicate they are safe. In the event that an employee misses a “call back,” a live operator is notified and a process is followed to locate the employee and summon assistance.
6. Travel Safety Checks – Conducted by the employee prior to travel to ensure a safe journey.
7. Vehicle First Aid Kit – Provided to all employees’ in the event personal first aid is required.
8. On-Site Risk Assessment – All employees arriving at a client site to provide services requiring them to work alone will perform an On-site Risk Assessment before 1) exiting the vehicle, 2) entering home/site, 3) inside home/site

Additional Control Options (High and Extreme Risk Levels)

9. Buddy System – Utilizing two Fraser Health staff members to complete the visit.
10. Mobile Security Escort - In the event a hazard is identified that is of high risk and the staff member must make the visit alone, the Contracted Security Provider (CSP) will be contacted to pick-up the employee providing the service and deliver them to the client’s address.
11. Police Escort - Departments may request the services and support from local police or RCMP when required to attend a client site deemed to be “extreme risk”.
12. Client Service Deferment – A process to follow when hazards to staff are so great that implementation of hazard controls would not provide an acceptable level of risk to the staff member.

Results

Initial concerns expressed by staff about increased workload and time requirements when performing the pre-visit risk assessments were largely overcome as the pilot progressed. The telephone assessment takes between 1 to 2 minutes on average to perform and staff are able to incorporate the “risk” questions into other required information. Feedback from staff indicated clients and families were comfortable with the questions being asked once they knew it had to do with ensuring FH staff safety. Based on random audits of risk assessment forms and verbal staff feedback, the pre-visit assessments have been confirmed as identifying and minimizing the risks prior to an employee visit. Employees were also empowered to report back to their manager if compliance with the controls were not being followed or they had identified other risks with an opportunity to obtain further departmental support to ensure their safety – up to and including deferment or withdrawal of service.

The CheckSafe system proved challenging to some staff unfamiliar with automated voice systems and mobile phone use. Others, accustomed to an autonomous work practice with minimal requirement to “phone in”, found it restricting. The requirement to create daily itineraries and route plans was considered time consuming by some employees. Perception of risk and personal safety also factored in some employees reticence to use the system. However, other staff reported ease of use of the system and comfort in knowing “someone will check that I’m okay if I don’t answer the phone”. Intercon Security and the Administrator-on-call team did experience a number of escalated missed calls, largely due to employees forgetting to end their sessions or leaving the phone un-attended. However, the WAP Administrator-on-call team reported some of these calls could have been serious and all employees were safely accounted for in a relatively short period of time. While modifications to the system were suggested to make it more user-friendly, overall, CheckSafe or a similar technology, provides the process to Check-In / Out without requiring administrative support staff to field numerous calls per day to ascertain staff safety.

Quantitative evaluation of the WAP by the user group was conducted. The perception of risk, access to safety resources and the awareness for the hazard reporting process all showed a statistically significant increase from pre- to post-intervention. The post survey for the WAP user group contained questions pertaining to specific WAP program elements. Specifically, questions around utilization, ease of use, safety and risk perception were asked. There were a few of the WAP components that were not used by the majority of the user group and as such the data around those components is reflective of that. Of the components that were utilized, most were deemed straightforward to use. The Safety Climate score also increased from pre- to post-intervention, providing evidence to the impact that the Working Alone Program had on the safety climate within the WAP user group.

Conclusions

Administratively and statistically, the WAP pilot progressed very well and Director, Manager and employee participation and cooperation were fundamental to its success. The Working Alone Pilot sites reported overall success in implementing the majority of the required elements.

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Empowerment of women and mental health promotion: New policy urgent in developing country

Poster

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Abstract

Background

The burden of mental illness is high and opportunities for promoting mental health are neglected in most parts of the developing world. Many people affected by mental illness live in developing countries, where treatment and care options are limited. In this context, primary health care (PHC) programs can indirectly promote mental health by addressing its determinants i.e. by enhancing social unity, minimizing discrimination and generating income opportunities.

Objectives

The objectives of this study were to: 1. Describe concepts of mental health and beliefs about determinants of mental health and illness among women involved with a PHC project in 5 rural areas of Nepal and India; 2. Identify perceived mental health problems in this community, specifically depression, suicide and violence, their perceived causes, and existing and potential community strategies to respond to them and; 3. Investigate the impact of the PHC program on individual and community factors associated with mental health.

Method

We undertook qualitative in-depth interviews with 32 women associated with the PHC project regarding: their concepts of mental health and its determinants; suicide, depression and violence; and the perceived impact of the PHC project on the determinants of mental health. The interviews were edited and analyzed by EPI info program.

Results

Mental health and illness were understood by these women to be the product of cultural and socio-economic factors. Mental health was commonly conceptualized as an absence of stress and the commonest stressors were conflict with husbands and mother-in-laws, domestic violence and poverty. Links between empowerment of women through income generation and education, reduction of discrimination based on caste and sex, and promotion of individual and community mental health were recognized. However, mental health problems such as suicide and violence were well-described by participants.

Conclusion

While it is essential that affordable, accessible, appropriate treatments and systems of referral and care are available for people with mental illness in developing country settings, the promotion of mental health by addressing its determinants is another potential strategy for reducing the burden of mental illness for individuals and communities in these settings.

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Facilitating Safe Workplace Environment for Nurses

Paper

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Abstract

Background

Work place violence is defined as “Incidents where staffs are abused threatened or assaulted in circumstances related to work, including commuting to and from work, involving explicit or implicit challenge to their safety, well being or health” (ILO, et al. 2002). This violence is performed against all categories of medical staff. Hostility at place of work has several categories and etiological factors.

Purpose

To (a) provide an overview of workplace violence; (b) identify etiological factors for violence in health sectors through the integration of loss of control of theory of violence; (c) discuss the strategies for providing safe workplace violence among nurses.

Method

An integrated review of relevant research and theoretical literature on safe environment for nurses, including Foucauldian’s analysis of workplace violence. Literature published during the period of 1999 to 2007 was searched through database and internet. Workplace violence, strategies for safe work environment, theory of workplace violence was used to search the literature. Total of seventeen articles were searched and reviewed.

Findings

Healthcare worker are 16 times more likely to experience violence at work than any other worker. Amongst these workers nurses are in the highest risk categories for workplace violence. Patient’s dissatisfactions towards hospital services and working in high risk areas in hospital expose nurse towards violence. Organizational strategies to reduce violence in health sector should include preparation of module for training its employees on ongoing basis. Moreover, zero tolerance policy against violence should be implemented and monitored by organizational authority.

Recommendations

Although workplace violence is an emerging issue for nurses working in hospital and several etiological factors are associated with it. However, through proper implementation of policies and training of nurses, violence could be compact against nurses.

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Its not part of the job: Risk assessment approach to tackling violence & aggression at work

Paper

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Abstract

This presentation, based on UNISON's publication, 'Its not part of the job', examines how trade union safety representatives can use the five steps of risk assessment to tackle & prevent violence & aggression at work.

It will include practical advice, using case studies based on incidents in health care settings, on what job factors increase the risk of violence & assault and measures that can be taken by employers to reduce that risk including training & support. These include types of training & support, and changes to the work environment & job design.

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Management of violent behavior in a maximum security forensic psychiatric hospital

Paper

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Abstract

We are employed on units 3-7 and 3-5. Both intensive care programs are provided in a highly structured maximum- security setting. Most patients admitted to the program are between the ages of 25-35 years with a history of violent behavior. Unit 3-7 is an adult remand assessment unit, servicing both males and females with a bed capacity of 16. We offer a complete and thorough assessment of the clients' mental state, fitness to stand trial, and degree of dangerousness to the public. The care provided is future orientated with the hope that the patient can return to a facility within the criminal justice system or to a general psychiatry program. For ongoing psychiatric care, once alleged criminal charges have been stayed or withdrawn by the courts. Remand assessments may result in a finding of unfit to stand trial or not criminally responsible, resulting in patients being transferred to unit 3-5. The unit will accept any adult person in custody who has been charged with an alleged criminal offense under the Criminal Code of Canada. Length of assessments may vary from 21-60 days and depending on the delicate nature and seriousness of the crime committed, can be drawn out over a year.

Unit 3-5, with a compliment of 20 beds, is an intensive care unit that provides assessment and treatment focused on the promotion of health and the stabilization of mental illness. A typical diagnosis would be schizophrenia or affective disorders; many patients have an underlying personality disorder with a history of poly-substance abuse. The unit accepts referrals from correctional facilities, NCR, unfit, and mental health act patients who have legal commitments and who are experiencing an acute psychotic breakdown, a relapse in their illness, or poses an imminent danger to self or to others. The length of stay varies from a few days to several years.

Approximately 85-90% of the populations admitted have committed violent crimes thereby having a higher potential for aggressing those around them. Staff exposed to these clients put themselves at risk for assault on a daily basis and are therefore highly trained and experienced. Severities of assaults on staff have ranged from broken bones, assaults with weapons, to being beat unconscious. Our units do not employ security staff, meaning it is the front line nursing staffs who are involved in the management of a client's violent behavior. Aggression derives in its various forms, from psychotics who may be delusional about a particular staff member, antisocial's who are not getting their way or just enjoy hurting people, a client under a treatment order who refuses to receive medication (most common), or clients fighting amongst themselves, be it for disagreements or unit dominance. The units employ many ways of managing and dealing with these aggressive situations, when medications have not had success.. Staffs are trained and are forced to attend refreshers every year on EDT, effective de-escalation techniques, which teach nursing staff how to physically restrain clients in any given situation while minimizing physical trauma to the client. In severe cases, where the client is highly violent, large in size, and/or in the possession of a weapon, staffs utilize fully body riot gear, with ramming pads. 2-5 point restraints are also utilized to manage violent and potentially violent patients. A few clients are so violent

with a track record of 30 plus assaults on staff/patients that the only safe way to manage them is to have them locked in a secured room 24hrs a day. These patients are not allowed on to the unit unless they are in hand and leg shackle restraints.

This is just a very brief description of the work environments on units 3-5 and 3-7 and the operational strategies employed in managing violence. The full presentation will also touch on risk assessment.

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Preventing and Managing Aggression and Violence: Integrated Systems and Solutions

Poster

*Kathy Finch, Riola Crawford, Alison Jones
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Abstract

This will be a dynamic and colorful display depicting our integrated approach to preventing and managing aggression and violence. Using our organizational models/diagrams titled "Preventing and Managing Aggression and Violence": 1) Riverview Hospital and 2) British Columbia Mental Health and Addiction Services(BCMHAS) Integrated Experience" as the centerpiece, key elements of this wheel (best practices) will be displayed and highlighted - descriptions, education initiatives, graphical results of patient and staff surveys.

- 1 Riverview Hospital, for example - Mission, Vision, Values and Goals, Psychosocial Rehabilitation, Therapeutic Relationships, Charter of Patient Rights, Clinical Practice Model, Staff Assault Management Program, Critical Incident Stress Defusing and Debriefing Program, Continuous Quality Improvement Projects, Nonviolent Crisis Intervention Training ® options and initiatives (exemplary care award-winning program, 2001, 2007), Respectful Workplace Program (based on the B.C. Human Rights Code), relevant Policies, Procedures, Critical Paths and Practice Guidelines, Education and Research, Integrated Care – all reflecting the hospital's Mission, Vision Values and Goals. We will also display graphic results of our successful effort to reduce staff injury from patient assaults.
- 2 British Columbia Mental Health and Addiction Services, for example – BCMHAS Mission, Vision, Values and Goals, Agency Organizational Structures, Philosophy/ Methods of Care, Therapeutic Relationships/Positive Work Environment, Patient Safety Initiatives, Patient Rights & Responsibilities, Collaborative Practices involving all Stakeholders, Critical Incident Review & Organizational Learning, Data Reporting, Analysis, Employee Engagement, Critical Incident Stress Management Services, Employee Wellness & Safety Programs, Respectful Workplace, Education & Research and Policies, Procedures and Practice Guidelines.

These frameworks will also be correlated with the provincial violence prevention program for all healthcare regions and facilities and to the Canadian hospital Accreditation Standards. Overall it will show a dynamic and interactive continuous quality improvement network that is evidence based and that promotes safety for all through best practice.

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Prevention and management of violence in Belgian psychiatric institutions: Does current practice respect international guidelines?

Paper and Poster

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Abstract

Background

A vast literature is dedicated to violence in psychiatric institutions and international guidelines exist to cope with this problem. Due to the lack of relevant information in Belgium, the Ministry of the Interior and the Ministry of Public Health jointly conducted in 2004 a study to assess the prevalence of violence in psychiatric institutions and in psychiatric units of general hospitals. This study demonstrated a higher prevalence of violence in psychiatry but also emphasized the lack of prevention, management and recording incidents involving violence. A study on this topic was commanded by the Ministry of Public Health in January 2007, including a 5-month survey.

Aims

To make an inventory of prevention and management of violence procedures used in Belgian psychiatric units and institutions with the purpose of establishing recommendations to hospitals and to healthcare authorities. What tools should be used to discern patients at risk and to prevent violence? What is the current level of implementation of international guidelines in Belgium? What are the difficulties and obstacles in actual settings?

Methods

A 5-month survey will be conducted from April through August 2007 in all psychiatric hospitals and psychiatric units (132 hospitals with 19000 psychiatric beds) based on questionnaires about the recommendations, their implementation and the difficulties encountered in practice. Data will be analyzed by means of appropriate statistical methods. Site visits will be made to understand or verify local evidences.

Results

All Belgian institutions having psychiatric beds (A, K, T, S6 index) were contacted (N= 132) and it was asked to each setting's head nurse to reply to the remote (online) survey. 103 (78%) institutions accepted to participate, with a potential of 447 settings. 374 head nurses (84%) finally replied to the survey. International guidelines are partially implemented in Belgium. A minority of settings (3 to 34%) fully apply the basic audit criteria promoted in the NHS-NICE guidelines. A majority of settings (47 to 74%) find these recommendations as fully feasible. The following main difficulties were identified: Lack of time, patient's illness, professional's shortage, scientific tools unknown, lack of institutional policy, inappropriate recommendation. Recommendations to healthcare institutions and authorities were proposed but their actual implementation will face difficulties and require further investigations.

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Principles and Guidance for the Use of Restrictive Mechanical Devices for People Exhibiting Severe Self Injurious Behaviour: Learning Disabilities and Autism

Workshop

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Keywords:

Intellectual disability, autism, severe self injury, mechanical restraint

Introduction

The project was driven by the main author who in her practice has supported many people with severe self injurious behaviour and personally had concerns about the lack of guidance for staff teams who were considering the use of restrictive mechanical devices as part of a proactive support plan. She was also of the opinion that in the field of intellectual disability restrictive mechanical devices are often used in a reactive way with no future planning for the reduction of mechanical restraint. The project started with the collation of data, in 2004 and initial literature review. Keywords: learning disabilities, autism, restraint, mechanical devices, self injurious behaviour.

Study aim

The aim of the project was to establish guiding principles for professionals supporting people with severe learning disabilities and autism who exhibited serious self injury, in healthcare settings, education and social care settings. The project was supported financially by the British Institute of Learning Disability (BILD).

Workshop

Over the following 3 years the author collected data and information from practitioners through focus groups, conference debates and personal contact which were a combination of e-mail and direct contact. Common practice themes emerged;

- A lack of clarity and guidance for professionals
- Often parents or carers insist on professionals identifying ways to prevent injury or stop self injurious behaviour
- A lack of professional understanding or expertise
- A lack of consistent advice and absence of frameworks
- Lack of understanding and agreement about what might constitute a mechanical device
- A 'feeling' that they (mechanical devices) are more widely used within children's services and education than in services for adults (although this is not supported by research).

The research period also highlighted that the use of restrictive mechanical devices could be split in to 3 categories, when considering severe self injury:

- Advanced planning as part of a behavioural support strategy
- As part of a therapeutic intervention
- Reactively to reduce risk to the individual and/or others as a result of their behaviour

The final document defines mechanical restraint within services for people with learning disability and/or autism as: “The application, as a last resort and use of materials or therapeutic aids such as belts, helmets, clothing, straps, cuffs, splints, and specialised equipment designed to significantly restrict the free movement of an individual, with the intention of preventing injury; as a result of behaviour that poses significant and proportionate risk to them self of serious long term harm or immediate injury. The use of the device must be based on the findings of a behavioural risk assessment”.

As a result of the three year project good practice guidelines were published in January 2008, by the British Institute of Learning Disabilities, the author believes they are the most comprehensive of their kind to be highlighted since Sailas et al (1984). The guidance principles also address issues of organisational structure such as risk assessment, environmental conditions and positive behaviour support as well as assessment of individuals. The guidelines seek to establish that people should be supported as individuals within appropriate frameworks and policies.

Conclusion

In January 2008 the Principles for Practice were published by the British Institute of Learning Disability (BILD), and limited feedback is available from practitioners who have used the guidance to date, although the responses received have in the most part shown the usefulness of the document in supporting people with complex self injurious behaviours who are not detained under the Mental Health Act (1983).

The document is a working document; as such it will be reviewed in light of feedback and future research. The full web version can be downloaded free of charge at <http://www.bild.org.uk/03behaviour.htm>

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Report on the Process and Recommendations of the American Psychiatric Nurses Association's taskforce on Work Place Violence (WPV)

Workshop

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Abstract

Violence is a pervasive problem that affects contemporary society. Nurses as healthcare providers are frontline responders who practice in a wide variety of settings with individuals facing many types of problems/illnesses. Experiencing and witnessing violence affects the individual's ability to function and colors perceptions of the world.

One of the most complex issues of violence facing nurses and others in the healthcare environment is work place violence. Exposure to violent individuals, lack of protective governmental regulations and prevention programs as well as the belief that violence is "just part of the work" create barriers to addressing the issue of workplace violence.

The literature illuminates the scope of the issue to include a broad spectrum of concerns. These concerns include: the rates of nonfatal assaults experienced by the healthcare workforce, underreporting of violent incidents and the effects on the health and safety of the work environment including recruitment and retention of qualified staff.

In an effort to examine the scope of the issue and identify solutions regarding workplace violence facing psychiatric nurses, the American Psychiatric Nurses Association chartered a taskforce. This presentation will report on both the process utilized to obtain the report as well as findings from the report from the taskforce.

Strategies for preventing and managing violence will be explored and discussed in an interactive format through sharing information, and highlighting best evidence based methods for prevention and management of workplace violence.

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Responding to Workplace Sexual Violence: Utilizing Forensic Nurses and Other Victim Service Professionals

Workshop

Jenifer Markowitz, Susan Chasson

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Abstract

Forensic nursing is a growing specialty, and responding to sexual violence is one of the most well known of the forensic nursing roles (Sexual Assault Nurse Examiners or SANEs). As clinicians and educators who work at the intersection of health care and the law, forensic nurses are particularly well equipped to address the issue of sexual violence in the workplace. This workshop will describe the utilization of forensic nurses as primary responders of sexual violence in the workplace and review ways in which forensic nurses and their colleagues in other nursing disciplines can participate in the primary prevention of this type of violence. Engaging communities and creating collaborative interdisciplinary partnerships in preventing workplace sexual violence will also be addressed.

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Restoring the Spirit of Nursing through Healing the Learning Environment: A Workshop on Nursing Student Abuse Bringing Together Dialogue and Transformation

Paper

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Keywords:

Healthy Learning Environment, Nursing Student Abuse

"A man can't ride your back unless it's bent". Martin Luther King Jr.

Introduction

Within nursing a culture of eating our young persists (Giroux, 2001; Hoel, Giga, & Davidson, 2007; Meissner, 1986, 1999; Rowe & Sherlock, 2005; Steele, 2001). Be it within clinical placement (Curtis, Bowen, & Reid, 2007; Hoel et al., 2007) and/or the classroom setting (McGregor, 2005), nursing students continue to be subjected to both covert and overt rankism (Clark, 2008) manifested via tribal tests (Randle, 2003) that impact their physiological, psychological and social health (Celik & Bayraktar, 2004; MacIntosh, 2005). Nursing students who began as tall poppies are slowly worn down by the sustained psychological distress to become squashed weeds (Cox, 1996; Farrell, 2001). In looking for a way to break the cycle of oppression, Freire (1970/2005) proposed dialogue composed of reflection and action (praxis), as a means to achieve consciousness and transformation. It is the act of this kind of oral communication that a shared new reality emerges to empower the self (Chinn, 2004; Freire, 1970/2005). The means to stop the ongoing cycle of squashing tall poppies and retrieving already squashed weeds (Cox, 1996; Farrell, 2001) exists through dialogue. Thus, to begin the process of transforming the oppressive learning environment created by nursing student abuse to one of empowered excellence, a safe forum for meaningful dialogue and critical reflection must be created.

Methods

In an attempt to initiate the process of transforming learning environments in Ontario, Canada, a workshop was put together wherein both nursing students and nurses could come together, without animosity, to pursue meaningful dialogue. To this end, we partnered with the Provincial Nurse Educator Interest Group (PNEIG) of the Registered Nurses' Association of Ontario (RNAO) and the Canadian Nursing Students' Association (CNSA) to deliver these workshops of dialogue. Entitled Restoring the Spirit of Nursing through Healing the Learning Environment each workshop follows a general format of icebreaker, dialogue and wrap-up. Since its inception in 2006, six workshops have been delivered with participation ranging from 10 to 35 participants (consisting mainly of nursing students) and lasting from one day to 1.5 hours. We have found that a minimum of three hours is necessary to allow participants enough time to dialogue. Due to the sensitive nature of the topic, each workshop is held in a private space with doors to ensure group privacy. Icebreakers begin each workshop to introduce and create comfort amongst group members so that a base-level of trust and openness can be achieved in preparation for dialogue

(Dimock, 1993). The dialogue portion is centered on two basic questions: (1) what does nursing student abuse mean to you and, (2) how would you go about resolving the issues you have raised on nursing student abuse. It is important to note that each participant is given time to speak and be listened to without interruption. The insights raised by the participants are recorded.

Results

To date, the information gleaned from the workshops are as follows:

Reflections on Nursing Student Abuse

1. Nursing student abuse continues to exist as a silent and in some cases dominant fixture within nursing student learning environments across Canada.
2. A culture of nursing student abuse acknowledged as a system of “eating our young” has become accepted and normalized by many nursing students as “just the way things are”.
3. In dialogue with nurses, scars from nursing student abuse incurred during their nursing student years persist so that some see themselves as “the walking wounded”.
4. Identification of a consistent overarching theme of “only being just”. A deeply held belief, nursing students see themselves as being “just” students. This label of “only being just” is not shed at graduation but is carried on turning “just” students into “just” nurses.
5. The shroud of taboo cloaking nursing student abuse must be lifted and so nursing student abuse can be included in any serious discussion on healthy learning and work environments in health care.
6. Nursing students were clear that in talking about nursing student abuse, their goal is not recrimination and retribution, but rather to be equal partners in affirmative change.
7. The phenomenon of nursing student abuse is not limited to undergraduate students but is found in all learning environments so that perhaps a more accurate description would be novice to expert transitional abuse.

Actions to Address Nursing Student Abuse

1. Nursing students and nurses must come together as partners to create healthy learning environments.
2. A CNSA position statement on Healthy Learning Environments guided by the information gathered from the workshops is developed.
3. Support must revolve around empowering nursing students to address issues of nursing student abuse in their individual learning environments.

Conclusion

Feedback from the workshops supports the literature in that nursing student abuse does exist in and persists as a real phenomenon impacting both nursing students and their learning environment (Celik & Bayraktar, 2004; Clark, 2008; Curtis et al., 2007; Hoel et al., 2007; McGregor, 2005; Randle, 2003). Considering that much of nursing student abuse is cloaked in silence – a chosen tactic in “play[ing] the game”(Clouder, 2003, p. 217) – each of the six workshops held to date, saw nursing students and nurses alike, talking with much candor, scope and ease. This leads us to believe that there is a strong desire and need to talk about nursing student abuse in an open and safe forum. The dialogue must continue. Further, the tone at each of the workshops was not one of retribution but rather of guarded hope. From the nursing student perspective, it was continuously stressed that nursing students want to be and must be included as equal collaborators in the positive transformation process of their learning environments. But, for all the positives of these workshops, much work still needs to be done as there lingers an underlying current of nursing students seeing themselves as “only being just”.

Acknowledgements

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STOP: For sexual harassment and other forms of violence at workplace in nursing in Slovenia

Workshop

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Abstract

Introduction

The beginning of education of nursing staff in Slovenia about prevention, identifying and dealing with the violence at the workplace started in the year 1999, when the largest regional Nurses Organization of Ljubljana carried out the research in that field. Following this initiative the Working group for non-violence in nursing was established in the year 2000 on the national level within Nurses Association of Slovenia, which is very active since the very start.

Purpose

To present the necessity of continuing education of nurses on the field of perceiving, preventing and dealing with the violence at the workplace environment with the workshop: »STOP to sexual harassment and other forms of violence at workplace in nursing in Slovenia«. One of the possible forms of education with the contents and goals we used successfully for the syndicate representatives of Slovenian health institutions will be presented.

Goals

The main goal of this workshop is to present our educational model; dealing with violence, selfreflexion, first support and assistance to the victims, some skills for solving the concrete cases of violence at the workplace are our main themes.

The content

- Part 1: The introduction of different types of workplace violence: verbal, psychical, physical, sexual harassment/violence, mobbing; risk factors
- Part 2: Presentation of the research project: "Violence and sexual harassment at workplace in nursing in Slovenia": 72, 3% nurses were eyewitnesses of the violence (any time during the working period), 59 % participants of the survey experienced verbal violence, 53 % psychical, 29 % physical, 24 % economic, and 18 % sexual; verbal and physical violence are mostly caused by physicians, patients and colleagues, the place of the event is usually the corridor, "recreation" room or the patient's room
- Part 3: Introduction the »Working group for Non-violence in nursing« and its activities
- Part 4: Managing the violence in nursing – film: We put out some accents important for particular cases of violence. We recorded a film "A beat of slowness«, where we expose risk factors for violence and some individual incidents of violence, which we analyze and seek for the best solution. We will present a protocol »Managing with violence at the workplace« as a good resource and directive how to react when the violent event occurs.
- Part 5: Evaluation

During these nearly ten years we carried out several educational workshops on violence in health sector round Slovenia in small working groups. We are satisfied that we has done more than enough because we started by zero and this field was complete taboo. Nowadays the whole nurses' population in Slovenia has some information about this sensitive field. Our determination is to continue in the future with this kind of education.

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The reporting behaviours of student nurses who have experienced verbal abuse

Paper

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Abstract

Background

There is evidence that student nurses are vulnerable to experiencing verbal abuse from a variety of sources and under-reporting of verbal abuse is prevalent throughout the nursing profession. The objective of the study is to explore the reporting behaviours of student nurses who have experienced verbal abuse.

Method

For this study a definition of verbal abuse was adopted from current Department of Health (England) guidelines. Questionnaires were distributed in 2005 to a convenience sample of 156 third year nursing students from one pre-registration nursing programme in England. A total of 114 questionnaires were returned, giving an overall response rate of 73.0%.

Results

Fifty one students (44.7% of responses) reported verbal abuse; all of these completed the section exploring reporting behaviours. The incidents involved patients in thirty three cases (64.7%); eight cases (15.7%) involved visitors or relatives and ten cases (19.6%) involved other healthcare workers. Thirty two students (62.7%) stated that they did report the incident of verbal abuse they experienced and nineteen (37.3%) of respondents reported that they did not. Only four incidents developed from an oral report to being formally documented. There was a statistically significant association ($P = 0.003$) between the focus of verbal abuse (patient/visitor or colleague) and the respondents reporting practices with respondents experiencing verbal abuse from colleagues less likely to report incidents. Most frequent feelings following experiences of verbal abuse from colleagues were feelings of embarrassment and hurt/shock. Most frequent consequences of experiencing verbal abuse from patients or relatives were feeling embarrassed and feeling sorry for the abuser. When comparing non reporters with reporters, the most frequent feelings of non reporters were embarrassment and hurt and reporters, embarrassment and feeling sorry for the abuser. When considering levels of support after the incident the mean rating score of respondents who reported the incident was 5.40 (standard deviation 2.89) and of those that did not, 4.36 (standard deviation 2.87) which was not statistically significant ($p = 0.220$).

Conclusions

1. Not documenting experiences of verbal abuse formally in writing is a prevalent phenomenon within the sample studied and reporting practices are inconsistent.
2. Both Higher Education Institutions and health care providers should consider emphasising formal reporting and documenting of incidents of verbal abuse during student nurse training and access to formal supportive services should be promoted.
3. Effective incident reporting processes and analysis of these reports can lead to an increased awareness of how to avoid negative interactions in the workplace and how to deal with incidents effectively.

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The role of the expert consultant in violence reduction

Workshop

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Abstract

The need for expert consultancy in creating a safer environment for staff and service users:

- **Specialist knowledge:** Violence is a complex risk to manage and one of many risks that an organisation has to address. Solutions often require the involvement of a number of organisational functions including Health, Safety and Risk Management, Clinical/Nursing, Security and HR/Training. Most organisations do not have a dedicated workplace violence lead or coordinator and responsibility often falls to an individual/function with general rather than specialist expertise.
- **Independence:** There is often value in obtaining an independent perspective from credible consultants. They can provide fresh insights, be less influenced by internal politics and introduce best practice.
- **Business Case:** This specialist, independent view may provide much needed leverage to release funds and promote action. It should also help an organisation to priorities and focus investment and resources for best results and value.
- **Implementation:** ‘When all is said and done, more will be said than done’. Good consultants will seek to help a client with strategy for implementing recommendations. Understanding of change management is critical – as the problems often lie within organisational culture and staff attitudes and behaviours. It is not simply about the behaviour of patients.

Obstacles to overcome

Consultants have mixed press and part of the challenge is overcoming initial cynicism. Consultants are also outsiders, walking in someone else’s world for a short period thereby ultimately limiting their influence in regard to interpretation and implementation of their findings and subsequent change. What simple steps and behaviours can help overcome cynicism, increase influence and earn respect?

Methods

A look at the different approaches to consultancy from holistic full review/audit of the risks and management of these, to more focused support with an aspect of policy or particular control measure. This could include problem solving with a particular service/service user.

Competency

What makes a good consultant? How do we define and measure competency and what do we expect in terms of qualifications, experience, professional standards and accreditation?

Key success factors

Are there identifiable methods and approaches to consultancy in this subject field that will increase the value of the consultant in contributing to sustainable change?

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The Violence Prevention Community Meeting (VPCM): A Measure of Hope

Paper

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Abstract

Objective

This research aims to reduce patient violence against staff through implementation of an innovative treatment program—the Violence Prevention Community Meeting (VPCM). The VPCM addresses causes, prevention, and response to violence, and it is well matched to the needs of nursing staff and patients on short stay, in-patient psychiatry units. A pilot study found a 50% reduction in patient violence after a 9-week trial of the VPCM in a single sample, repeated measures design (AGPA, 2005). As a result of this presentation the National Institute for Occupational Safety and Health (NIOSH) and the Veterans Administration Central Office (VACO) are funding this program nationally for the next two years. The primary objective of this research is to validate, in multiple psychiatric units, that the VPCM reduces patient violence and does so more effectively than alternative treatment controls.

Research Design

Three groups will be compared: VPCM Treatment vs. Intensive Traditional Community Meeting (ITCM) vs. Treatment as Usual (TAU). A 21-week, 4-phase, repeated measures design will be used: Pretreatment (3 weeks); Transition, in which VPCM or ITCM is introduced (3 weeks); Treatment, in which VPCM or ITCM continues (12 weeks); Posttreatment (3 weeks). It is hypothesized that (a) patient violence will decrease in the VPCM group from Pretreatment to Treatment and Posttreatment and (b) this decrease will be greater than for the alternative treatment control groups. This hypothesis will be tested in 9 in-patient psychiatry units in 9 different VHA facilities; units will be randomly assigned to one of the 3 treatment groups and matched on factors related to rates of patient violence.

Methodology

All patients on 9 in-patient psychiatry units (approximately 180 at any one time) will participate in the VPCM, ITCM or TAU. The VPCM is a specialized form of Community Meeting in which avoiding violence and promoting non-violent problem solving and interpersonal civility are focal. A training manual will be used to train staff to function reliably as leaders. All patients and nursing staff will participate in the VPCM during Treatment weeks, twice-weekly on Days and weekly on Evenings. The ITCM is also based on a Community Meeting format which is common on psychiatric units. It will meet with comparable frequency to the VPCM but will not focus on violence; a manual for training staff will ensure comparability across sites. The TAU will consist of brief, once-weekly Community meetings. To record instances of patient violence (verbal or physical; against property, other patients, staff), every nursing staff member will carry a small event recorder and, each time patient violence is observed, the staff member will depress a key for verbal and/or physical violence. At the end of Day, Evening, and Night shifts, every staff member will record totals on a Modified Overt Aggression Scale log. Patient violence will be recorded over all 21 weeks of the study. Hypotheses will be tested in terms of (a) violence overall, (b) physical violence, and (c) verbal violence against (d) nurses vs. other patients vs. property.

Clinical Findings

Evidence of the efficacy of the VPCM will support its use as a new, low-cost, and empirically validated treatment to reduce violence against nursing staff in in-patient psychiatry units.

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Threat assessment of workplace violence

Paper

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Keywords:

Threat assessment, threat management, workplace violence

Threat assessment of workplace violence is a challenge. The identification of risks is an ongoing process which requires continuous evaluation. Neither threat nor violence are static phenomena. There always exists a path to violence where interventions are possible. A crucial point is the integration of information from collateral sources. The threat assessment is best performed by an interdisciplinary team. Threat management of workplace violence in the health care sector offers a strategy that moves away from the prediction of danger to the identification and handling of risks. This approach does not only focus on the direct target but on associated victims as well.

Threat assessment of workplace violence is a challenge

In the health care sector professionals are dedicated in their work to the needs of patients; professionals are not trained in coping with violence at their workplace. They often believe that this will not happen to them; and they do not expect that their patients or even they themselves can become the target of violence whilst in treatment. In general, threatening and/or violent behavior at the workplace is seen in four different forms: threats, harassment, violent behavior, and lethal actions. In the majority of cases the perpetrator is acting on a real or perceived grievance (Barton 2008). For the offender, threatening behavior and/or violence is seen as a coping strategy and as a solution of his or her problems. The relationship between the threatening person and the workplace can be described as follows:

- no personal connection
- clients/patients or their relatives targeting the workplace
- co-workers against the workplace
- personal relationship (e.g. domestic violence)

When someone carries out threatening and/or violent behavior outside the workplace and it then comes to the knowledge of the workplace environment, this would raise special concerns. Threats and violence take place in a continuum. The magnitude of violent acts in the workplace situation in general is illustrated by the following figures from the United States (Turner, Gelles, 2003):

- 1000 deaths annually due to workplace violence
- 1'000'000 workers annually are attacked
- 6'000'000 are threatened annually
- 16'000'000 are harassed at work

For the health care sector it can be expected that around 50% of professionals experience threats and/or violent attacks while on duty. Depending on the definition used up to 20-30% of all co-workers in the health care sector became the target of serious stalking. In a Canadian Survey around 14% of physicians indicated that they have been the victim of stalking; 57% were male and 36% were female. Only 9% of the physicians indicated that they received some training in coping with stalking (Abrams 2008).

Risk Assessment

The identification of risks is an ongoing process which requires continuous evaluation. Risk assessment is not a single event! The assessment has to clarify how serious a threat is, and how to react to it. The most effective way of intervention is the prevention of violence (before serious problems take place). Violence is not a characteristic trait of a person, rather it is a behavior multi-factorially influenced. The path to violence is best regarded as a process where dramatic moments (Meloy 1992) contribute to its escalation. During this step by step process various interventions are possible: Grievance – ideation – planning – preparation – action (path to violence). A threat may be: (1) direct, (2) indirect, (3) veiled, or (4) conditional (according to Mary Ellen O’Toole, FBI Profiler, quoted in Barton 2008). The threat may be expressed: (1) spoken, (2) written, or (3) gestured. Any threat using a weapon is considered as a serious threat as long as it is not proven otherwise. Various medical conditions are associated with an increased risk of violent behavior due to impaired executive functions, especially those disorders affecting the central nervous system (neurological and psychiatric disorders, e.g. substance abuse, personality disorders) (Simon et Tardiff, 2008). However, past violent behavior can best predict future violence. The gathering of collateral information is crucial in threat assessment. Relatives are often an excellent source; in most cases they know about access to weapons (e.g. guns); they know about suicidal and/or homicidal ideations; and they are often informed about those targeted by the perpetrator.

Protection of reporters/whistleblowers

All organizations require a reporting facility independent from the institutional structure and not part of the executive board. The facility operates on a counseling level and reports to the management/security department. Co-workers will only report cases when they feel protected and when their reporting has a significant effect. In the ILO report this is underlined: Reporting is an essential precondition for an effective response (Di Martino, 2002). Without reporting the awareness of workplace violence remains a hidden topic.

The effects of threats and violence

Violence can be targeted towards People (physical, psychological) and property. The consequences of threats and/or experience of violent outbursts are psycho-traumatic in their nature – no matter whether directly targeted or witnessed. Often we see a poly-victimization due to various aspects of the traumatic experience. Whether an event is perceived as traumatic depends on a variety of factors: (1) cultural aspects, (2) individual vulnerability or resilience, (3) level of personal functioning, (4) intensity of exposure, (5) protective factors, and (6) level of support. The resulting impairment may be considerable and often requires professional support and treatment. Exposure to traumatic experiences leads to a continuum of psychological symptoms ranging from simple grievance to severe and prolonged personality disorders. Cognitive behavioral treatment has the best documented effect on overcoming traumatic experiences.

Threat Management

The first step of any effective management is acknowledging the problem and to make it an institutional subject. The following flow chart illustrates the decision making process:

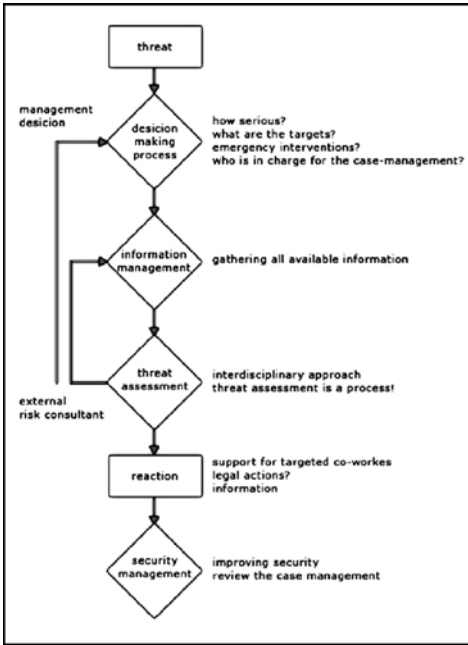


Figure 1 Risk Management Flow Chart

Crisis management is more effective when implemented and trained without a real threat. Security personnel have not to react under pressure and feel well prepared if a threat is posed. The intervention dilemma addresses the issue that each intervention can contribute to further escalation – sometimes the best approach is not to intervene directly; indirect interventions may help victims to cope better with the situation. The threat assessment helps in the decision making process over which type of reaction is more appropriate.

Help for (potential) offenders

At first glance the idea of helping offenders sounds weird. However, when we achieve in helping a person to find other conflict resolution strategies then we contribute in avoiding violent and threatening behavior. In many cases therapeutic interventions are possible. Four factors have been identified which contribute in helping people avoid committing serious crimes: (1) attachment, (2) commitment, (3) involvement and (4) belief (Hirschi 2008). For the offender violence is their way of coping with the situation; he or she feels completely legitimated. Only if this person can identify other ways of handling the situation, he or she will do so. Therapeutic interventions should therefore not be considered as a kind of last resort – when they often fail – rather they should be discussed as one possible approach along with other strategies right at the beginning of problems arising.

Conclusion

Health care institutions can learn from others that have experienced threats and crisis in the past. Threat assessment is more than focusing on overtly violent behavior, as it starts with more subtle signs. Threat assessment offers a strategy to identify risks and how to handle them. Two crucial preconditions for successful responses are reporting facilities and the training of professionals on

workplace violence. The confrontation with threatening and violent behavior must be considered as a risk inherent in the profession and preventive strategies must be implemented – the best way to cope with workplace violence is to prevent these situations from escalating by early interventions. Therapeutic approaches for (potential) offenders may help to overcome grievances and may also contribute in finding other solutions.

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Using a participatory approach to develop effective, usable violence prevention interventions for the healthcare industry

Paper

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Keywords:

Participatory Research, Canada, Intervention, Violence Prevention Resources,

Introduction

Violence is a widespread and expensive problem in healthcare in British Columbia (BC); healthcare workers make up only 10% of BC's provincial workforce, yet have 40% of the violence claims [1]. The healthcare context presents a number of challenges to addressing violence, including a culture of underreporting [2] and chronic understaffing, recruitment, and retention issues [3]. In order to tackle this issue, a Provincial Violence Prevention Steering Committee (PVPSC) has been created through joint collaboration of BC's Healthcare stakeholders. The mandate of the PVPSC is to develop and oversee implementation of a comprehensive, cohesive, and effective provincial violence prevention strategy for healthcare worksites in BC. BC also has six Regional Violence Prevention Committees within each of the 6 Health Authority regions who are charged with a similar mandate, and which interface with the Joint Health and Safety Committees at each of the facilities or organizations within their respective regions.

Goal

The goal of this study was to complete an environmental scan of current violence prevention policy, practice, and resources in BC healthcare workplaces, consult with industry stakeholders, present a review of the collected information, and as well, make recommendations that will be both useful and usable in diverse healthcare settings, including acute care, long-term care, home and community care, and public health.

Methods

The environmental scan consisted of two methodologies: 1) collection of violence prevention resources and 2) engaging violence prevention stakeholders via discussions with the Regional Violence Prevention Committees (RVPC).

Resource collection

Employers and union stakeholders were contacted and asked to forward any policies, clinical practice guidelines, surveys, checklists, training manuals, online modules, or PowerPoint presentations pertaining to violence prevention in healthcare. Relevant materials were also obtained from the Occupational Health and Safety Agency for Healthcare (OHSAH) in BC, WorkSafeBC, and the websites of several national and international regulatory or occupational health and safety (OHS) agencies such as the US Occupational Safety and Health Agency (OSHA), the National Institute for Occupational Safety and Health (NIOSH), and the Canadian Centre for Occupational Safety and Health (CCOHS).

Once collected, violence prevention resources were classified by: 1) Origin (specific organization and union versus employer versus regulatory); 2) Healthcare sector addressed (acute care, long term care, or home and community care); 3) Priority area (risk assessment, incident investigation, incident response, or policies and procedures); and 4) Type of resource (tool or educational material). Frequencies and figures were calculated using SPSS v14.

Following classification, the research team conducted a high-level, heuristic review of collected materials, comparing the collected resources to the framework laid out by the 'Elements of a Best Practice Violence Prevention Program for BC Healthcare' manual [1]. The focus was on finding program areas that are complete or well-established, as well as areas that require further development. The data collection process proved to be a challenge given the demands and time constraints facing the individuals solicited for this project.

Stakeholder Focus groups

A team from the PVPSC (consisting of at least one employer representative, one union representative, and one OHSAH researcher representative) visited each RVPC throughout the province during one of their regular scheduled meetings. This was done to develop relationships and enhance the collaborative process between the PVPSC and RVPCs. Each visit started with a five to ten minute presentation describing the Provincial Committee initiatives. The presentation involved sharing the PVPSC's violence prevention action plan and timeline and introducing three discussion topics to the group: 1) RVPC goals for collaboration with the PVPSC, 2) RVPC initiatives and activities, and 3) any gaps or challenges faced by the RVPCs.

The presentation was followed by a 20- to 45-minute discussion session, conducted in a focus group format led by the researchers. There was particular focus on answering questions about the presentation; obtaining RVPC feedback on their goals for collaboration with the PVPSC; gathering information on RVPC initiatives and effective/successful activities; and determining any gaps or challenges faced by the RVPC, particularly those which might be unique to geographical healthcare regions or sub-sectors. Participants were also asked for feedback on facilitating factors, i.e., the characteristics or actions which made violence prevention efforts easier. OHSAH researchers delivered the presentations, led feedback discussions, and recorded stakeholder comments. Following each meeting, feedback comments were summarized using thematic analysis [4]. Topics, discussion points, and participants' views from the focus groups conversations were compiled and organized into themes, and then synthesized into an overall summary of stakeholder feedback.

Results

Violence prevention resources

Over 200 distinct violence prevention resource items were collected. Each independent document, poster, PowerPoint presentation, manual, and pamphlet was counted as one resource regardless of its length or content quality. The majority (63%) of resources were provided by the health authorities (employers), while 7% were provided by the unions, 6% from WorkSafe BC, and the remainder from other regulatory agencies and non-government organizations (NGOs).

In terms of the key violence prevention program elements represented, policies and procedures accounted for the largest portion of collected documents (28%), followed by risk assessment items (19%) and incident response items such as code white, post-incident debriefing, etc. (16%). Incident investigation items accounted for a surprisingly small amount of collected materials, comprising only 6% of the collected materials. In addition, the bulk of resources collected were educational materials while only a small portion consisted of tools. Educational materials included

PowerPoint presentations, training manuals, group activities, or speakers' notes. Tools included checklists, surveys, report templates, or other 'how-to' guidelines for program components. Although the collected resources were often developed with different care settings in mind, the majority of the resources were broad enough to be relevant to all care settings (56%), without being specific to any. A large number of materials collected were designed for facilities, particularly acute care facilities. Within acute care, there was a particular focus on emergency departments, which is not surprising since this tends to be a high-risk area. As such, some resources that were pertinent to acute and long-term facilities (16%) were not applicable to home and community care.

Initiatives, challenges and collaboration: themes from the focus groups

In the focus groups, regional committees asked for increased interaction and collaboration with the provincial committee ranging from help to conduct risk assessment to attending every regional meeting to sending quarterly reports. Participants described challenges in finding time to train workers in units that were understaffed and burdened with overtime. Within this challenging environment, participants also described the need for consistent, knowledgeable support and commitment from management and supervisors. The themes and sub-themes are listed in table 1.

Themes and Subthemes
Urgency of the violence problem and need for immediate action
Lack of consistency in response to violence
Systemic healthcare factors affecting violence in the workplace
Shortage of staff (recruitment and retention)
Aging population (both workers and patients)
Illness and disability (both workers and patients)
Management commitment and resourcing
Provision of resources and financial support
Incorporating violence prevention into all departments and job descriptions
Linking worker safety to better patient care
Acknowledging success
Communication
Increase community and public awareness
Cultural shifts regarding violence (e.g. reporting of violent incidents)
Ensuring the right people are at the table
Training and education
Training for supervisors and managers
Training for new and current workers
Training challenges
Links to healthcare professions
Unintended consequences of interventions
Underserved geographical regions
Legislative initiatives: mandating participation/compliance with VPP elements
Stated needs for the PVPSC and the 2008 Action Plan
Minimize the overlap of scope
Effective communication between the PVPSC and RVPCs
Enhance facilitating factors for RVPC success

Table 1: Themes and sub-themes compiled from Regional Violence Prevention meetings

Discussion

Among collected violence prevention resources, ‘policies and procedures’ were typically overarching policies and position statements. Some of these were organization-wide, but many focused on specific workplace hazards (such as working alone or in isolation) or program component (such as code white or respectful workplace). There were more resources on evaluation and program review than expected, although most of these were reports on existing pilot program components rather than tools outlining how to conduct an evaluation. Tools and clinical practice guidelines were under-represented, representing a gap in the collected materials.

The proportion of items dealing specifically with acute, long-term care, and home and community care is similar, but the specificity of these items and the amount of ‘how to’ content was lower in long-term care and lower still in home and community care.

The focus group discussions at regional committee meetings highlighted that stakeholders see a need for more ‘how-to’ guidelines showing what realistic (rather than idealized) implementation of violence prevention programs look like. Furthermore, even the best and most feasible resources need widespread commitment, financial support, resources, and knowledge to implement. The challenge is determining the optimal strategies for implementing violence prevention materials to a healthcare system that is, to varying degrees, substantially overburdened, often with imperfect or incomplete OHS structure or function (i.e. joint occupational health and safety committees) that currently has a generalized culture of accepting violence as part of the job. Because of these challenges, any violence prevention resources will need to consist of, or be accompanied by, efforts to shift this culture, improve the OHS infrastructure, and provide meaningful resources and support.

Setting Priorities

Given the policies collected and the themes relating to regional committee goals and challenges, a list of criteria was developed to define ‘best practices’ for different components of violence prevention programs. For example, risk assessment requires commitment and understanding of the process from all levels of management, the participation of a joint, multi-disciplinary team, and a timeline and process for following up on recommendations. Additional resources and attention will be needed in areas where challenges are limiting the implementation of the best practices. Future work will involve working with stakeholder groups to develop practical and realistic implementation strategies that address the challenges and make use of the facilitating factors to achieve relevant and usable ‘best practice’ model at each worksite organization.

Recommendations for next steps

Developing comprehensive violence prevention strategies is an ambitious undertaking, and needs to be approached strategically. Matching the framework laid out by the PVPSC’s ‘Elements of a Best Practice Violence Prevention Program for BC Healthcare’ document to the environmental scan described in this report has identified some key areas in which to focus efforts. Stakeholder feedback from RVPC meetings has highlighted some practical and logistical considerations to include in the process. The process of developing violence prevention resources will contain the following steps: 1) Creating and coordinating an expert working group(s) and scheduling contact with this group(s); 2) Agreeing on ‘best practice’ criteria for resources in each key area; 3) Compiling existing resources into content guidelines and draft templates; 4) Reviewing compiled draft templates in working groups; 5) Selecting curricula based on approved templates; and 6) Packaging resources and developing a communications plan.

Acknowledgements

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Workplace violence in the healthcare sector - a project carried out in the Czech Republic

Poster

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Abstract

Presented by the Trade Union of the Health Service and Social Care of the Czech Republic (TUHSSC CR)

Workplace violence has become an alarming phenomenon worldwide. Health sector personnel are particularly at risk of violence at their workplaces. Violence finds its expression in physical assault, homicide, verbal abuse, mobbing, sexual harassment and psychological stress. Violence does not only occur as one single incident but also may be expressed in repeated small incidents which together create severe harm. The ILO, ICN, WHO and PSI carried through a joint project (2000-2001) with the aim to reduce incidence of violence in the health sector and to minimize its negative impact on the victims and services. One of the outcomes of the project was the publication 'Framework Guidelines for Addressing Workplace Violence in the Health Sector', published in 2002.

TUHSSC CR published a translation of the publication and distributed it among its members. Then it initiated a project based on the one carried through by the world institutions, in which it also participated. The project called 'Violence at the Workplace in the Sector of Health and Social Services in the Czech Republic' was started in 2004. It was financed by the Ministry of Labour and Social Affairs of the Czech Republic and its leading coordinator was the Institute of Healthcare Policy and Economics (IZPE). Further institutions participating in the project were TUHSSC CR and Research Institute of Security at Work. The project was to last for 5 years and its basic aim was to contribute to building better awareness of the problem of workplace violence in the area of health and social services and the widest possible follow-up practical implementation of the knowledge gained.

The project made use of qualitative and quantitative sociological methods, policies analyses and secondary analyses. The project was based on a wide concept of workplace violence not only in the sense of exposure to danger of workers in their interaction or contacts with clients/patients; it took into account also further issues concerning those interactions like human resources management in the health and social services, working conditions, organisation and funding of the services, the impact of the reform processes in the health and social care sector and the quality of the provided care. The project had to be finished prematurely owing to impacting reform changes leading to abolishment of the IZPE.

The latest achievement has been translation and publication of a follow-up brochure published by ILO, called 'Framework Guidelines for Addressing Workplace Violence in the Health Sector: the Training Manual'. The Czech translation of the manual was published at the end of 2007 and distributed at the beginning of 2008. It will be used in training courses for the staff of healthcare and social care institutions in the country organised by their employers or by the trade union. Presentation of some of the project results

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Workplace Violence Prevention at the Massachusetts Nurses Association: A multifaceted approach to educate nurses, employers, legal and legislative representatives about workplace violence prevention

Workshop

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Abstract

Late in the 1990's the Massachusetts Nurses Association (MNA), the professional association for 23,000 nurses in Massachusetts, USA, learned that a nurse member was told by a Municipal Court Magistrate that being assaulted by a patient was "part of the job". MNA members and staff did not agree. Modeling from previous successful activities related to Domestic Violence Advocacy and Prevention the Workplace Violence and Abuse Prevention Task Force (WVAPTF) was formed. Task Force members and MNA staff have spent the last ten years tirelessly addressing, researching, networking, testifying and activating on the issue of workplace violence and abuse prevention.

This presentation is designed to share the materials and methods of the MNA Workplace Violence and Abuse Prevention Task Force. MNA materials include a Position Statement, advisory pamphlet, fact sheets related to assaults and bullying, contract language on prevention workplace violence and caring for victims, and directions for negotiating the judicial system. Methods of addressing these issues include working with local District Attorneys to support nurses who have been assaulted and are attempting to hold perpetrators accountable for their actions. Task Force members have provided testimony for legislative efforts on behalf of mandated comprehensive violence prevention programs. An overarching goal of the MNA legislative agenda is to improve working conditions through improved staffing ratios. Research shows that low staffing levels also factor into opportunities for perpetrators to act out.

Of greatest importance is the work of the WVAPTF members providing emotional support to nurses and others injured both physically and psychologically from assaults at work. Victims of violence are often referred to the Task Force members for psychological support. Task Force members may be the survivors of violence themselves and have a true sense of the despair they are hearing on the other end of the telephone. Victims often state that their MNA support system was the first time anyone said, "You did not deserve to be treated like that. I am sorry this happened to you." This response is in direct opposition to the most frequent response from their employers "What did you do to provoke this" or "what would you do differently next time so this would not happen again." Both of these questions, often asked of the victim by their employers; perpetuate the phenomenon of blaming the victim.

A Workplace Violence and Abuse Survey was conducted in several local hospitals. The results were published. Since 2005, this survey tool has been used by nurses in several other states as well as in university settings.

MNA released an On Line Continuing Nursing Education (CNE) program entitled Workplace Violence. Since 2006, nearly 500 nurses from across the United States and several foreign countries have learned about violence prevention from this activity. There is no charge for this program for any nurse or other interested person.

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Workplace violence: a growing challenge to health care workers in emergency departments

Poster

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Abstract

Key issues

Where as there is impressive progress in health care delivery in developing countries, workplace violence is tremendously rising in female dominated professions like nursing which are highly affected by this vice. Emergency departments have become common places where low level daily violence which include verbal abuse and threats of assaults are tolerated and widely under reported. Health workers in these departments experience the highest volume of assault.

Meeting challenges

To curb this worrying trend, key issues on workplace violence have to be addressed and solutions found at the earliest time possible. Few institutions have policies on prevention and management of this occupational hazard. Health workers in emergency departments experience different forms of violence both physical and psychological with common forms of violence including verbal abuse, threats, assault, bullying and harassment. Explanations for these constitute long waiting hours, poor communication, dissatisfaction with hospital policies and increased public awareness on human right to quality health care. Understaffing, inadequate security and unrestricted movement of the public in emergency departments predispose especially young females to assault. Realities such as staff shortages and increased patient acuity create substantial barriers to eliminating violence. Absence of violence prevention programmes and lack of staff training are associated with elevated risk of violence in emergency departments. Professional associations and trade unions have an important role in ensuring safety at workplace by engaging management in determining acceptable intervention measures.

Conclusion and recommendations

A zero tolerance policy on violence should be made public to patients and customers attended to in emergency departments. There should be a violence prevention strategy which includes specially trained security staff, managers, supervisors and workers. All health workers should be encouraged to record incidences and assess risks. Medical care and psychological counselling should be provided for employees experiencing or witnessing violent incidences. Adequate staffing should be provided during long shifts like night shifts and areas where violence is common like the emergency department. A system to track and evaluate possible assault behaviour should be established and a way to pass information from one shift to the next made. Emergency staff should be trained in reorganising and managing hostile and aggressive behaviour. A work site analysis should be completed by a task force which should analyse records, trends, workplace security and give screening surveys to staffs to help them identify hazards.

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Protecting our caregivers and clients from workplace violence and aggression

Workshop

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Abstract

The issue of workplace violence is increasing in Canadian healthcare workplaces. It is a widespread issue of growing concern and a serious threat to the health and safety of our caregivers. The Ontario Safety Association for Community and Healthcare (OSACH), a not-for-profit provincial government organization, established under the Workplace Safety and Insurance Board, is the designated Health and Safety Agency for the Ontario Healthcare sector. As the designated health and safety agency for the healthcare sector, we recognize the unique challenges of our healthcare organizations and their challenges to attract, retain and safeguard the safety of our valued healthcare human resources and our caregivers. Hence, OSACH has taken the lead both provincially and nationally for the development of workplace violence prevention resources for the healthcare sector and have presented these materials both nationally and internationally. Recently updated in 2008 following the tragic death of a nurse in an Ontario hospital, the Developing a Workplace Violence Prevention program includes recommendations made at the corners inquest. The four book series includes:

- **Implementing a Workplace Violence Prevention Program: Book 1** will guide an organization in the development of a prevention program that addresses all forms of workplace violence with the exception of client aggression. Included are assessment tools to assist health care workplaces to identify their individual risks related to workplace violence and aggression. This includes monitoring incidents as well as determining factors in their work settings that may contribute to or increase the risk of violence to their workforce.
- **Developing Crisis Prevention and Communication Strategies:** Designed to provide the skills necessary to recognize and respond to the various stages of violence, Book 2 would be of most benefit to front-line staff and management, and focuses on effective communication strategies and addresses issues such as how to support staff following violent incidents.
- **Developing Human Resource Strategies for Managing Workplace Violence:** The title of Book 3 defines its target audience as human resource professionals. Participants will benefit from important topics such as the prevention of violence among employees, strategies for dealing with all forms of harassment, domestic violence, bullying, threats and weapons in the workplace. Book 3 also outlines hiring and termination best practices.
- **Preventing Client Aggression Through Gentle Persuasive Approaches (GPA)TM:** Created by the Continuing Gerontological Education Cooperative, the Gentle Persuasive ApproachTM is grounded in the principle of person-centred care for dementia patients. OSACH developed Book 4 as the program infrastructure to support the GPATM curriculum. This program was designed to complement existing resident care strategies and systems. It integrates the MOHTLC Resident Care Standards, the College of Nurses of Ontario standards and practice guidelines, and Ontario health and safety legislation.

- The newly released video “Reducing the Risk of Workplace Violence in Health and Community Workplaces” funded by our Ontario Ministry of Health features a general education segment on the prevention of workplace violence and in addition features modules customized for the hospital, long-term care and community care sectors.

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You're Not Alone – The Royal College of Nursing's campaign to protect lone workers

Paper

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Abstract

Violence against anyone in the workplace is completely unacceptable. It is a sad fact that nurses are four times more likely to be physically assaulted than the national average, second only to those working in protective/security services, and twice as likely to be threatened (Budd 1999). To date, many of the initiatives to tackle violence have focussed on hospital environments but due to changes in the way care is delivered, including policy initiatives to provide care closer to home, the working environment for many of our members will be the community and in patients' homes. This in itself presents new risks particularly as the dynamics of the patient/nurse relationship changes as, the nurse becomes a 'guest' in the patient's home. Members working in the community report incidents of being cornered in patients' homes and threatened by weapons.

In 2005 the Minister for Health announced that healthcare staff in England who work on their own in the community would have their very own 'guardian angel' in the form of a high-tech protection device. This device, an ID badge holder which works on mobile phone technology, was extensively trialled by healthcare staff and positively evaluated by the body in charge of strategy and operational matters in relation to the protection of healthcare employees in England (NHS Security Management Service 2005). However, Royal College of Nursing (RCN) commissioned research (Smith 2007) found that two years after this announcement only 3.5% of our members working in the community had access to this device. The majority relied on mobile phones as a means of raising the alarm and some really were alone with no means of raising the alarm. This and other concerns raised in the lone worker research such as a lack of information on the risks when going on a home visit, under reporting, lack of training and lack of awareness of lone worker policies led to the launch of the RCN's 'You're Not Alone' campaign.

The RCN's campaign strove to tackle the concerns at both a local and national level with the development of a five point action plan. The presentation will detail the lone worker research findings and the subsequent development and execution of the 'You're Not Alone campaign'.

Knowledge of the experiences of violence and perceptions of risk of lone working community nurses in United Kingdom.

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Chapter 7 - Scientific, methodological, operational aspects and instruments regarding workplace violence

A modification of the perception of patient aggression scale: does this measure one factor, and what does it mean?

Paper

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Background

Our group is interested in interventions to prevent or modify the risk of violence for health workers, particularly community health workers, based on previous New Zealand surveys that have asked nurses [1], general practitioners [2], service managers [3], caregivers [4] and psychiatrists in training, other doctors in training [5] about adverse events, in a manner in which the events were defined, and a range of events, including verbal and physical aggression, sexual harassment, stalking, and harassment by means of formal complaint were included in the instrument.

Although these results are interesting, the authors did not attempt to develop a uni-dimensional summary measure. In 1986, Yudofsky [6] reported the reliability of the Overt Aggression Scale on 37 patients (16 children, 21 adults) had reasonable intra-class reliability (over 0.75) for all factors. However, the authors have considered the internal consistency of the scale. Instead, many of the outcome scales, such as the POAS [7] and MAVAS [8] use the attitude of staff to violence, rather than the perceived rate of violence, as an outcome. Oud developed the perception of patient aggression scale (POPAS) [9] as a brief (10 to 15 item) proposed outcome scale for interventions around violence for mental health nurses. We modified the POPAS to for use in New Zealand by adding two of the more distressing events from previous surveys (stalking and complaint) and modifying the language for the New Zealand reader. To our knowledge, the psychometric properties and factor structure of this scale have not been reported. We were therefore interested as to if the POPAS could be used, either in a shortened form or as it currently is being used.

Method

260 patient care-givers in the Otago, New Zealand Region completed the modified POPAS. The reliability was assessed, and the components of the instrument were dropped in a stepwise manner to maximise internal reliability. An exploratory factor analysis was performed using polychloric correlations, and the factors described. All analyses were undertaken in Stata

Results

The NZ modification of the POPAS is cohesive (Cronbach's standardised alpha was 0.911). The reliability of the scale was improved by dropping 5 items. The seven remaining items, had a high internal reliability (Cronbach's standardised alpha was 0.942). An exploratory factor analysis using polychloric correlations (to accommodate the ordinal and skewed nature of the responses) and looking at a two-factor solution found that one factor loaded aggression (in a similar manner to the 7 items above), and the second factor loaded sexual and non violent aggression. A one factor solution was also acceptable, with a goodness of fit index of 0.98.

Conclusions

Patient initiated aggression takes many forms, including violent, sexual, and non violent (stalking and vexations complaints). The reliability of the survey is improved by decreasing the items to seven (anger, threats, physical aggression, destruction of property, attempted assault, assault (or being hit), and injury). However, the 12 items scale includes five other items which are not uncommon and of concern: humiliation, sexual harassment, sexual assault, stalking and vexatious use of formal complaints. The full scale has sufficient internal reliability that a summed violence perception score could be used as an outcome scale: the researcher needs to balance the improved reliability of the 7 item scale against the broader focus the 12 item scale provides.

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Exposure to violence at work in the health sector in Europe: Evidence from the fourth European working conditions survey (2005)

Paper

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Abstract

The exposure of workplace violence has been charted and monitored by the European Foundation for the Improvement of Living and Working Conditions in successive waves of the European Working Conditions Survey (ewcs) from 1995 -2005. In the 2005 edition of the survey, around 30,000 workers were interviewed in 31 European countries, including all of the Member States.

According to the fourth European Working Conditions Survey (4ewcs-2005) 5% of European workers report having been exposed to bullying and harassment in the workplace in the previous twelve months and another 5% report having been subjected to violence either from fellow workers or from others. However, these low European averages mask significant variations between countries which may be attributable to differing levels of awareness of these problems in different countries as well as variations in actual incidence. In general, reported exposure to workplace violence is higher in northern Europe.

The health and social work sector reports the highest incidence of bullying and harassment of any sector. In occupational terms, life science and health professionals and associate professionals (including doctors, dentists, nurses, dental technicians, etc.) report high levels of exposure to psychological violence.

It is interesting to note that professionals – those generally holding more senior positions – have a high level of exposure to violence from non-colleagues but comparatively low levels of exposure to violence from colleagues. Conversely, associate professionals are more likely to experience violence at the hands of fellow workers.

From a gender perspective, female workers are more exposed to workplace violence - especially bullying and sexual harassment – than their male counterparts. Younger women are at greatest risk of all. It is therefore not surprising that the health sector with its high proportion of female workers records the highest incidence of workplace violence. However, multivariate analysis of the survey data reveals that the higher exposure of workplace violence among women is likely to relate to specific circumstances of female employment such as sector, gender of boss, proportion of employees in customer-oriented roles than gender per se.

In terms of impact of workplace violence on health, those workers exposed to psychosocial risks, particularly bullying and harassment, report significantly higher levels due to work-related ill-health than those who do not. The most common reported symptoms are sleeping problems, anxiety and irritability. Though psychological violence is, by its nature, more cumulative in its impact than physical violence, 4ewcs data confirms that its negative health effects measured in

terms of absenteeism due to work-related ill-health are more severe than those associated with physical workplace violence.

Finally, evidence from the 4ewcs suggests that certain features of work organisation are associated with higher levels of bullying, such as low levels of autonomy, high levels of work intensity, and working in frequent contact with customers, clients and other non-colleagues.

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Measuring Bullying (Ijime) among Japanese Hospital Nurses: Dimensionality of the Revised Negative Act Questionnaire (NAQ-R)

Paper

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Abstract

Background

Bullying in hospital settings is recognized as a serious violence issue. Nurses who are victimized by workplace bullying may be unable to provide optimal care to patients, experience decreased job satisfaction, and resign from the workforce. Little is known about the experience of bullying (ijime) or its measurement among Japanese hospital nurses. The Negative Act Questionnaire has demonstrated utility in diverse international samples, but had never been used with a Japanese sample. Factor analytic results of these studies have suggested a variety of structures, from unidimensionality to as many as 5 correlated factors.

Aims

To describe responses to the 23 item Japanese translation of the revised Negative Act Questionnaire (NAQ-R), to explore dimensionality using factor analysis, and to compare results with those from other international samples.

Methods

This is a secondary data analysis of an ijime study among Japanese hospital nurses. Responses from 881 registered nurses who answered all 23 NAQ-R items and who were working in 89 medical or surgical units of 18 hospitals in Tokyo and Southern Prefectures of Japan were used for the analysis. We used descriptive statistics to summarize item responses, replicated the principal components (PCA) approach used by other international investigators, and estimated exploratory maximum likelihood (ML) models with 1-5 factors.

Results

Responses to the 5-point (1 = "never" to 5 = "daily") NAQ-R items were very skewed. The response of "never" was used most often, with item means and standard deviations ranging from 1.04 to 1.72 and .31 to .89, respectively. Of the 570 response patterns represented in the data; the most common (n = 165) was to reply "never" to all 23 items. Surpassing the first threshold to "now and then" was easiest for "withholding information that affects your performance;" the most difficult was responding "weekly" to "threats of violence/actual abuse." Internal consistency reliability (Chronbach's alpha) was .94. PCA produced 3 components with eigenvalues greater than 1. All 5 ML models were rejected using the chi-squared test statistic.

Discussion

With the approaches we used, there was little evidence for unidimensionality of the bullying concept; however, the skewed quality of responses to the NAQ-R contributed to difficulties in estimating traditional factor analysis models. Item response theory or ordinal factor analysis may be more useful ways to gain insight into test functioning.

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Must the workplace deal with different types of impulsive violence?

Paper

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Keywords:

impulsive violence, reward-delay impulsivity, rapid-response impulsivity, differentiation violence, risk assessment.

Introduction

Most of us know that violence can be used to achieve a certain goal. Usually it concerns moderate and restrained violent behavior as in giving the door an extra push when it's jammed. Generally we know when to stop before reaching the point of overstepping the critical line. Deliberations are made whether it pays to exert the amount of violence and assessing whether the violent act is suited to the situation and remains within the boundaries of the law. Apart from limited and restrained violence there are also many instances of impulsive, instinctive and exaggerated violence that are often the focus of media attention.

The situation in which this violence takes place, occurs instantly. Persons use the words as "I blew my top" and "I wasn't myself". In imitation of Jaspers this behavior is referred to as "impulsive" because the person acts without having made a decision about it beforehand. Impulsive violent behavior occurs in both healthy and sick people in a range of diagnoses. The violence is often limited to minor incidents but in cases of more severe violence the sentence may involve detention in a custody centre. More or less violence can be expected in different settings in the (mental) health sector. Patients and personnel are at risk. In the current fourth generation of risk assessment three elements are formulated: first, level of violence, second, violent risk factors and third, level of motivation for change. Brouwers (2007) proposed to add a fourth element: the kind of violence.

Research questions and previous results

It is estimated that sixty to ninety percent of violent crimes are impulsive in nature (Stanford et. al., 2002, Kockler et. al., 2006) although there is considerable correlation between instrumental and impulsive violence. Impulsivity and violence are shared factors in diagnoses like borderline personality disorder, psychopathy or antisocial personality disorder. Does this situation always involve a violent act or do people get into such a state like this without demonstrating violent behavior? Are we dealing with an affliction, a separate psychopathological entity, as suggested by Plutchick and Van Praag (1998).

Impulsive violent behavior (affective defense) is distinguished from instrumental violent behavior (predatory attack) (Weinschenker and Siegel, 2002). The literature shows that there are different views on impulsivity (Swann et. al., 2002, Evenden, 1999). On the one hand, it is consistently argued that impulsivity can be related to the inability to delay a certain response (reward-delay impulsivity). On the other hand, according to the antecedent viewpoint the key issue is that the context is not involved in determining the response. Should we split up impulsive violent behavior in two separate forms? The first type (t-type, reward-delay) can be related to personality traits

and functions as a diagnostic criterion in for instance periodical explosive disorder (inability to resist aggressive impulses). Consequently, impulsive violent behavior can be considered a separate psychopathological entity on the basis of rapid response impulsivity (c-type). So anyone can act violent if he wishes to do so but not anyone will act impulsive violent on a perceived provocation.

This view has consequences for looking at current psychopathology and violence: the diagnosis will not predict the kind of violence that can be expected.

Current research

Studies on the factors associated with impulsive violent behavior (Brouwers et al., 2005, Houston and Stanford, 2001) demonstrated the following biological, cognitive and social psychological factors: a traumatic history (mainly typified by physical violence) alcohol and drug abuse, a positive but unstable self- image, problematic self-control and impulsivity, hostility, low verbal intelligence, belonging to a violent group and the presence of a weapon. The factors can be grouped into three higher ranks that produce the profile of the perpetrators. Firstly, being under the influence of alcohol or drugs and having a weapon at hand. Secondly, a capacity of a lower verbal intelligence and thirdly, a tendency to react impulsively to physical violence, impulsivity, anger, hostility and arousability. The group of drugs, alcohol and weapons together with lower verbal intelligence seems to contribute most significantly to impulsive violent behavior.

Our current research must show if laboratory measures of impulsivity can be helpful in differentiating impulsive violent behavior. Are different types of impulsive violence associated with different psychopathology or violence promoting factors? For instance, Dougherty et. al. (2003) found that adolescents with disruptive behavior disorders exhibited higher commission error rates, lower inhibited response rates after a stop-signal and twice as many reward-directed responses. Two rapid-decision tasks were included (IMD/DMT and go/stop) and two reward-delay tasks (TwoChoice and SingleKey). Swann et.al. (2002) revealed that rapid-response impulsivity was associated with a life time axis-I diagnosis.

Ortner et. al. (2003) found that alcohol intoxicated participants tended to discount delayed rewards at lower rates than sober participants and blood alcohol level was inversely correlated with delay discounting so that alcohol not always increase cognitive impulsivity.

Conclusion and discussion

In the workplace situation different types of violence can be expected. Type of violence is a fourth element in risk assessment. Instrumental violence is planned, the perpetrator decided to use violence to achieve a goal. Impulsive violence happens after a perceived provocation. There are indications that impulsive violence can be split up in two types: one based on reward-delay and one based on rapid-response. The instrumental violent perpetrator planned to be violent to get a painkiller prescription and threaten the use of force. The impulsive violent perpetrator t-type (reward-delay) is violent after hearing that he has to wait for the prescription but can be turned off if he hears that it will be immediately arranged. The impulsive violent perpetrator c-type is violent after he heard there is no doctor to prescribe and can not be stopped till he cooled down, he loses contact with the situation for a while. Differentiating types of violence is a step forward to deal with workplace violence.

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Nurse bullying in Ireland: a review of the studies 1995-2007

Poster

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Abstract

Workplace bullying occurs in the health services in Ireland (O'Moore et al, 1998; O'Connell et al, 2007). Recent priority setting exercises both regionally (McCarthy et al, 2006) and nationally (National Council for Nursing and Midwifery, 2005) have shown nurses and midwives have identified the issue as a priority for research. The first study on nurse bullying in Ireland was conducted in 1995 and was followed by a number of other small empiracle studies. Much of this work is unpublished however, and so remains hidden in the 'grey literature' of university thesis. This poster brings together this somewhat fragmented body of work and makes it more visible. It will show the timelines, the methodological approaches, and the main findings of the studies conducted. It will offer recommendations regarding how the corpus of work can develop into a more substantive piece for informing policy

To give an overview of research studies conducted on nurse bullying in Ireland.

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Nurses and Workplace Violence: Online Information Exchange for nurses to report on, reflect on, and act on aggressive behavior in the workplace

Paper

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Abstract

This paper considers nursing and work place violence from an information exchange viewpoint. It considers the possibility of developing web based instruments for managing, communicating and resolving nurses' experience of workplace violence. Nurses engage in an intense, contingent and immediate practice in which there is little chance for reflection. They face a duality in their daily work, being both the recipients of kindness and gratitude for their caring, as well as of negative responses for being the immediate human interface for the medical profession and hospital administration. This negativity often escalates to violence under conditions of stress. Nurses are not enabled, by present cultural and professional practice within the hospital system, to address the emotional and psychological pain they endure in a swift and comfortable manner.

It is well documented that de-briefing, if done professionally, works. But it seems that it is costly and often not implemented at the right time. There is also a stigma related to face to face acknowledgement of involvement in violent incidents. It is the argument of this paper that if de-briefing can be complemented by the development of a convivial asynchronous space on the Internet for reflection, nurses might be freed from the complex binds of lateral oppression and be enabled to express, heal and comfort themselves. This paper suggests that nurses should not forget and sublimate their initial and immediate responses to aggressive incidents but record and objectify them and be enabled to take steps that bring about a reflective, educated and an assertive response collectively. There should also be an accessible record of such experiences, reflections and responses which can be drawn upon in the future. This paper proposes that, using the new social software of Web2.0 nurses across the world can create nursing communities where nurses can informally chat and professionally write about their work. Through the use of blogs and Nurse Wiki's nurses can seek active contributions from each other and offer each other a refreshing mix of professional advice and insight.

The challenge is to create a non- hierarchal on-line arena free from stigma, where nurses would feel free to visit. This space could be used to post an incident form and this avenue could provide a 'safe space,' for information exchange on both a professional level (how to get training, debriefing etc) and on a human level (hey, that happened to me too).

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Nurses Association of Botswana (NAB): Workplace Violence Project (WVP) in the Health Sector

Workshop

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Abstract

Workplace violence affects all categories of workers; however the health sector is considered a major risk due to the fundamental characteristics of the services delivered. An international response was initiated in 2002 through the joint development of framework guidelines for addressing work place violence in the health sector by the ILO, WHO, ICN and PSI.

In Botswana, in recent years, incidences of work place violence were increasingly reported both in the media and to the Nurses Association. Incidences included both physical and psychological violence, which occurred between health workers and between health workers and their clients and vice versa. As nurses form the majority of health workers, they were most often affected. In response a three year project was started by the Nurses Association of Botswana in 2006 to make violence related issues visible and work towards its reduction. Eleven teams of nurses throughout the country, representing the various health facilities, were formed and trained, to start implementing activities. At the end of the project, teams hope to have achieved:

- Awareness through the media, development of IEC material and sensitization of health workers and the community.
- Collection of data on risk, incidence and impact of work place violence.
- Development of a national, zero tolerance policy, and
- Implementation of risk reduction strategies.

So far, the first two objectives have been met, but whilst these remain ongoing, the project teams are now concentrating on the remaining two. Sensitization of health workers and the community, through mini workshops, has been implemented, media exposure on national television and in the newspapers has been achieved, printed material has been developed for country wide dissemination and data on risk, incidence and impact have been collected. Furthermore, through the WVP it has become evident that workplace violence is much more common than originally anticipated and it is no longer perceived as a normal part of one's work. In addition, capacity building of team members has taken place in terms of project development and related activities and research skills.

The project is endorsed by the Ministries of Health and Local Government, the main employers of health workers in Botswana. To enhance sustainability of the WVP, the Association is working closely together with relevant departments in these ministries, in order to promote integration of the WVP activities into various relevant government programs, especially the government's wellness program for health workers.

The WVP was initiated by the Norwegian Nurses Association through funding from NORAD and is being carried out in collaboration with the International Council of Nurses (ICN), the SADC AIDS Network for Nurses and Midwives (SANNAM) and the national nurses associations of Lesotho, Swaziland, Zanzibar, Mauritius and Botswana.

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Occurrence of PTSD symptoms and their relationship to professional quality of life in nursing staff at a Norwegian forensic psychiatric security unit

Poster

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Abstract

Background

Psychiatric nurses often experience violence at their workplace. Being forced to manage violent patients often provokes adverse feelings and negative workplace experience which often causes feelings of fear and anxiety. A substantial number of psychiatric nurses have signs of burnout and recent findings indicate high level of emotional exhaustion. Compassion fatigue and burnout is a phenomenon of importance and the relation between different aspects of job satisfaction, compassion fatigue and risk for burnout has not been broadly explored. The role of violence directed towards nurses has already been shown to have a severe psychological impact on nurses afflicted who in turn increase the risk of more long term psychological consequences. The risk of having to leave nursing profession due to psychological consequences is substantial and risk for post traumatic stress disorder (PTSD) after assaults against nurses is demonstrated.

Objective

The aim of this study was to explore relations between, and occurrence of, job satisfaction, burnout and symptoms of PTSD among nurses in high frequency violence environment.

Methods

The study was conducted among nurses at Brøset forensic psychiatric unit which is a Norwegian regional unit for severely mentally disordered patients too difficult to manage in regular psychiatric setting. The unit consists of 4 wards with a total number of 21 inpatients. During the year of the study (2006), staff experienced 215 incidents of threat and violence corresponding to 13,4 incidents/bed/year of which 7,4 incidents /bed/year were physical attacks on staff members. All staff members were administered questionnaires regarding occurrence of PTSD-symptoms and their professional quality of life. For assessing symptoms of PTSD, the PTSD Checklist, civilian version (PCL-C) was used. This is a questionnaire following the DSM-IV criteria for the diagnosis of PTSD. The different symptoms are answered by the respondent on a 5 point Likert scale. A symptom was considered as meeting the threshold criterion if an individual reports that it has bothered him or her moderately, quite a bit, or extremely (i.e., an item endorsement of 3 or greater on the Likert scale). Assessments of professional quality of life were made with the Professional Quality of Life Scale (ProQol). Occurrences of any PTSD symptoms as rated with PCL-C were correlated to items in the ProQol scale, ward and years of experience in forensic psychiatric care with a multiple logistic regression procedure. The questionnaires were anonymous.

Results

70 staff members answered the questionnaires. There were no individuals reaching cut off levels for PTSD diagnosis but several had at least one symptom reaching cut off level. In the

logistic regression procedure, 2 variables independently contributed to a higher risk of having PTSD symptoms, low scorings on compassion satisfaction (CS) in the ProQol and length of experience.

These results are interesting, the low occurrence of PTSD in spite of fairly high levels of violence contradict other studies and argue that other factors contribute to PTSD together with trauma. Such a factor could be having low satisfaction and low compassion in your working situation. Length of experience as contributing is probably a question of long exposure time. If these results will be corroborated, it could be argued that staff experiencing low work satisfaction perhaps should lessen their clinical duties over time and perhaps being used as mentors for younger staff members instead?

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The Dante-project: prevention of aggression and violence within intercultural dialogues - a phenomenological teaching research process

Workshop

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The project

The phenomenon of aggression and violence put the social cohesion in the community at risk. They occur daily in working fields of multipliers in the health sector and intercultural social work (Heitmeyer 2003). Research shows that destructive violence expresses a social loss of existential confidence (Rosenblatt et al 2003 Gestalt basics). Hence humans can't distinguish between constructive and destructive aggression. It turns out currently that you can't prevent or eradicate aggression and violence as social phenomena by educational and political moralizing. Thus we have to develop innovatively a positive acceptance and integration of the aggressive forces, which we see in contrast to dismissing them in a moralizing manner. In accordance with the way in Dante's "divine comedy" to reach liberal individualization beyond authority, multipliers in social work and the health sector shall be coached in their personal dealing with phenomena of aggression and violence, as an innovative approach to prevent aggression. Adult educators and multipliers in the health sector will be accompanied to extend their intercultural skills and competences of awareness and dialogue in their pedagogical practise.

Research procedure

Based on the intercultural dialogue (Muth 1998) and Gestalt approach we create the "Dante Project" as an integral research procedure with practical relevance (Fuhr / Dauber 2002). With reference to action research the project is obliged to both theoretical deepening of practically oriented questions and the practical relevance of theory (Wulf 1977). Our interest is directed to develop dialogue research as a phenomenological approach to research, which avoids the usual splitting of researcher and research object. In creating an open learning space we want to develop a way of teaching Intersubjectivity (Muth 2008) as prevention of aggression and violence in a process of self-confidence and self-esteem. Our needs analysis of usual vocational trainings shows a lack of education of personality in its humanistic meaning (Muth, Nauerth 2008). Our integral research project with practical relevance contributes to develop personality.

Aim

The aim of the project is the growth of personality within intercultural dialogue for adult educators and multipliers in social work and in the health sector as prevention for aggression and violence to rectify the loss of personality education we realize in the education system. The multipliers are invited to broaden their communication skills and to sensitize to intersubjective space as an increasing interpersonal competence and personal fulfillment. Insight in oneself and joint reflection within an increasing aesthetic – ethical competence of awareness creates confidence. A professional dialogue competence is based on recognition and establishment of interpersonal dignity (Muth, Nauerth 2008). This competence referring to phenomena of aggression and

violence in the particular working fields will be extended by personal aesthetical-ethical skills of awareness, by a competence of performance which preserves actively radical plurality and by the particular right of existence as a distinct expression for European citizenship based on understanding and respect of human rights and democracy. Multipliers will learn and experience these competences in workshops and reflect them in their practise fields being accompanied by dialogue coaches. So the transfer evaluation to practice happens at the same time. The workshops intend to train the awareness of the “hell” in us and in the other which means the phenomenon of the evil in terms of aggression and violence. Further the “purification” lies with the acceptation of the aggression as social phenomenon which can’t be prevented by political or pedagogical moralizing alone. For prevention it is rather a question of exploring consciously the own potential of violence and dealing with questions of how and when violence arises and will be realized in daily life. For prevention of aggression and violence the improved insights including the intercultural comparison could be “paradise”, meaning the growth of confidence and trust. Our educational goals are the development of a conscious knowledge how people become aware of their different types of aggression and become responsible of it and according to “a living concept of intersubjectivity” (Muth 2008) the insight that people are not separated individuals but always interconnected with the world.

Evaluation

Complementary the entire process will be reflected and evaluated along the grounded theory approach of our dialogue research. The structure of the project is a humanistic hermeneutic and phenomenological one, working with interactive processes within dialogue. The evaluation follows an open explorative – qualitative approach within the scope of participant orientated research of impact. Therefore the participants’ (the research team, dialog coaches and multipliers) own questions and their own statements about how they do have experienced their own process of learning and development of personality education interest mostly. The evaluative-functional analysis indicates with questions like: What did I learn? What is the relevance of the learned stuff for adult education? Is it usable? Has competence been advanced and how? In dialogue groups, with a Gestalt approach and interpretative methods the whole project and research is in process to explore the inner structures of acting: How do I proceed concerning confidence and aggression? How is the own attitude of aesthetic awareness towards violence and aggression structured? So the aim is an ideational realization of the own established order. So we now could decide freely about these orders. The insights of oneself and experiences of the entire project group are to be documented in written reports and questionnaires, can arise out of dialogue and will be reflected in supervision. The research team is continuously reflecting the ongoing project process by evaluation of the written reports, by regular exchange with all participants and by feedback loops. Due to the principles of action research the research team consists both of supervising professors, research assistants and dialog coaches.

The methodological approach

Our research procedure defines our methodological proceeding. We follow the research procedure of Reinhard Fuhr (2002) who describes an integral research procedure with practical relevance in the education sector (“Praxisentwicklungsforschung”). He combines in his approach educational practice, scientific cognition, development of personality and common sense. “Praxisentwicklungsforschung” (means : research in interaction with development of practice) is “an extended frame how practice can be developed in a scientifically replicable and proven manner and how in the same time or afterwards improved knowledge in different sights can be gained” (Dauber / Fuhr 2002,78) (Translation SMW).

The principles of research in interaction with practice are:

1. The connection of practice and research in the tradition of action research (Wulf 1977) where not only empirical research is accepted but also an extended concept of science as subjective and intersubjective procedures (Muth 2008, Orange / Atwood 2001, Devereux 1988)
2. Process orientation, which is a real challenge and innovative principle of research as in a usual scientific context only the results are of interest. Process orientation means a continuous reflecting of the ongoing process by regular dialogues within the whole project group, within the research team (which consists of both researchers and dialogue coaches and multipliers) and by the evaluation of written experience-based personal reports. Further the ongoing of the project is developed by reflecting in feedback loops. The process and the end are in a radical way really open. We don't know yet where we go, but the next step. This thinking in process and the reconstruction of it is not arbitrary but a difficult and unusual task
3. The integration of the "four dimensions of reality" is epistemologically a multi perspective access to improving knowledge, which is described by Ken Wilber, a scientist and philosopher who works in fields of integral conscious research. The "four dimensions of reality" is like a map on which you can look up during the journey of research. The model describes four different ways to improve knowledge which all are connected and of equal value. Wilber differentiates an individual and collective perspective on reality and an inside and outside perspective. The inside perspective allows knowledge of deeper structures; the outside perspective gives information about the structure of the surface. In our Dante project we work predominantly in the individual and collective inside perspective, as we expect within the intercultural dialogue and intersubjective processes knowledge on deeper structures of phenomena of aggression and violence.
4. Self reflection in dialogue. Each person is invited to reflect his and her own questions, experiences, thoughts, personal philosophies. This is a focus in the Dante project as we intend to develop a conscious knowledge how people become aware of their different types of aggression and become responsible of it. To learn enter in real dialogue as the philosopher Martin Buber (2002) described in his fundamental work "I and Thou", which can happen in intersubjective encounters is the leading intension in our contribution to prevent aggression and violence

Besides the usual research methods the research teams are therefore challenged to use unconventional methods of improving knowledge. Especially subjective and intersubjective experiences and processes which usually are not subject of scientific research can thus be researched. Main focus of our work is creating an open learning space for intersubjective processes. Our pedagogical principles and the teaching methods will be subject of our workshop as well as the first experiences and outcome of our project.

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The Effects of Music on Psychiatric Patients' Emotional Control

Poster

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Keywords

Music, emotional control, seclusion room.

Abstract

Background

In psychiatric acute care settings, patients with severe psychotic symptoms, such as delusion, agitation, or suicide attempts, commonly exhibit violent behavior due to uncontrolled emotions. Seclusion and restraint are widely used to protect and calm such a patient as well as to save others from harm. However, use of seclusion and restraint might easily disrupt the therapeutic rapport between psychiatric nurses and the patient and adversely affect other patients as well. Previous studies suggest that music therapy can help psychotics manage their own agitated emotions and violent behaviors. Few studies have, however, researched the possible effects of music on psychotic patients restrained in a seclusion room.

Purpose

This study examined the effects of music on psychiatric patients' emotional control in a seclusion room in a psychiatric acute setting.

Methods

An experimental research design was used. Data were collected in a psychiatric acute unit in a medical center located in the southern part of Taiwan. Fifty-six patients who were restrained at a seclusion room since their uncontrolled emotional expression were recruited and randomly assigned to one experimental and one control group. Each group consisted of 28 subjects. The experimental group completed the Brief Symptom Rating Scale (BSRS) before (Time 1) and after (Time 2) a 30-minute music intervention to evaluate their emotional status. In addition, subjects' physical condition, such as breathing, pulse rate, and blood pressure were also examined before and after the 30-minute music intervention. The control group received no music intervention; they only experienced an equivalent 30-minute period of restraint and seclusion. There was an additional posttest (Time 3) including physical and emotional information for each subject three days later to test for ongoing effects from music intervention. Paired T-test and Individual T-test were conducted to examine the differences between the two groups on measures of BSRS, including anxiety and hostility, as well as physical condition.

Results

In both groups, there were significant differences in subjects' physical condition, including breath ($p < .001$), pulse rate ($p < .05$), and average blood pressure ($p < .001$) in measures at time 1, time 2 and time 3 after the 30-minute restraint and seclusion, no matter whether subjects did or did not accept the music intervention. The similar outcomes were also seen in emotional condition. In experimental and control groups, both anxiety ($p < .001$) and hostility ($p < .001$) at time 2 were significantly different from time 1; similarly, there was a significant difference in both emotional

variables between time 3 and time 1. There was no significant difference between the two groups concerning their physical and emotional conditions. The results indicate that both restraint and music intervention may be effective in controlling psychiatric patients' impulse and aggressive emotion. On the other hand, compared to music, restraint and seclusion were found to have a direct and major effect on emotional control in psychiatric patients.

Implications

The findings have demonstrated the positive effects of music on controlling psychiatric patients' emotions. This information can be used to guide future research on this topic and to shape emotion-control interventions in psychiatric wards.

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Violence as a Form of Expression: Danish experiences with the prevention of violence in the Social and Health Sectors

Workshop

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Keywords:

Violence, workplace, prevention, methods, communication

Introduction

Violence at the workplace is a well-known problem, especially in the social and health sector – but the employees shall not accept it as a condition at the workplace. Conflicts are unavoidable, but it is an imperative necessity to prevent their development into violent incidents. The challenge is to create a culture at the workplace where dialogue and openness about violence is self-evident and a precondition for a healthy work environment, and where the relevant methods for preventing and handling violent incidents are embedded in the backbone of everybody.

Violence as a Form of Expression

Eight per cent [1] of all Danish wage earners are exposed to physical and/or psychological violence on the job each year. In Denmark the prevention of violence has recently become an increasingly urgent issue. Over the last ten to fifteen years research into this problem has been carried out, and strategies for reducing violence and methods for managing violent incidents at the workplace developed. Preventive measures have to a great extent been carried out through the national project Violence as a Form of Expression, which is managed and developed by the Social Development Centre SUS. The project is financed by grants from governmental funds. Since 1992 the project has attempted to restrict violence and its adverse effects within the social and health care sectors, both of which are particularly exposed.

Violence as a Form of Expression has focused on implementing knowledge and practical skills in areas such as:

- New professional and pedagogical methods – new communication strategies.
- Policy on violence and crisis plan.
- Methods for registration and subsequent analysis of violent incidents.
- Training courses in the handling of conflicts and violence prevention.
- User (clients, citizens, patients, residents etc) influence.

The underlying principle behind Violence as a Form of Expression was – and still is – the assumption that people, who need care and support are not especially violent, but rather that violence is a language used only when they feel they are not listened to and understood through other forms of expression. This is why it is important to understand the cause of violence and why much of the focus on workplaces must be on studies of interaction, practice and of communication methods. Violence as a Form of Expression employs a unique cooperation between governmental ministries, counties, municipalities, professional organizations, user organizations and a large number of

workplaces, both locally and regionally. This ensures implementation and future commitment to the cause of minimizing violence on all levels of society. The effect of Violence as a Form of Expression can be seen on two frontiers: First of all, the experiences indicate that the constant focus on prevention of violence reduces the numbers of incidents and the degree of violence. Secondly, the focus has also succeeded in reducing the negative psychological consequences the employees experience after being exposed to a violent episode. It is important to note that if implementation and strategies are not deeply rooted in both practice and the organization it will fail at the workplaces, because the prevention of violence will be forgotten in time. The same might occur if the workplace does not have a enough violent incidents to keep registration efforts, policies and routines alive.

New professional and pedagogical methods – new communication strategies

An increased focus on professional and pedagogical methods is an important means of prevention, and is a shared responsibility. It is essential to view working methods in relation to users – their understanding of situations and consequently their reactions. Methods and approaches must be adapted to the individual user, and it is important to be aware of his or her life story and to observe the behavior.

Violence as a Form of Expression encourages the use of hands-on tools, i.e. keeping a journal registering violent incidents, used to develop and evaluating agreed courses of action. Another tool involves observing users and staff by video recordings of everyday incidents as well as “difficult situations” and subsequently analyzing them in preparation of development of new communication methods with users.

Policy on violence and crisis plan

- Violence as a form of expression recommends all workplaces to have a policy on violence.
- It creates visibility, homogeneity and continuity in the efforts to prevent violence and aggression.
- It signals a common will to manage violent incidents, and can improve the working environment by creating more openness about the problem.
- It can make existing routines more visible and contribute to their adjustment and the development of new methods.
- It can ensure the registration of all violent incidents.
- It acts as a safety net for the staff and brings a greater sense of security to the interaction with users.

A policy on violence – and possibly a set of guidelines – typically contains the definition of violence of the certain workplace, and methods to prevent, minimize and handle violence. Often a crisis plan is an integrated part of the policy on violence. It ensures care for employees who have experienced a violent incident and follow-up – both in relation to the implicated employee and in relation to reporting the incident to the relevant authorities. Typically the plan for each member of staff contains:

- A list of colleagues the employee wants assistance from in case of a critical situation, and a list of people to contact
- Guidelines for psychological first aid and advice on support
- Guidelines for the follow-up on the incident.

The crisis plan should be adjusted at regular intervals to keep it updated.

Methods for registration and analysis of violent incidents

In order to make violence visible and improve preventive measures, it is important to register all violent incidents at the workplace. Violence as a Form of Expression recommends using a registration form, which provides information on the violent incident:

- Where and when did it happen?
- What happened and who was involved? – were colleagues present?
- How did the implicated employee react? – what was planned as follow-up?
- How do we handle a similar situation in the future?
- It is also important to record who the incident was reported to.

Training and supervision

Through training employees get a common understanding of how to cope with violent behavior. The training can be given on special feature-days or courses, through conferences and professional networks. Violence as a Form of Expression has managed and designed many such.

Some workplaces choose to train especially resourceful employees who are given the task of maintaining focus on violence prevention and who train and support colleagues on the issue.

Methods such as peer counseling and supervision are likewise efficient ways of developing professional skills and secure knowledge sharing.

User influence

Violence as a Form of Expression emphasizes user influence as an extremely important aspect of the prevention of violence. It is easier for the staff to adapt their practices to suit the individual if they have a sound understanding of the different users' own perceptions and wishes. Combined with ensuring users' empowerment this will create a sound foundation for positive communication and a better working environment for the employee as well as a better quality of life for the users.

Other notable focus areas

- Technical solutions: Alarms, surveillance cameras etc. can create a greater sense of safety for the staff. Project Violence as a Form of Expression underlines that it is important to acknowledge that technical solutions should not stand alone but always be combined with other methods to minimize violence.
- Physical surroundings: The physical environment influences the escalation or de-escalation of conflicts and the occurrence of violent incidents – it is important to ensure airy and pleasant surroundings which do not contribute to a stressful environment for both employees and users.
- Violence prevention as part of education and training: Through various activities Violence as a Form of Expression has raised awareness about the prevention of violence in institutions and educations supplying the social and health sector. The purpose has been to raise students' awareness of the risk of being exposed to violence and to introduce them to prevention methods.

Afterthoughts

Experiences from Violence as a Form of Expression show that there are good possibilities of reducing the number of violent incidents. Since the onset of the project in 1992 we have learned that workplaces achieve the best results if they apply hands-on preventive measures simultaneously, such as: A policy on violence, registration and analysis of violent incidents, an efficient crisis plan, ongoing supervision, awareness of means and ways of communication, and a modified physical environment.

The conditions for successfully minimizing violence at the workplace are openness about the challenges and facing up to the issue as a problem. Fortunately the increased focus on the subject has made this less complicated. It is now acceptable to admit that you are exposed to violence at work. Evaluation reports from workplaces show that social and healthcare workers now see violence in a different light and that their ability to cope has improved considerably.

As a central side-effect from addressing violence the experiences show that the psychological work environment often improves significantly, thus ensuring better conditions for e.g. recruiting and retaining employees.

In Denmark there has been an increase of violent incidents amongst people working in other sectors than the social and health sector in recent years – mainly the service sector, where people work in e.g. tax collector's offices, busses, libraries, public swimming pools and job centers. The challenge of the future is to modify preventive methods generated from Violence as a Form of Expression to fit these 'new' areas, and at the same time continue to spread and develop new methods within the social and health sector and generally promote openness about the issue.

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Chapter 8 - Social and psychological theoretical perspectives on workplace violence

“Balancing Safety and Service” Employing best practice methodologies in developing a cohesive organisational response to work related aggression and violence

Paper

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Abstract

While the problem of work related violence has gained considerable recognition at professional and organisational levels, for a variety of reasons efforts to address the issue have not fully appreciated the complexities involved in understanding the problem as being embedded within a service relationship. This has sometimes resulted in responses which are instituted in isolation from the context in which the problem occurs. Dissatisfaction with such approaches has prompted the recognition of the need for total organisational responses to the problem which are now widely acknowledged. Notwithstanding this recognition, there has been little attention as to how such responses can be achieved at national levels.

This paper will present how a national, standardized, coordinated response has been developed within the Irish health service which has the potential to simultaneously improve the service experience of recipients, the quality of the working life for staff, and the overall effectiveness of the health service organizations. The development of this strategic approach required critical reappraisal of some fundamental assumptions regarding how the problem is understood and managed. However it was only through developing this informed view of the complexities of the problem, that the clarity of the responses required became apparent.

The resulting strategy has incorporated four best practice approaches from organizational and health disciplines into a strategic response which has been thoroughly considered, draws heavily on evidence and international best practice, is innovative in approach and comprehensive in scope.

This paper will briefly present the four approaches on which the strategy is founded including:

- a contextual understanding of aggression and violence within healthcare
- an integrated balanced organizational response,
- a public health preventive approach, and
- a partnership ethos of working.

The contribution and interdependence of each will be presented and supported by discussion of the underpinning value base. The presentation will conclude with by suggesting the need for cohesion between strategy, guidance and policy and the role of each of these in informing a structured implementation plan of achievable and sustainable improvements.

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Exposure to workplace violence affecting the mental health of nurses occupied in the demanding field of care provision

Poster

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Abstract

Introduction

Post-traumatic stress disorder (PTSD) was mentioned for the first time in the WHO International Classification of Diseases in 1992. Initially it was connected almost exclusively to the military personnel as the psychological aftermath of combat. It is realized today that, among others, this syndrome develops in victims of disasters, and violence (sexual and social) and that it may also affect the health professionals who care for such individuals.

Purpose

The aim of this study is the exploration of the psychological aftermath that the exposure to, or the experience of traumatic events (violence included) could have on the health-care professionals and more specifically on the nursing staff.

Methodology

The search had three sections. The first explored the threatening incidents of assault, verbal threats, and injuries by which the personnel working in psychiatric departments are faced with. The second explores the psychological impact of being working under a potentially self-harming occupation, and / or caring for people with urgent medical needs. The third section explores the emotional sequence of being exposed to traumatic material, suffering, or death in the everyday practice of the profession.

Results

The review of the literature, documented the development of PTSD or PTSD-related reactions in the nursing staff, in all three sections of the search.

Conclusion

The literature describing these symptoms is not vast, however it is indicative of a problem that-among other- has been blamed to lead to job turnover, negative impact on the nurse-patient relationship, and loss of money by the health institutions (due to sick leaves).

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Harassing Patients: A Family Physician's Personal Reflections and Suggestions

Paper

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Abstract

Objective

Family physicians may encounter harassing behaviour from their patients. The aim of this presentation is to increase awareness of these phenomena and explore approaches that address harassing behaviour.

Sources of information

A physician's personal reflection of a stalking incident combined with information gathered from the literature.

Results

I was stalked by a female patient and after reviewing the literature became aware that any family physician could become a victim of a stalker. Family physicians provide comprehensive care in a wide variety of settings; hence their routines and schedules are public knowledge making them particularly vulnerable to harassment or violence such as stalking by patients.

The prevalence and incidence of patients' harassment of family physicians is unknown and we rarely think of women stalking women; however this could be more common than we realize. My patient harassed me initially through loitering, and telephone calls. She then became aware that she could page me through the voice mail attached to my beeper, day or night interrupting my sleep and provision of patient care. She left threatening messages on my answering machine at home which frightened my family.

The stalking escalated to that of lodging false complaints; first to the police, and then to my medical licensing body. Upon review of the literature, early recognition and intervention of inappropriate behaviour is important however physicians may cope by denying or refusing to acknowledge the problem. In my case the inappropriate behaviour was overt with the uttering of death threats. I was told that I could not abandon my patient and therefore transferred her care to a male colleague in my practice setting.

The death threats and harassing behaviours escalated and she was then transferred to another clinic. During this episode, stalking in Canada was not considered a criminal offence; so while the police were supportive, they indicated they could not intervene until physical violence had occurred. I kept copies of voice messages and letters and document every incident including discussions with colleagues. I kept this documentation in a separate file and it was most helpful when my stalker lodged false complaints. I found the support of family and colleagues invaluable during this stressful period.

The development of Canadian legislations and laws that include staking as a criminal offence will assist in stalking cases. Nevertheless, more mechanisms need to be put in place that enables physicians to terminate communication and relationships with patients that pose a threat.

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Re-framing the problem of workplace violence directed towards nurses in mental health services in the UK: A work in progress?

Paper

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Background

Research suggests nurses working in mental health experience an increased risk of assault and recent recognition of this issue as significant has been marked by a series of policy initiatives in the UK. However, such initiatives can be characterised as being based upon two mutually contradictory 'frames' of the phenomenon. These are an 'individualising' and a 'co-creationist frame'.

Goffman (1974) contended that we use 'frames' in order to make sense of our life experience. In his description, frames are internal cognitive structures consisting of systems of classification and rules of interpretation. The concept of framing has though recently found application in the study of social policy where the process of framing is described as involving the selection of some aspects of a perceived reality that in turn, promotes a particular problem definition, in such a way as to construct a particular causal interpretation, moral evaluation and consequently specific recommendations regarding the type of solution that needs to be adopted (Entman 1993:52).

Snow and Benford (1986) propose that we can usefully distinguish between 'master frames' and 'domain-specific interpretative frames'. Master frames signify meaning on a broader scope and serve to organise sets of 'domain-specific frames', such as those, which both depict and inform how we should understand and thus respond to the issue of violence to mental health nurses. In the case of workplace violence in mental health the influence of a series of master frames can be identified. First, is the classic frame of deviancy, whose premise is that deviants (whether real or imaginary) are easily identifiable, the reasons for their deviancy reside within the individual and social actions to control or punish them are justified. Indeed, because such actions serve to clarify the moral boundaries between the good and the bad that must always be maintained, a failure to punish the deviant would be remiss. Deviancy as an explanatory paradigm is of course intrinsically flawed and is in part the result of the fundamental attribution error which suggests that our attributions for others' behaviour are more likely to focus on the person we see, not the situational forces acting upon that person that we may not be aware of. Because such frames and biases operate transparently upon those affected they are effectively blinded to their influences on both their thinking and behaviour.

It might be supposed that the frame provided by mental illness would in most circumstances absolve a perpetrator of culpability for their behaviour. However, the possession of a diagnosis does not mean that punishment may not play a role in the course of treatment. The use of coercion in contemporary services is often justified by reference to the need to maintain a safe environment but the perspective of service users is often that coercion is being used to

punish rather than to enable treatment (Duxbury 2002). The use of systematic punishment to induce compliance, as a form of treatment was once orthodox practice. The belief that 'fear (is) the most effectual principle to reduce the insane to orderly conduct' may have repulsed (Tukey 1882:90) but to assume that such long established frames no longer exert any influence on practice is to deny reality.

The interaction between such discourses produces an 'individualising frame' that both provides an explanation for why such an individual is violent and legitimates if not demands the use of punishment against the perpetrators of violence. Exemplified in social policy terms by the 'Zero Tolerance' policy on violence adopted by the National Health Service of the England in 1999 such approaches promote intolerance of aggression by service users and/or provide for greater punishment of perpetrators.

Snow and Benford (1988) observe that in order for frames to be successful they must resonate with the sentiments of the population concerned. The individualising discourse with its location of the reasons for deviancy within the individual has several advantages in this respect. Research into the explanations for the violent acts of in-patients suggests a tendency amongst nurses to stress aspects of the service users personality as causal (Duxbury 2002). However, service users explanations for violence tend to differ stressing instead the situational dimensions of violence particularly that it was often a response to controlling behaviour by staff. The preponderance of individualistic explanations by nursing staff for violence by service users means though that an individualistic framing of the problem would have resonated with their existing beliefs as to the origins of violence.

The seeming success of the safety security discourse may though also stem from the form of the frame it uses to construct the problem of workplace violence. Gamson (1992) argued that three kinds of issue frames delineate how problems are constructed. What he terms 'Aggregate' frames effectively define putative issues as 'social problems' but the burden of responsibility for action to resolve the issue is placed with individuals. 'Consensus' frames, in contrast, whilst also defining an issue as a social problem, represent it as one that can only be solved via collective action but leave unspecified who must act. 'Collective action' frames differ in three key respects from aggregate or consensus action. Firstly, they define the problem as one, which is intrinsically 'unjust'. Secondly, 'agency' i.e. responsibility for the problem is placed with an identifiable actor. Thirdly, and perhaps crucially, the frame establishes an adversarial relationship between 'us' in terms of identity as members of the in group and 'the other' i.e. whomsoever the imputation suggests is responsible for the problem

Evidence of the use of the latter frame is exemplified in the title of the Zero Tolerance resource pack sent to every NHS Trust in England (HSC 199/226). Entitled 'we don't have to take this anymore' the identification of an 'innocent' in' group and an implied 'other' is clearly evident and an adversarial if not counter aggressive dimension is suggested. Responsibility for violent behaviour is placed solely with the perpetrator. In terms of social policy the resulting discourse is productive, more specifically deontic in creating an obligation on those charged with protecting nurses from such a threat to address the injustice.

This construction evoked what appears to have been a search for solutions to this construction of the problem. This was found in the adoption of Control and Restraint, or as it became known 'C&R' an approach to the problem of violence developed within the English prison service. The conventional explanation for this is that it followed on from an inquiry into the death of a patient while being restrained. Given the lack of serious concern deaths about such deaths outside the special hospital sector over this period this explanation is actually somewhat implausible. Rather the adoption of C&R provided a means of responding to growing concerns over the

problem of violence towards nurses that was congruent with the dominant individualising frame of the problem.

Why was there no opposition?

The interaction between the individualising master frame and the frames of biomedical psychiatry produced what Michel Foucault (1986) has described as an episteme. Epistemes exercise an all-pervasive influence saturating and governing thinking. Rather than being held consciously their power is exercised insidiously by delimiting how we can think about a given issue. As a result of the dominance of this episteme the conceptual tools offered by alternative paradigm such as social psychiatry and sociology essential if the social dimensions of causation were to be recognised were seemingly mislaid.

It is important to recognise that not all settings, services or practitioners adopted the individualising frame. That there were many gaps in the dominance of the frame supports Snow and Bedford's (1986) observations that while we are susceptible to influence by frames we are also capable of reflection and opposition to the frames we encounter. Opposition to the dominance of the individualising frame has grown persistently over the last decade representing the emergence or perhaps more properly re-emergence, of an alternative discourse that has been described as co-creationist (Paterson and Miller 2006). The new/old frame operates from very different assumptions in adopting a focus that extends beyond the pathology of the individual. Violence is seen as arising from the interactions between individuals operating within complex social systems. In this frame the problem of violence to the worker is defined not as 'injustice' but as a failure to adequately understand and address the root causes of violence. Pathology in terms of the origins of violence is seen as potentially residing in the staff involved, the organisation, the perpetrator and the pattern of their interactions, which are collectively co-created. Each of these provides a focus for action.

Conclusion

Co-creationism thus provides a starting point for any organisation aspiring to be smart in identifying and responding to the multiple and diverse roots of violence. It demands that we balance our focus on individual consumer pathology with an increased recognition of the sources of violence in our sometimes corrupted cultures, attitudes and care practices (Wardhaugh and Wilding 1993). Only by engaging fully with the implications of co-creationism for violence prevention can we realise strategies in which an emphasis on primary prevention becomes embedded in the culture rather than merely the fashion of the moment.

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Violence against Healthcare Personnel: A Psychological Trauma.

Poster

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Keywords:

Workplace violence, psychological trauma, violence in health setting.

Abstract

Introduction

Currently, workplace violence is being an emergent matter to death and injury in the world. In 2002, World Health Organization reported that homicide is second leading cause of death in workplace of America. In European countries, it is estimated as 3 million workers suffering from workplace violence. Research in the United Kingdom has found 53% are victimized and 78% are witness of such behaviors. In Sweden, it is estimated that such behaviors has been a factor in 10-15% of suicides. It is not a new issue however, reporting system of such cases has been increased nowadays. Workplace violence has many effects on individual healthcare personnel but this paper will indicate the psychological aspects of workplace violence.

Purpose

1. To establish the understanding of causes and psychological effects associated with workplace violence.
2. To identify strategies in order to decrease the rate of workplace violence in healthcare sector.

Method

An integrated review of the literature from 20 research articles gathered through electronic medium device published between years 2000 to 2007 by using google, pubmed, altavista, Blackwell-synergy and BMJ search engines. To search these articles key word inserted were “workplace violence”, “psychological trauma” and “violence in health setting”. Also incorporated the “Broken Window Crime Prevention Theory”

Results

Verbal abuse, threats, physical assaults, sexual harassments, and racial insults are the acts of violence from patient, of which healthcare personnel become victimized. There are certain causative factors which give arise of workplace violence including patient’s personal factor (e.g. alcohol or drug abuse, mental disorder, poor coping skills), situational factors (e.g. frustrations, deaths, emergency), organizational factors (e.g. delay in care, work load, communication problems, and turnover rates); societal factors (e.g. cultural differences, economical status). Responses to violence vary, as per person’s tolerance power. Despite the fact that, psychological pains with fist fighting have long lasting effect after the exposure to violence as compare to physical bruises. Mainly, individual depict psychological symptoms such as anger, depression, sleep disruption, low self esteem, irritability, panic attacks and Post Traumatic Stress Disorder (PTSD). Additionally, person might repetitive experiences whole scenario through nightmares and day screaming. Moreover, due to this violence, healthcare workers suffer from stress which decreases their capacity and productivity of work.

Limitation

There were limited studies available on workplace violence in developing countries especially in Pakistan. Those available studies of developing world were not significant to our topic.

Recommendation

Therefore, we recommend that there is an intense need to work on psychological aspect of workplace violence in developing countries. Moreover, healthcare workers should not accept violence as a part of their job; it should be clear in all patients' mind that illness is not an excuse for abusive behavior.

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Chapter 9 - Staff training and education issues regarding workplace violence

A Framework for Employing De-escalation Techniques Effectively when Working with Members of the Deaf Community

Poster

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Abstract

It has been established that lack of awareness and failure to apply cultural congruence when working with members of the deaf community may propagate challenging behaviour (Jeffery and Austen, 2006). Since consistent communication is a pivotal feature of the de-escalatory process, a hearing person's lack of awareness of the intricacies and nuances of the deaf person has potential to impact on the effectiveness of strategies designed to calm anger.

This poster presentation sets out a de-escalatory framework that employees may consider when confronted by an angry deaf person in the workplace. The SIGN© framework is unique in that it has robustly examined the core components of de-escalation and adapted them for specific use with the deaf community. The application of this framework utilises the notion of deaf awareness and cultural cogence. At this present time it is the only de-escalatory strategy meeting the needs of the deaf person and those working with them.

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A Workplace Violence Training Program That Works

Seminar

Phyllis Kritek

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Abstract

This session will explore with participants an exemplar program for multidisciplinary training that equips health care professionals to address workplace violence in a constructive and successful fashion. This program was developed and refined over the past 12 years by the Center for Nursing Leadership at the University of South Carolina furthering the Center's goal of creating safe, supportive work environments through relationship focused leadership development programs.

In this session, participants will acquire valuable take home tools essential to conflict resolution, consensus building, and the creation of a violence free environment. Program content blends the Center's leadership development relationship work with conflict engagement and resolution training based on Dr. Phyllis Kritek's work and book, *Negotiating at an Uneven Table*. Urgency for such training is evidenced by the findings of United States health care improvement groups, including the Institute of Medicine, the American Hospital Association, the Five Million Lives Campaign and the Joint Commission (JCAHO) which has introduced 2009 standards focused on conflict resolution and disruptive behavior, key elements in workplace violence.

Recent studies have demonstrated the high cost of conflict is staggering, both in time spent by individuals engaged in conflict, and more importantly, in the costs of errors and sentinel events that compromise patient safety.

This dynamic program opens the dialog about "workplace violence", exploring its nature and causes and assisting participants in discovering personal behaviors that contribute to workplace violence, physical and interpersonal. Participants in this session will explore three key components of successful training programs addressing workplace violence:

- (1) institutions must invest in both the process and the relationship competencies of conflict resolution;
- (2) competencies such as analyzing conflict, recognizing shadow projection, naming the "elephants in the room" and building consensus take time to master; there is no quick fix; and
- (3) multi-disciplinary partnerships among health care professionals and practice, academic and professional organizations result in more successful and comprehensive training programs.

Participants attending this session will gain from the interactive, time tested, and collaborative approach that focuses on process, relationship building, and skill acquisition, using a personally introspective lens unveiling behaviors that enable and deter workplace violence . Successful leadership development programs help health care professionals expand their own consciousness and improve their conflict resolution competencies.

The result is they are able to create supportive work environments where the possibility of workplace violence is managed to ensure safe, quality patient care.

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Addressing the aftermath of untoward incidents in acute mental health care in the UK - implementing post incident review and support to staff and patients

Paper

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Background

Workplace violence is a problem which has been steadily increasing particularly in acute inpatient mental health settings. Within the UK this is, in part, as a result of the changing face of acute inpatient care. The nature of the staff demographic in many inpatient areas is that of poor skill mix where many experienced nurses have moved on to community settings to develop their skills and expertise. This has resulted in some areas being staffed by inexperienced practitioners with a reliance on agency staff and poor recruitment and retention to these areas. The inpatient demographic has also changed. While specialist community services have developed and evolved in the UK resulting in many service users being cared for within the community setting, those who find themselves in acute inpatient settings are usually acutely unwell and often exhibit disturbed and distressed behaviour which can be difficult to manage on the part of both the inpatient and the staff charged with caring for them in acute care settings. The result can be an environment which is fraught with conflict and tension, with little therapeutic intervention to manage the distress experienced by inpatients and a perceived lack of support by staff working in these settings. The study which underpinned this presentation examined the psychological impact of one aspect of violence (restraint) within acute inpatient settings (Bonner 2007). This study focussed on the aftermath of restraint and found that both inpatients and staff experienced psychological consequences following the experience of restraint. The qualitative interviews from this study highlighted that verbal abuse also had psychological consequences and was worthy of further investigation, and this was followed up by a current study (McLaughlin, ongoing) which is examining the impact of verbal abuse. Although post incident review is advocated in current UK guidelines (NICE 2005a) to address the aftermath of restraint, it is patchy and inconsistent in many areas with little guidance as to what form post incident review should take. Consideration must also be given to the potential for trauma related reactions to aggressive incidents however there is very little research evidence related to how this may be addressed effectively for staff and inpatients within acute care settings. UK Guidelines for Post Traumatic Stress Disorder (PTSD) (NICE 2005b) suggest that a psychological first aid model should be used following a traumatic event in the general population. This model emphasises practical psychosocial support and watchful waiting for subsequent symptoms (Bisson et al 2007; Everly et al 2006); however the psychological first aid model has not been evaluated as an approach to consider the aftermath of restraint in acute inpatient settings.

Methods

Mixed methods of gathering data were used to consider the experiences of restraint for thirty staff and thirty inpatients as part of a larger study (Bonner 2007). One element of the study which is being reported in this presentation was a model for post incident review which was used in the form of a semi structured interview. This was subsequently evaluated by participants

for usefulness in considering the aftermath of restraint. In addition, the Trauma Screening Questionnaire (Brewin et al 2002) was used to identify those participants who may warrant further screening for PTSD. Early findings related to this element of the study suggested that verbal abuse was an aspect of management of aggression which was of concern to participants. With regard to this a prospective diary study was undertaken to investigate the psychological impact of verbal aggression. The diary was semi-structured, designed to examine situational forces, perpetrator and victim characteristics, victim orientated factors & effects of the experience along with coping mechanisms marshalled to deal with this. Participants who experienced verbal aggression were also asked to complete the Impact of Events Scale (Revised Version) (Weiss & Marmar 1996). Findings will be presented separately but highlight the need to recognise the impact of non physical violence and offer appropriate support post incident.

Results

The consequences of restraint ranged from distress and anxiety, fear and terror, re-experiencing earlier traumatic events as a result of the restraint intervention, through to early symptoms of Post Traumatic Stress and subsequent development of PTSD (Bonner and McLaughlin 2007). The study also found that using a non-threatening approach to post incident review was perceived by both staff and inpatients to be very helpful (Bonner 2008), however this approach was not routinely used in practice and no structures or clear guidance was in place to ensure that post incident review was available. The findings of the study supported findings from other earlier studies (see for example, Bonner et al 2002; Needham et al 2005; Lee et al 2002; Sequeira and Halstead 2002) and highlighted the need for clearer systems of post incident review and support for both inpatients and staff.

Moving the findings of research studies into practice

The study highlighted that post incident review was an area of practice in need of much wider consideration. Staff and inpatients had welcomed the opportunity to discuss events in a non-threatening way and had valued the opportunity to review their experiences; however at the end of the study there would be no system in place to continue this opportunity. In order to address this, teaching sessions were arranged and facilitated by the researchers to inpatient staff on one site of the study to provide training related to post incident review, psychological first aid, and early indicators for trauma. On completion of training, these clinicians volunteered to be available to inpatient areas to offer opportunities for post incident review following untoward events and regular supervision was offered by the researchers.

Conclusions

Often research studies are undertaken which highlight issues for practice but for a variety of reasons the findings are not implemented to effect change. This presentation will highlight how findings can be considered and adapted to influence changes in practice. The findings of the study reported here are only the beginnings of a much wider practice development initiative. Post incident review training and supervision is now being expanded throughout the whole of this UK NHS Trust and will be evaluated as the initiative progresses.

Acknowledgements

Many thanks to all the staff and inpatient participants who took part in this study. Further thanks to Professor Suzanna Rose and Professor Nigel Wellman who have offered invaluable supervision to both of the presenters during the course of their research careers.

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An audit of the use of breakaway techniques in a large psychiatric hospital: a replication study

Workshop

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Abstract

We conducted an audit of the effectiveness of breakaway training in a specialist inpatient mental health hospital. We did this by testing staff's (N=147) ability to breakaway from potentially life threatening scenarios using the techniques taught in annual prevention and management of aggression and violence training. We found that only 14% (21/147) of participants correctly used the taught techniques to breakaway within ten seconds. However, 80% of people were able to break away from the scenarios within ten seconds, but did not correctly use the techniques taught to them. This audit raises some serious questions about breakaway training at our hospital, and adds to the ongoing national debate about the usefulness and effectiveness of such training.

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Continually Moving Away From Coercion: The Use of Positive Behavior Support to Create Safe Environments

Paper

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Keywords:

Non-coercive, safety, positive behavior support, restraint

Introduction

Relationships are the context in which human services are provided to and received by individuals served. Non-coercive relationships are key to reducing the use of restraint. To help people recover from traumatic experiences, the relational environment created by staff relationships must be beneficial to growth through the non-coercive implementation of positive behavior support.

Methodology

In a paper prepared for the Joint Commission, Dr. Peter Breggin enumerates 10 principles for the elimination of restraint. The first principle states “restraint should be defined as broadly as possible in order to facilitate the goal of reducing coercion as much as possible in health care settings.” (Breggin, 1999) In applying these ideals to practice, the relationships must “continually move away from coercion” (NAU, 2006) and empower the creation of environments in which all people can live, learn, work and play with an increased perception of safety.

The model of Invitational Education (Purkey & Novak, 1996) states that education is where the processes of teaching and learning meet, which is the result of the interaction between:

- People – all of the individuals in the environment, including leadership, direct support professionals, individuals served, families, etc.
- Places – the physical location in which services are provided and received, and the manner in which they are maintained, adapted, and modified.
- Programs – the choice of programmatic interventions, including Positive Behaviour Support, staff training programs, etc.
- Policies – the organization of resources, their maintenance and replacement (including staff hiring, promotion, retention, training, discipline and termination of employment.
- Processes – the approach to quality assurance used by the organization and the manner in which the information is disseminated to staff and service users.

In the provision of training to human service organizations, we have integrated the model of Positive Behavior Support as defined by Northern Arizona University with the models presented in Invitational Theory (Shaw, 2005) to develop a one day session we call Corporate Culture Change.

When organizations with more than 250 staff decide to use our Train-the-Trainer program, we require that the leadership staff of the organization focus on changing the five vectors identified above – People, Places, Programs, Policies, and Processes – to become more beneficial to the staff and the individuals served.

Our belief is that the individuals we serve breathe the “relational exhaust” of the staff. They are negatively affected by the ways in which we interact with each other, and the culture created by staff relationships has a negative or toxic effect on individuals served. (Chan, J.S., & Yau, M.K. 2002) When organizations focus on consciously and continuously moving away from coercion, the people relate with each other in ways that demonstrate the four core elements of Invitational Theory – Optimism, Respect, Trust, and Genuineness.

Policies are re-written using the principles of Positive Behavior Support to teach staff new behaviors, end the presence of old behaviors, or maintain the presence of current behaviors. Personnel policies are simply behavioral programs for staff. By using the principles of Positive Behavior Support consistently with all people, regardless of role, we are able to create organizational structures where “equality of worth, difference of role” (Bowen, 2006) becomes a reality instead of an ideal.

Quality Assurance is part of the “Processes” discussed in the model of Invitational Education. Practice Based Evidence (Miller et al, 2004) offers an innovative approach to understanding outcomes in a way that moves away from coercion in the process of collecting outcome based data instead of ensuring the process has been followed. Practice Based Evidence (instead of Evidence Based Practice” asks service users for their input into understanding outcomes instead of only measuring professionally approved outcome measures. The “My Voice, My Choice” program used in Ohio to rate the outcomes experienced by service users in community based residential services is an excellent example of this approach (Ohio Developmental Disabilities Council, 2004).

This new work style has resulted in the synthesis of People, Places, Policies, Programs and Processes to form environments which are “hospitable and engaging to survivors of trauma” (Fallot, 2005). Survivors are engaged in the work of recovery as resilient people. The characteristics of resilience identified in a study group (MacDonald, 2007) included “a process of interaction with the environment”. In order to recover from trauma, the environment in which services are provided to and received by those who are most wounded and therefore in need of services must be beneficial, and not toxic.

Outcomes and discussion

Creating the conditions for a beneficial presence to be created by organizations requires Positive Behaviour Support to support instead of control others and to continually move away from coercion. We are then able to understand that there is a reason behind even the most difficult of behaviours, and apply a large and growing body of knowledge about how to better understand people and make humane changes in their lives. (NAU, 2005)

Developmental Services of Nebraska provides residential services to over 250 individuals affected by developmental disabilities within the state, in community based residential settings. In the past 12 months, they have begun to move past “restraint free” environments and have developed QA tools to measure “coercion free” environments. Lutheran Services of Iowa provides residential services to over 200 youth affected by varying mental health and intellectual disabilities. They have reduced the use of restraint by 90%, with no injuries to individuals served in the past year, and two minor injuries to staff, neither requiring hospitalization.

The Calgary School Board began utilizing this training approach one year ago, and in one school reduced restraint by over 70%. One family had evaluated the school prior to training, and did not allow their child to attend the school.

After training was implemented, the family visited the school again, and responded by saying “This is the same building, but it is a different school.” The atmosphere of the school had changed from toxic to beneficial, and was evident even on a brief visit to evaluate the program.

The New Jersey Department of Health, Division of Mental Health, operates 5 psychiatric hospitals. One year after receiving training using the Corporate Culture Change model, two of the five hospitals (Hagedorn and Anne Klein Forensic Psychiatric Hospital) have seen significant reductions in the use of restraint and in injuries to individuals served and staff.

Potomac Ridge Behavioral Health in Maryland provides residential and educational services to adolescents in a pre-adjudicative program. Injuries to staff were reduced by over 85% in the first year after training with similar results in a second program.

Summary

In this brief paper there is insufficient space to review all of the elements within the approaches taken by Northern Arizona University and Invitational Education. The training approach implemented in The Mandt System® structures interactions in ways that consciously minimize coercion and has resulted in decreased injuries to individuals served and staff, as well as an increased perception of psychological and emotional safety.

Acknowledgement

The author would like to express his thanks to the thousands of people who have embraced the concept of “continuously moving away from coercion” in their provision of services and supports. Writing and presenting theoretical approaches is useful only when the practice of theory produces evidence that our work is beneficial and not toxic. The work done by Northern Arizona University in understanding the non-coercive nature of Positive Behaviour Support has been invaluable. I would also like to acknowledge Dr. William Purkey for his comments on Invitational Education, Dr. Karen Heller for her review of the material and her contributions to the Corporate Culture Change presentations, Dr. Randall Hines for his determination to eliminate the use of restraint in human service settings, and David H. Mandt, Sr. for his lifelong quest to continually move away from coercion.

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Control, avoidance or contact?

Workshop

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Abstract

Training and developing a different attitude towards managing aggression and disruptive behavior in daily practice of (child) mental health care and (special) school service. Considering the management of aggression and disruptive behavior of children/clients in (special) school and mental health care institutions, there seems to be a gap between professional intentions and the daily practice on the shop-floor.

In general, the authoritarian approach in education of the last century was left behind, due to its negative results and outcomes. Too much control in combination with too little autonomy led to fear, aggression and a non-assertive, non-responsible attitude of the child/client. The 'laissez-faire' education of the late sixties and seventies of the last century wasn't evaluated that positive either. Too much autonomy and too little control led again to fear, aggression and a non-responsible, selfish attitude of the child/client. Nowadays the authoritative approach, that integrates aspects of both former strategies, is generally evaluated as best practice in education, both in family life as in public educational services. The central themes of this third educational style are 'relation, dialogue, respecting autonomy of children/clients according to age and developmental possibilities, maintaining reasonable rules and structure (authority) in combination with intensive emotional support and concern'. Both perspectives and attributions of parent/teacher/professional and child/client are to be considered as equally important in this approach.

Although scientific research evaluated the authoritative educational style as best practice, professionals hardly seem to be able to manage aggressive and disruptive behavior in accordance to this approach once there is arousal, hostility or a (potential) threat on the shop-floor. In general, professionals seem to fall back on the two former styles of educating or treating, which leads to either strategies to control and suppress, either strategies to avoid the conflict (wanting to prevent), while escalation appears inevitable in the end, which again leads to a more suppressing strategy. In both ways the working alliance can be severely damaged, because genuine contact with the aroused child/client is lost, right at the moment this is needed the most, when considering crisis as a chance to change problems.

When professionals start to consider aggression and disruptive behavior as an interactive fact and as a message within the relationship, the conceptual dichotomy of 'perpetrator' and 'victim' can be left behind, while the child/client can again be seen and heard in it's real needs. In order to improve professional (therapeutic) practice, it is important that professionals learn to attend to this message. Training can focus on increasing awareness of one's own counter-violence or other emotional reactions during an incident and ways to cope with these human reactions in order to develop more professional distance and deal with aggression in a more professional way. The focus during an incident should be on making and maintaining contact while physical interventions could be applied in order to create safety for all and safeguard this contact. Physical techniques should therefore be pain-free in any circumstance.

Next to the importance to invest in staff-training towards an approach that is more in accordance with the best evaluated educational perspectives and intentions so far, scientific results show that a more comprehensive organizational approach is required to generate and maintain positive training results.

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Defensive Tactics, Escape, & Self-Protection Training - The Missing Element In Your Facility's Workplace Violence Plan

Workshop

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Abstract

The purpose of this workshop is to direct participant attention to the need for hands-on staff training in defensive tactics, self-defense, attack avoidance, and escape procedures - the missing elements in most workplace violence plans and policies. Topics will include:

1. The incomplete nature of most plans and policies,
2. The myths & realities about self-defense training and violent behavior,
3. The use of natural human defense triggers and mechanisms as a basis for the techniques and training,
4. The possible legal liability problems of not providing defensive tactics training, regardless of whether a Workplace Violence Plan is in place or not.

The scope of the presentation will also include examples of easy-to-learn, liability-conscious, and patient-sensitive techniques that are designed specifically for the unique needs of health care facilities, staff, and support personnel.

Methods and Expected Results

By combining lecture and instructional teaching methods, participants will come to understand what is needed when adding defense training to a workplace violence plan in a health care facility. Then, using a hands-on approach, participants will be taken through a sample training class that could be used by an actual facility to train its people. The result will be that participants, whether management, administration, or field care-givers, will realize that:

1. training for health care providers must be unique and specific to the environment in which services are provided
2. such training increases the level of professionalism and capability of the organization, rather than diminishing it
3. training and staff proficiency reduces stress in assault situations, thereby reducing the possibility of collateral damage due to panic and staff acting from a position of not knowing
4. techniques, tactics, and strategies can be easily learned and practiced with a minimal amount of training with the correct approach and initial premise.
5. training reduces such organizational problems as:
 - A. High employee turn-over
 - B. Workers compensation incidents and down-time
 - C. Liability and financial loss arising from incidents and leading to employee-victim initiated law suits and claims

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Developing learning modules to address interpersonal conflict among nurses

Paper

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Abstract

Study background and objectives

The ongoing nursing shortage has become inexorably linked with concerns regarding patient safety. Turnover and understaffing have been correlated with a decrease in the quality of patient care; ranging from lowered patient satisfaction to serious and sometimes, fatal medical errors. A growing body of literature is aimed at identifying the environment within the workplace as a contributing factor to turnover and the overall nursing shortage. More recently, the connection between interpersonal conflict and nurse stress, errors in patient care, job dissatisfaction, and quitting the job has begun to surface. This interpersonal conflict is known by many names, including bullying, horizontal or lateral violence, verbal abuse, or disrespectful behavior. Numerous professional healthcare organizations have begun to recognize the need for the development of a 'culture of safety' with regard to conflict in the work environment. Yet little attention has focused on better understanding the nature of interpersonal conflict in nursing practice environments and potential interventions aimed at their reduction. The objectives of the current study are to survey nurses regarding verbal abuse in the workplace and to design and evaluate learning modules aimed at developing skills to recognize and manage interpersonal conflict.

Methods

The project entails two phases. The first phase involves a descriptive survey design of randomly selected registered nurses residing in the state of Nevada. A modified version of the Verbal Abuse Scale (VAS) along with open ended questions and a demographic tool will be used using an electronic survey platform. Data will be analyzed using descriptive and inferential statistical analyses for the Likert-type items and content analysis for the open-ended questions. The second phase of the study will be to use the results of the survey along with a comprehensive literature review and expert consultation to design, implement, and evaluate learning modules related to nurse-to-nurse interpersonal conflict. Four, two hour modules will be conducted over eight weeks. A large teaching hospital in the community will serve as the recruitment and study site. The sample will be a randomly selected group of staff nurses from that facility. A repeated measures design will be used to assess participants using the Silencing the Self Scale for the Workplace (STSS-W).

Results

Results of the state-wide survey and the process for developing the learning modules will be shared. Information related to the development, implementation, and evaluation process for the learning modules will also be provided. It is anticipated that the knowledge gained in this project will lead to a larger, experimental design using the learning modules and ultimately, education packages relevant for all healthcare providers and students in healthcare programs.

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Education as a Change Strategy: Preparing and Keeping Healthcare Providers Safe

Paper

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Abstract

Worldwide, violence and terrorism have new, personalized meaning for everyone's core human need to feel safe. Healthcare personnel experience personal vulnerability to violence from patients, patient families, co-workers, visitors/intruders, and personal relationships. Patients are also victims of violence. When violence occurs in an interpersonal context, it is critically important for the healthcare responder to have a toolbox of de-escalation and intervention strategies to safely intervene.

Response behaviors to escalating violence are predicated on personal past history with violence, stigmatizing attitudes and beliefs, educational preparation, expectations in the healthcare environment, and the presence of positive role models. Systems Theory, Change Theory, and Adult Learning Theory explain the necessity for multiple educational strategies which target both the styles of learning and the benefit of change to the learner. Principles of restorative justice and ethics inform the content.

Educational strategies also need to be in alignment with the corporate culture, mission, vision, and values of the organization to be successful. Senior administrative support and role modeling of expected behaviors are essential for success. An experienced U.S.-based Psychiatric Clinical Nurse Specialist, baccalaureate nursing faculty member, and consultant will discuss samples of extensive multimodal, evidence-based, integrated educational strategies, which she has developed and/or implemented in a large multi-hospital acute care system.

Strategies which will be discussed include: orientation modules for all healthcare employees, international de-escalation certification programs, author-composed computer-based learning modules, training the trainer modules for skill upgrades, physician education (lectures, verbal/physical de-escalation training, self-learning packets), skills-based evaluation, student nurse modules, targeted face-to-face 30-60 minute modules (for leadership, maintenance/housekeeping, volunteers, etc.).

Development and recognition of key role models reinforces the value of the incorporation of violence prevention, reduction, and postvention strategies.

Outcomes include:

- A. increased patient and healthcare provider safety,
- B. meeting and exceeding regulatory requirements,
- C. congruency of interventional behaviors with theory and evidence-based practice.

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Exchanging workplaces, learning from each other's practice

Seminar

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Keywords:

Seclusion, peer review, exchange, learning skills, nurses, psychiatry

Introduction

Peer review is a scientific practice in which colleagues, working in the same area of research, anonymously judge each other's work (e.g. a submitted paper to a medical journal) on the basis of certain criteria. Furthermore, among Dutch medical specialists, peer review in the workplace has been an accepted method to check and improve the quality of care provided by the specialists. With this form of peer review, a delegation of doctors performs a site visit and judge (using criteria provided by their respective medical associations) various aspects of quality of care provided by their peers.

Till now, nursing staff are not familiar with a review by peers to enhance the quality of their work. In the mental health institutions in the Netherlands quality systems have been developed to make comparisons possible between mental health institutions based on their output (benchmarking). However, these systems are impersonal (e.g. number of seclusions on closed ward) and do not take in consideration care as a relationship between patient and nurse other than measuring the satisfaction of a customer of care. Judging each other is not a practice.

There are more interesting differences between nursing staff on the one hand and scientists and medical specialists on the other. One of these is the way they deal with new knowledge, i.e., the way they learn. The best working scientific communities are open learning networks with free flows of people and information, making sure that new information can be transformed into new knowledge. Nursing staff, often do not by theory, but by actual practice.

By giving nurses an opportunity to exchange workplaces amongst different organizations, we try to create an opportunity to learn in practice. With a questionnaire based report and a collective evaluation we have evaluated the effectiveness of the exchange.

Use of coercion in the Netherlands

The use of coercion in psychiatry is a radical measure. Research into the confinement of individuals in a separate cell designated for this purpose suggest that Dutch mental health care establishments separate clients on a widespread basis in comparison with other countries. At the same time, this research shows that sometimes the effects of separation or seclusion are harmful or damaging (Jansen, Hutschemakers, Lendemeijer, 2005). Therefore, forty-two organizations in the Netherlands are trying to reduce the frequency and the duration of seclusions with 10% in one year, and they try to develop a best practice guide.

Violence and aggression are common reasons for seclusion. In order to achieve a reduction of 10% the forty-two organizations developed and use different methods to deal with violence and aggression without the use of seclusion. Multiple studies have shown that the attitude of the nurse and the culture of the ward have a considerable influence on violence and aggression and the use of seclusion (Werner, Mendelson, 2001). A common way to influence the attitudes and cultures is training and education (Grol et al. 2001).

Ways of learning

The effects of training and education in critical situations have been researched, but the results are not unambiguous. Some studies find no measurable effect and others find that training and education do have effect on crisis situations (Mc Donnell, 2007). Nurses' attitude and treatment is crucial factor in crisis situations. The right attitude and skills to maintain a relationship with patients isn't achieve by theory, but must be developed during work time. Kolb (2005) investigated the different ways people learn. According to Kolb (1984) learning is the process whereby knowledge is created through the transformation of experience. In the education that is usually offered the emphasis lies on contemplation and the forming of a theory (assimilating education). When during the training attention is paid to experimenting and experience (accommodating education), then this will be regarded as a fake situation, not comparable with the nursing reality (Kwakman, 2001).

Method

Due to the aiming for reduction of coercion, we want to influence the developing of skills and attitude in a certain direction. To give the possibility to nurses to learn and develop in real situations we have established a project in which nurses are facilitated to exchange amongst different organizations. Within the other organization the nurses can experience different methods of dealing with the situations in other wards and their cultures. In ways of a on a questionnaire based report and a collective evaluation we will evaluate the effectiveness of the exchange.

Intervention

The exchange will normally take three uninterrupted workdays. Every ward will exchange one nurse. There will be exchanges between wards with a similar target group and a comparable environment. The exchangee will take part in the duty-roster. A ward may choose to supernumerary schedule the nurse. The exchangee works normal workdays during the exchange and performs participant observation. Each respondent was given an evaluation form with important topics of observation (culture, treatment, interaction, equipment, staffing, security, vision). The report made standardization of the responses on the experiences of exchange possible. Also it helped the participating nurses to focus on the subject at hand; reducing seclusion, coercion and making the workplace a safer place to work.

The content of the reports was analyzed by mapping the descriptions. Mapping helped us to describe good practice concerning the reduction of seclusion and coercion and contributes to the conceptualization stage of Kolb's learning phases. The gathered information was also used as means of reflection on the receiving ward to measure their own state of the art and helped to improve clinical

Study sites:

Five organizations for mental health in the Netherlands, 15 wards for acute psychiatry, 15 nurses.

Study design:

A prospective intervention study, with questionnaire based reports and a collective evaluation.

Results

We find that most clinical wards develop their service through evidence and experience, in a very isolated manner. By lack of comparison between wards changing caring practice turns out to be a very slow and difficult process. Through exchange we think this process can be speed up. We also think that describing your own practice will help to consolidate ward policies, and can help in the fine tuning of further development. During the group evaluation the exchangees discuss the experience and findings and this contributes to the conceptualization of the learning experience.

Conclusion/discussion

The exchange as a learning activity adds to more traditional/common methods of learning: education and training. The exchangees were inspired by the exchange. Their experiences proved to be useful additions back home (on their own workplace), and their rapports were very helpful to the ward they exchanged to. The new experiences will now be used to improve the current situations.

We recommend exchanging amongst different organizations as a useful method to influence ward culture, and the learning skills of individual nurses. These skills are important to constantly enhance the quality of caring work.

Acknowledgements

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Horizontal Violence - Strategies for educating nurses

Workshop

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Abstract

Therapeutic communication is well established as a very important component in nursing curricula, especially in psychiatric nursing courses. Traditionally educators introduce students to the topic of communication within the context of the nurse-client relationship. However, interpersonal conflict among nurses/nursing staff, called horizontal violence, is an area where effective communication strategies could help students address this conflict professionally in school and practice.

In all types of settings nurses face challenges to communicate effectively. The therapeutic use of self is constantly called for in facing these challenges whether they be with patients, families, colleagues, or supervisors. The literature emphasizes that horizontal violence has a profound impact on the well being and retention of nurses in practice. The effects include: powerlessness, rigidity, poor morale, and dissatisfaction.

This interactive workshop will address strategies for teaching the skills needed to refrain from or deal with horizontal violence. Strategies utilized by the author, those examined in the literature and best practices developed by the participants will be shared.

Nurse educators should include effective professional communication strategies in the curriculum, to enable new nurses to develop the strength and skills necessary to influence the practice setting, helping to make it less toxic.

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Introducing the Bergen training model in psychiatric in-patient care in Stockholm

Poster

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Abstract

The Bergen model is a training program for the prevention and management of psychiatric in-patient violence. The model was developed at the forensic psychiatric unit in Bergen. It is based on current scientific literature, the use of non-pain inflicting techniques and integrated into the clinical organization by educating regular clinical workers as trainers.

In 2004, Eviprg-members Geir Olsen (Norway) and Anna Björkdahl (Sweden) decided to use the Bergen model in an extensive development project in Stockholm. The aim of the project was to train all psychiatric in-patient staff members working in Stockholm county council (about 70 wards and 2500 staff members). After an initial pilot project, the full project was formally started in 2006 and is now in peak progress.

The trainers are selected from a specification of requirements. Theoretical and practical physical knowledge is taught to the trainers who have their regular jobs on the ward floor in a 3x3 day course. The model includes scheduled refreshment hours. This paper gives an introduction to the content and principles of pedagogic applied in the program for training the trainers in Stockholm.

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Keeping Safe: Applications for Safety in Public Health and Community-based Settings

Paper

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Keywords:

Safety, public health, field worker, education, administration

This paper applies the process of keeping safe, which was developed from a qualitative study of 19 public health nurses, to community-based field worker practice (Nielsen-Menicucci, 2004). The model of keeping safe was developed by exploring the perceptions of safety among field public health nurses with the objective of determining a substantive theory (see figure 1).

Model Overview

The process of keeping safe suggests that public health workers can take a proactive approach to their safety during home visits. There are three stages within the process of keeping safe. Risk awareness was the first stage. The public health nurses achieved awareness of risk through vigilance. Assessment and awareness were essential components of this stage. This model supports vigilance as a learned response. Theoretical work on automaticity in everyday life purports that, while many human responses to stimuli evolve from not-conscious processes, as an individual engages in a skill, less and less conscious attention is necessary to master it (Baugh, 1997; Baugh & Chartrand, 2000).

The second stage in the process of keeping safe was risk estimation. In this stage, the nurses estimated their level of risk by determining their vulnerability and ultimately deciding if the level of risk was manageable or too risky to pursue the visit. Determination of the level of vulnerability was dependent on the several factors. The second element of risk estimation was safety decision-making. Once the nurses had determined their level of vulnerability, they needed to make decisions regarding their safety and the action required. If the nurses believed that their risk was manageable, they would continue the visit. Continuing the visit was predicated on the probable success of risk limitation actions taken by the nurses. Conversely, if the risk was determined to be too great or considered unmanageable by the public health nurses, they would terminate the visit.

The final stage in the process of keeping safe was risk limitation. In this stage the nurses advanced from determination of risk and safety decision-making to implementation of a selected course of action. If the identified risk in the situation was deemed manageable, the nurses continued their visits. Conversely, when the situation was deemed uncertain or too hazardous the nurses determined the appropriate way to extricate themselves safely from the visits.

Model Application

This model provides a framework for practice for seasoned and novice public health workers and is applicable for the multiple venues of public health practice. Safety is a concern for all field workers practicing in the community and does not change in importance at different levels of responsibility or experience. With a clear explanation of the process of keeping safe, there may be additional individuals who enter into the practice of public health. In an atmosphere of uncertainty

or fear regarding safety, field workers considering employment options might be hesitant to enter the field. Public health workers need to be made aware and reminded of the importance of keeping safe. With open communication and safety programs developed by administration, each field worker will have the support and information they need to maintain their safety (Leiba, 1987).

Assessment, planning, and intervention programs that address the issues of safety for health care workers in community settings have been described (Najera & Heavey, 1997). Areas that are purported to be the most beneficial for employees include programs that enhance communication between administration and field workers, self and organizational assessment, appropriate supervision and support of employees, and education and training on safety and workplace violence prevention (Fazzone et al., 2000; George, 1996; Kendra & George, 2001; Leiba, 1987; Mulligan, 1993; Nadwairski, 1992; Rogers & Maurizio, 1992; Snow & Kleinman, 1987). Currently, in the U.S. the Occupational Safety and Health Administration (OSHA) requires employers and agencies to maintain a record of all injuries and threats against employees; however, there are no legal requirements for agencies to develop a plan for field workers working in the community (OSHA, 2003). Any prevention program developed would be voluntary on the part of an employer.

This model highlights the need for appropriate supervisory support. Field workers have reported their concern about the lack of support by administrators at higher levels in their organizations. Most field workers however, believed that immediate supervisors were concerned about their safety and maintained appropriate safety nets for their protection. In a study by Hood and Smith (1994), field workers and support personnel who had leaders that expressed personal concern and support for their employees had higher job satisfaction and were more likely to state that they would be continuing in their present job situation. Increased attention to issues of safety by administrators at all levels will be necessary for agencies experiencing high turnover or inadequate recruitment rates due to these concerns. Public health workers should be their own advocates regarding safety in the field. Issues and problems should be openly discussed and effective safety plans should be joint efforts between the field workers and supervisors. Ultimately keeping safe is the responsibility of the field public health worker.

Historically, home visit safety for students has been an area of concern and research (Castles & Keith, 1971; Hayes, Carter, Carroll, & Morin, 1996; Whitley, Jacobson, & Gawryls, 1996). Public health education can derive much from the findings of this model. The process of keeping safe could be integrated into any curriculums to teach students how to maintain risk awareness and the elements of vigilance when working in the community.

Parallels can be drawn between Benner's (1984) model of skill acquisition and the potential benefit this model may have in education. This model might be useful for all stages from novice to expert, but are most likely to be used in educational programs for the novice and advanced beginner.

At the novice stage, beginners with no experience could be educated on the basic process of keeping safe. From Benner's perspective students could be taught about field safety with "objective attributes" and be given "context-free rules" to guide their actions in situations that may put them at risk (1984, pp. 20-21). Objective attributes in this model could be viewed as the elements of vigilance and risk estimation. Attributes of vigilance, such as identification of idle young men, dogs, suspicious behavior, drug abuse, angry family members, and communicable diseases would be entry level skills. Context-free rules would include education regarding the best time of day to visit families, safely maintaining visibility, avoiding mistaken identity, and potential distractions. Because of the concrete nature of a novice's decision-making, any sign of risk or threat would be countered with a risk avoidance strategy. Educators should encourage students at this stage to leave a setting in which they have reason to be fearful. Field workers

transferring into public health could also be considered at the novice stage and might benefit from similar education during their orientation. Many authors have described the need for specific and direct teaching strategies for novice field workers on the topic of field safety (Fitzpatrick, 1971; Lewis & Hallburg, 1980).

Moreover, advanced beginners or students with some level of experience could add to their level of skill acquisition by being taught guidelines to follow during home visiting to maintain safety and increase understanding of the context of each of the attributes of vigilance. These guidelines would incorporate safety decision-making and utilize risk limitation strategies during field visits. As a learning exercise, experiences and stories told by the more seasoned professionals could be used as exemplars for education of both novices and advanced beginners.

In conclusion, the model of the keeping safe has implications for all areas of service in community-based settings. Workers in public health can draw inferences for their own safety and educators and administrators can develop educational programs to promote safety in the field.

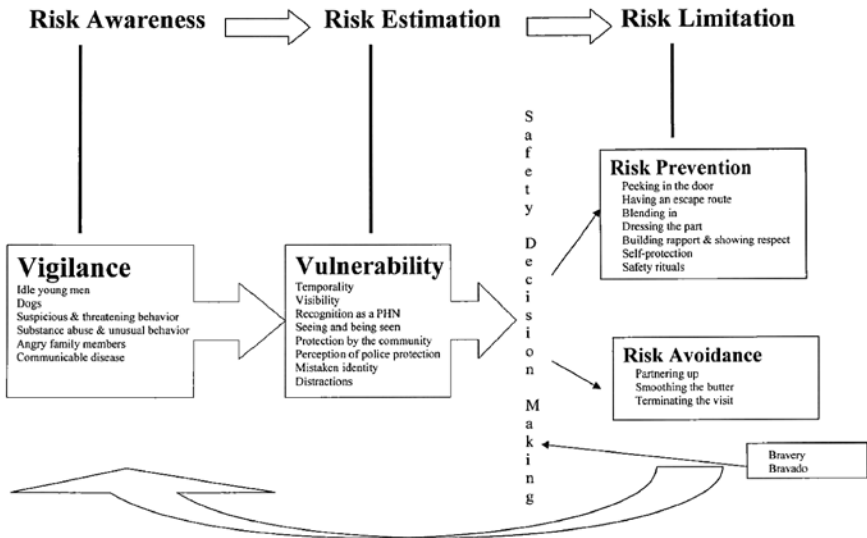


Figure 1: The process of keeping safe

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Swan Kalamunda Aggression Management Program (SKAMP): how well are staff satisfied with the program?

Poster and Paper

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Abstract

Background

In June 2004 the Health Department of Western Australia (WA) implemented several policies to tackle the increasing violence being experienced by hospital workers in WA public hospitals. In 2005 Swan Kalamunda Health Service (SKHS), keeping in line with the newly implemented policies, developed and commenced mandatory aggression management training for all staff working within the Health Service. SKHS is situated in the metropolitan area of Western Australia in the Swan Valley which has two main campuses located 15 kilometres apart.

Program

The SKHS one day mandatory training contains theoretical and practical techniques to enable staff to recognise triggers anticipate and intervene early to de-escalate a situation. A total of 544 staff have participated in this program since its inception until May 2008, equalling approximately 67% of the staff at SKHS.

Results

90% of staff attending agreed that the content of the program was useful and extremely relevant to their work. Overall the evaluations are extremely positive and supportive of the program and believe that the practical techniques are invaluable. This is also demonstrated in the number of reported incidents of violence at SKHS. Prior to implementation of SKAMP (Swan Kalamunda Aggression Management Program) there were 125 reported incidents of aggression towards staff. Two years after the implementation of SKAMP the number of reported incidents was down to 50 incidents reported between 1 July 2006 to 30 June 2007.

Conclusion

Staff are satisfied with the mandatory aggression management training provided at SKHS. The outcome of this Aggression Management education and training has better equipped staff to anticipate, prevent and manage situations as they arise thus promoting a safer working environment.

Recommendations

A follow up study is undertaken on the retention of knowledge gained through SKAMP and the use of the practical techniques taught.

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Motor Skills Learning in Breakaway Training Using the Evidence Base of Sports Science

Paper

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Abstract

The paper reviews the applicability of the learning theories associated with sport science to the teaching of breakaway skills to nurses. An over-view is provided of the development and role of breakaway training in the National Health Service (NHS) and the current provision of training in the management and prevention of violence. An audit of the effectiveness of the current training is summarised and there is a description of the deficiencies it identified in the retention of breakaway skills. The recognition of potential problems in the ability of nurses to retain the motor skills involved in breakaway techniques leads to an attempt to integrate the theoretical basis of sports science to a training course for nurses in clinical practice. Potential areas for improvement to the delivery of this training are proposed through the application of a sports science coaching model to this element of nurses training. The consequences of failing to evaluate training and to address the weaknesses identified using current educational research are reviewed. Limitations of using theoretical constructs in evaluating training in the absence of evidence supporting their utility in this area are discussed.

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Nurses and Workplace Violence: Towards effective intervention

Paper

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Health care workers are recognized as working in one of the most dangerous professional sectors. Nurses are frequently the target of a range of unacceptable forms of violence including verbal harassment, physical and sexual assault and harassment, bullying, and threat. Both North American and European studies have consistently demonstrated that a very high proportion of nurses have experienced assault in the context of work and an astonishing 86% report that they were verbally abused at work in the one year period preceding the study (Lanza & Kayne, 1995; Poster, 1996; Uzun, 2003). In addition, violence against nurses clearly occurs in all settings (Fernandes, Bouthilette, Raboud & Bullock, 1999; Gates, Fitzwater & Meyer, 1999; Poster). A large Canadian study has recently demonstrated that high rates of violence continue to be an issue for nurses (Duncan, Estabrooks. & Reimer, 2000; Duncan et al., 2001). As well, it is becoming more clear that verbal abuse, threat and violence are significant factors affecting nursing morale, recruitment and retention (Callaghan, 2003; Jackson, Clare & Mannix, 2002).

In this paper I will present a summary of a research study designed to identify, implement and evaluate an intervention intended to address violence against nurses in a variety of health care workplaces. The present study derived from a larger study designed to understand nurses' work with abused women. The original study was entitled "Nurses' social construction of self: implications for work with abused women" (Henderson, 2001a, 2001b). It was a qualitative study conducted in two countries (UK and Canada) designed to answer the research question 'How do nurses make sense of the interface between themselves, their working environments and their nursing actions with abused women? In it, four groups of nurses were interviewed in each country, using a combination of focus groups and with individual interviews. Thus all the participants were interviewed twice – in both a focus group and an individual context – but a few volunteered to be individually interviewed when hearing about the study via word of mouth; several also provided written feedback on a preliminary synopsis of main findings.

In the course of the first focus group, and in the context of discussing the role of nurses in caring for abused women the nurses identified the provision of a safe environment as key. When asked to describe how they went about this task the nurses began a discussion of how they kept themselves safe at work. For most of the remainder of the session, their safety, rather than that of the abused women, became the focus of the discussion and it became abundantly clear that (a) nurses frequently experience violence at work, and that, (b) they feel unsupported but administration in any attempts to address the situation. These findings became part of the remainder of the interviews and were confirmed overwhelmingly. In addition, it became clear that many of the nurses had also experienced, either personally or vicariously, through relatives or friends, of personal violence. Some had been in abusive relationships, some had been child witnesses to the abuse of their mothers and two had been sexually assaulted. Of the 49 participants only 18 had no personal experiences. One of the main conclusions from the original study was that it is obviously unreasonable - some, including me, would claim unethical - to hold nurses responsible for providing care to a physically threatened group of patients if we are not prepared to offer these nurses the support they need to stay safe while engaged in this task I hypothesized that

experiences of both violence and/or abuse directed at them, coupled with perceptions of lack of support from management regarding their concerns, would have a significant influence on, not only their care of abused women and their morale, but also of their abilities to handle violence directed at them in the context of their work. Thus the present study was conceptualized.

The study presented here is entitled “Nurses and Workplace Violence: Towards effective intervention.” The research objectives were

1. To understand the impact of the workplace environmental culture, including current measures to address workplace violence, on nurses’ perceptions of their ability to be safe and healthy at work.
2. To understand the impact of workplace violence on nurses’ ability to function effectively in their jobs.
3. To understand the impact of lifetime experiences of abuse and violence on the way nurses respond to and handle workplace violence.
4. To pilot test an intervention addressing workplace violence, developed from nurses’ accounts of their experiences

The study is designed in four phases.

Phase I

In phase I incident reports for the last four years (the time since the latest anti-violence policy and procedure document had been accepted and implemented). These reports were analyzed to reveal the type of incident that got reported and, more importantly, the types of incidents that were not reported. For example, the literature is clear regarding a high level of horizontal violence among health care workers yet, as demonstrated in a recent study fewer than half the incidents were reported (McKenna, Smith, Poole & Coverdale, 2003). Indeed this proved to be the case here in that almost all reports of violence were of patient or visitor aggression. Incidentally the method of categorizing the reports as a mass made it difficult to tease out intentional violence from any other incident report.

Phase II

Focus groups and individual open-ended qualitative interviews were conducted in a number of different clinical settings, both community and hospital based, in order to gain a sense of the kinds of experiences the nurses were having, what they thought was working in addressing such incidents, what was no working and what they would like to see implemented to address workplace violence.

Data collection in this study proved to be a challenge since, something that we had not anticipated, nurses were reluctant to talk to us in focus groups. Several factors may have been at work here. First, we held information sessions to introduce the study and nurses seemed so engaged during these sessions that they talked about their issues then. By the time it came to sign up for a focus group they seemed to have said everything they had to say. There also seemed to be some reluctance to talk about areas of vulnerability in front of colleagues. This was an anticipated problem that we had hoped to address by making plain we only intended to discuss generic issues of setting, patient population, management response etc in the group and that there would be an opportunity to talk about more individual issues in the personal interview but this did not seem to be enough. The result was that only two focus group interviews were conducted.

Findings of the individual interviews illuminated nurse experiences and demonstrated their concerns. While many interesting findings emerged, two in particular form the basis of the interventions that are reported on here. First, nurses felt unprepared to handle rapidly

escalating aggression from patients, visitors or other health care personnel. They wanted to be better prepared to de-escalate the situation more effectively and to keep themselves safe when de-escalation failed. Second they were deeply resentful of the perceived lack of support for them from administration.

Phase III

This phase is currently underway and involves the delivery of an intervention based on the concerns identified in Phase two. Several of the units involved in the interviews are involved. On those units the nurses are being offered a programme containing information on anti-violence/de-escalation techniques as well as techniques to help them to stay safe if de-escalation didn't work. This phase is underway and the specifics will be explicated at the conference. At this point this piece is evolving as it is offered so it is refined and honed.

The intervention is designed in distinct pieces. The first involves the presentation of findings to the attending nurses. In this way, nurses are able to see that the rest of the intervention sessions derive specifically from the content of their interviews. The second part provides them with specific information about de-escalation and planning to protect their own safety. As stated above, the specifics of this portion will form the basis for most of the conference presentation. An over-arching theme running throughout the first two phases of the study has been the feelings of disconnect between front-line staff and management in that staff currently feel unsupported and blamed when incidents occur. This reality is also a part of the overall intervention. Therefore, in the final part of this intervention, the nurses are led through a discussion with administration about responses to the incident reports and ways in which the communication can be enhanced between the two groups.

Phase IV

The focus of this phase will be evaluation and should be close to complete by the time the conference occurs. Two units with reported high levels of violence will be selected and will be followed to see how the nurses are feeling about the effectiveness of the intervention, responses to subsequent incidents and also how they feel about their own ability to be effective in such circumstances.

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Nursing students' experiences in managing patient aggression

Paper

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Keywords:

Aggression, violence, nursing student, nursing curriculum

Introduction

Aggression is present in human life like love, sorrow and joy. Although nursing students are prepared to deal with emotions of patients they often seem ill prepared to deal with aggression. Research undertaken by the British Home Office and by the North Eastern Health Board in Ireland has shown that the nursing profession has one of the highest risks to be assaulted [1-4]. Within this professional guild nursing students are very often the target of patients' aggressive behavior [5-8]. Given these findings it is safe to assume that the capacity to manage patient aggression should be an essential competence for all nurses. However, there is little known about the specific situation of nursing students. It is feasible to assume that nursing students are in an especially delicate situation, as they often are very young and inexperienced in dealing with aggression. To date educational programmes concerning aggression or violence are offered only - if at all - to post-graduate staff [5, 9]. This finding also applies to the situation in Germany [10]. Thus, the intention of this study was to gain insight into how nursing students experience patient aggression in order to ameliorate nursing education. To this end the following research question was addressed: What do nursing students perceive as problems, resources, necessities, needs, and wishes concerning the handling patient aggression?

Materials and method

After being granted permission by the Ethical Commission of the Charité Universitätsmedizin, Berlin twelve nursing students were recruited from an urban school of nursing in Stuttgart, Germany and participated in semi-structured interviews. The interviews were conducted on the school premises in the students' mother-tongue German. The students received a stimulus making clear that aggression in nursing settings is a common problem [6]. Then questions were posed to all interviewees in a process oriented sequence. The students were invited to report situations in which they had successfully and unsuccessfully handled situations involving aggressive patients. They were also encouraged to express their opinions on what should be undertaken to improve working placement conditions and students' education regarding patient aggression.

After transcription of the interviews the data were analysed employing qualitative content analysis as described by Mayring [11].

Results

The narrative design of the interviews and the questions ranging from problems to resources enabled the identification of issues which may have gone undetected when just concentrating on necessities alone. The experiences of twelve interviewed nursing students were pooled from 47

non-psychiatric work-placement settings. Three students had also completed practical training in psychiatric settings. All students had absolutely no doubt about the relevance of the topic for general nursing education.

Member checks by the individual participants were conducted after conclusion of data interpretation with each participant receiving the interpretation personally and requested to check whether the interpretation was congruent with their own individual representations.

The analysis demonstrated that the interviewees experience aggression as a multi-faceted phenomenon and revealed that the issues students were addressing refer to workplace related competence. To distinguish the issues we drew on the following concepts which have already been investigated: Antecedents and control [12, 13], issues of interpretation [14-16], handling [17], coping [12, 18, 19] and overall organizational issues [12, 17].

Antecedents and control of aggression

Sometimes staff's thoughtlessness may trigger aggression e.g. when nursing interventions are conducted routinely in a certain way and at a certain time. Nursing routine is applied because it is judged to be beneficial to the patient or because it is stipulated by persons in authority irrespective of the patient's opinion: "We do this because it is either ordered or it is simply necessary".

The interviewed nursing students accentuated their need of knowledge about reasons of emerging aggression. They would prefer to remove antecedents or triggers for tense situations rather than having to establish a calming influence or – if aggression emerged – to deescalate. One student reported: "The fact of the matter is: the patient would not have become aggressive if I had not hindered him leaving the ward. It is important to know how the patient perceives the situation. Then we can use such knowledge for further care." Other students reported remarks such as: "Purely the gesture of sitting down and saying 'I have time. I'm listening, what is on your mind' is helping."

Interpretation of what is happening

The participants expressed the necessity to be able to perceive aggression in a non-personalized way. The lack of knowledge about relationships between aggression and illness, organizational issues and other triggers may entice students to view aggression as a product of personal interaction and may lead to feelings of excessive demand and helplessness. Sometimes students were unable to react in any way because they had absolutely no idea how to interpret the occurrence: "What shocks you as a new student is when the patient freaks out and you have absolutely no clue what body language to use, how to speak, or how to respond. And then you just stand there and say nothing, you get emotionally involved and you do precisely what you shouldn't do." Another participant reported: "This is how it always goes for me: if someone shouts at me or sneers at me, I stand there like a drenched poodle and I usually don't know what to say."

Dealing with the aggressive patient

The nursing students express the wish to be more self-confident in difficult situations, to be able to handle the situation more calmly, and to empathize and esteem patients. Therefore they demand knowledge about types and reasons of aggression, objectives, professional and legal guidelines for handling verbal and physical aggression and desire to be trained in aggression management. One participant put it so: "If I could comprehend in part why he reacted the way he did then I can emotionally distance myself from the incident and be able to look at the situation from a professional standpoint." A further participant reported: "I would need this knowledge to be able to have enough self-confidence to defend myself if something happened. Be it verbally or physically." The fact that counter-aggression or feelings of humiliation may occur after a verbal

attack is perceived as problematical by the participants. One student reported her thoughts after misogynous abuse: "That's the last straw. It's me who is getting aggressive now."

Coping with perceived stress

"Sometimes verbal attacks hurt more than physical ones. They affect your self-esteem and if you cannot release these emotions you will break down. However, never in my life could I have approached someone and said: 'I feel bad now – what can I do?' You withdraw and think you can cope with it." This citation demonstrates several points on dealing with aggression induced stress. The participants reported repeatedly that aggressive occurrences induce feelings of annoyance, sadness, frustration and guilty conscience with prolonged after-effects. Nursing students may find themselves in an ambiguous situation in coping with stress: On the one hand they may be embarrassed to talk about such experiences and on the other hand they sometimes overestimate their capability to cope without help. Some students suggest to stop denying of the presence of aggression on the wards and recommended to learn how to demand social support and help to cope successfully: "If you have a protective setting around you - the teaching staff or the class, the team, your family, your friends - then you can cope with aggression in a completely different way."

Organizational issues

The students also pointed out that it is not justified to focus exclusively on personal issues. There are also organizational issues to be considered which facilitate or obstruct students' development of competences. Substantially more lessons on organizational issues should be provided at school. The teachers and staff members should be easy to talk to and show an interest in giving assistance by helping to clarify aggressive occurrences. One student reported the following disappointing example of indifference after having endured a physical attack: "No one cared about my haematomas". Of course students also gave examples of successful support. Other organizational problems were the fact that even experienced nursing staff was untrained in handling aggression, the tendency to respond imprudently, and the lack of a clear safety policy. One student summarized: „The fully-educated staff is completely overtaxed with this problem and in most cases the students are given the job to nurse the aggressive patients." Additionally, nursing students frequently do not receive sufficient information about patients with a prior history of aggressive behavior before nursing encounters.

Discussion

This study set out to discover German student nurses' experiences in handling patient aggression. The results of this study reveal reasons to include preparation for managing patient aggression in undergraduate nurse education and correspond with the results of other studies. For example as a result of a review of literature already in 1996 Whitley et al. [20] emphasized the obligation of nurse educators to prepare students. Several researchers reached similar conclusions [6, 10, 21, 22]. But internationally there seems to be an neglect of the students' situation regarding patient aggression: A literature review in CINAHL, Medline and PsycInfo on student nurses in combination with aggression or violence revealed only 17 research articles and only 13 articles discussed nursing students' issues [23]. Twelve of these articles revealed that nursing students have problems with patient aggression in non-psychiatric settings. Only two studies [24, 25] addressed open questions to students in order to explore their feelings and opinions.

The interviewees in this study highlighted the need for being trained not only for major aggressive occurrences but also for handling tense situations and de-escalation. Therefore, nursing education should also consider milder kinds of patient aggression such as refusing nursing interventions

or the violation of ward rules. Furthermore the participants highlighted their dependency on environmental conditions for support and protection. The best scholarly educational programmes in dealing with patient aggression are likely to fail if there is insufficient support provided by training institution. One student remarked on the situation in a training institution: "Many nurses do not know what aggression is and are completely overtaxed and ... do not know how to handle the situation." Thus, educational programmes should be accompanied with the development of safe culture encompassing organizational strategies such as training programmes for staff, modifications of working environment, safety-guidelines [12, 26-28], which emphasize that organizational strategies are required because an individual's competence in dealing with patient aggression is insufficient. Similar suggestions have also been made for the situation in Germany [10] and has been confirmed by a Health and Safety Executive research report [29] which added the recommendation for benchmarking of good practice.

Some limitations to this study must be considered. As the main investigator is a member of the staff of the nursing school under scrutiny we cannot exclude the possibility that students were not totally frank on reporting their experiences. However, the results demonstrate that the students perceived the interviews as an opportunity to express their experiences. Furthermore, the fact the interviewees accrue from a single school of nursing renders generalization problematical. However, as the twelve students reported experiences from 50 different working placements, we do feel that the results are typical of the local nursing settings.

Conclusion

We conclude that nursing students need more competences in handling patient aggression. They should be able to detect and remove causes of aggression, to interpret aggressive situations correctly, to de-escalate and to cope with their own perceived stress. This study suggests that there are good reasons to give nursing students the opportunity to acquire knowledge about aggression, awareness of contributing problems, self-confidence in dealing with aggressive patients, communicative skills such as assertiveness and empathy, and the ability to cope in an appropriate manner. Additionally, the safety policy of hospital where students' placements occur should be examined for appropriateness to support nursing students, other staff members, and - last but not least - the patients themselves.

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Prevention and Early Intervention of Violence at work

Paper

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Keywords:

Staff awareness, crisis intervention, safety education

Healthcare systems were designed to help people in need achieve their optimum level of health. In the past decades there have been significant increases in the number and variety of violent acts in all areas of life including hospitals, clinics, and schools. The numbers of violence in hospitals are staggering, especially when it is suggested that the violence is under-reported due to various reasons. According to the United States Bureau of Justice Statistics Report 1993 to 1999 there was an average of 1.7 million victims of violent crime while working; medical workers are at significant risk: From 1992 to 1996 non-fatal assaults on nurses, others in health care and mental health settings were similar in frequency to those in law enforcement, well over 200,000 annually. Annual average assaults in health care settings included 69,500 nurses, 24,000 technicians, 56,000 other health care workers and 10,000 physicians. In mental health settings 50,300 assaults were reported on professionals, 43,500 on other workers and 8,700 on workers in custodial positions. In 2000, 48 percent of all nonfatal injuries from occupational assaults and violent acts occurred in the health care and social services sectors, according to the Bureau of Labor Statistics. Most incidents occurred in hospitals, nursing and personal care facilities and residential care services. Data indicates that healthcare workers are at high risk for experiencing violence in the workplace. In 1999, the Bureau of Labor Statistics identified a rate of 8.3 assaults per 10,000 workers in the healthcare industry. This rate is much higher than the rate of non-fatal assaults for all private sector industries, at two per 10,000 workers. According to the Occupational Health and Safety Report compiled by Susan Wilburn, "nurses suffer the largest number and the highest rate of non-fatal workplace violence. Healthcare patients are the source of more than half of nonfatal workplace assaults, with current and former co-workers accounting for 8%. Mental health and emergency departments are typically the most noted areas for violence; however, all departments in healthcare settings are at risk". As health care providers, staff in these settings entered their professions to help people. In this day and time there is an increase risk of personal safety while trying to do one's job. There are several factors involved, including the specific area of work and types of clients as well as their families and staff's personal issues (such as those dealing with divorce or custody issues) that carry over into their work environment. An example of an area that has been identified as a high risk for staff safety is the Emergency Department due to a number of factors including the unpredictability of numbers of people coming into the area, the physical and emotional needs of patients as well as their families, and the accessibility of the area to the public. It is important to realize that as violence has become more common in all areas of the world, there is not really a 'safe haven' anywhere today. Webster's Dictionary defines violence as: exertion of physical force so as to injure or abuse; an instance of violent treatment or procedure; vehement feeling or expression. The National Institute for Occupational Safety and Health defines workplace violence as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty." Therefore any physical assault, threatening behavior or verbal abuse occurring in the work setting is violence. A workplace may be any location, either permanent or temporary, where an employee performs any work-related duty. In health care settings, workplace violence

can be perpetrated by patients, families, friends, visitors, co-workers, physicians, supervisors and managers. Violence may be verbal and/or physical. Examples of verbal violence are abusive language, bullying, ethnic slurs, intimidation, ridicule, swearing, yelling, threats of injury and violence. Examples of physical violence include biting, chasing, grabbing, hair pulling, spitting, pinching, kicking, punching, throwing, and any unwanted physical contact. The types of clients, families, location of work, and overall health care system contribute to the risks and safety of staff and clients.

A key issue in prevention and early intervention is the awareness and acceptance that violence could occur in the work environment. In the United States health care workers experience almost 40% of the non-fatal attacks on employees. 80% of nurses are assaulted at least once in their careers (Berg et al, 2001). There is often an attitude of denial regarding the risk of violence by clients, their families, and even other staff. In health care settings, workplace violence can be perpetrated by patients, families, friends, visitors, co-workers, physicians, supervisors and managers. The types of clients, families, location of work, and overall health care system contribute to the risks and safety of staff and clients. Depending on the specific area of work, it is possible to develop appropriate interventions to minimize as well as to respond to violent actions. There are general principles that can be taught so that staff may increase their awareness of early manifestations of potential violent behaviors, thus providing intervention at an early stage which breaks the cycle of escalation to more verbal and physical violence. This is often a difficult step for one to take because so many personal ideas, preconceptions, and cultural experiences influence personal belief systems. A basic educational intervention is the identification of anxiety with the follow-up of reducing anxiety in the individual so that a group does not have increased anxiety with the additional development of aggression. A key is to recognize that a person is beginning to escalate and then provide interventions early which prevents the cycle from continuing into more aggression and harm. One of the first signs is often restlessness, a non-verbal cue that may be overlooked due to the nurse's focus on immediate needs of patients. Some people may have a short time period of escalation and others have a longer time frame. It is possible to prevent violence by early detection and appropriate interventions.

Sometimes the acknowledgement of the individual's feelings of frustration and concern can provide enough attention that the behavior does not escalate to aggression. Being honest and respectful to the person provides a way of developing trust. Avoid becoming defensive about the situation but do provide factual information. Crisis intervention techniques include the focus on the present situation, remaining calm, avoid emotional responses or defensive postures but do show compassion and empathy, maintain calm and quiet tone of voice and manners, keeping interactions and conversations continuing which will help develop a rapport and relationship, set the expectation that the other person (whether patient, family member, or coworker) will do the right thing, and allow enough space to provide alternatives or quickly exit the area. Always be aware of the environment and maintaining personal safety. Everyone should be familiar with their own work area and the people that belong there so that any strangers or suspicious people can be identified, their motives examined and any potentially violent situations resolved quickly. It is vital to continue to encourage people to maintain safety for both patients and staff by knowing who is where they are supposed to be. Once common principles are taught and learned, it is possible to develop appropriate responses for specific locations of work environments, the types of clients most often contacted, and the staff available in order to deal with situations. While it is impossible to anticipate all potential situations it is highly probable to develop interventions that will minimize the harm to people by early identification and appropriate intervention. Education is more than providing information to people. It is on-going, often times requiring emotional support for interventions that are taught in classroom settings so that the staff is comfortable in implementing the techniques presented. Encouraging staff to share their concerns about situations that have happened in the past can be a tool to provide possible alternative interventions that could

be effective in similar situations in the future. Role playing and case studies can be effective tools for learning. Education is both formal and informal, especially when the situation is safety of self and others.

In summary, it is important to recognize that everyone has personal feelings about violent behaviors that are based on culture, experience, beliefs, and knowledge. Education is on-going. Often it is necessary to deal with the emotional aspects of beliefs so that awareness of the need for education can be developed with individual staff members. Dealing with violence and the potential for violence requires internal changes in attitudes, self-awareness, knowledge, and education for the tools to have appropriate techniques of interventions.

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Realistic Evaluation as a means of evaluating aggression management programmes

Paper

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Abstract

Many aggression management programmes evaluate to the level of trainees reactions to the course, and though such evaluation can be useful in improving training programmes, it does not demonstrate how learning has been integrated into practice or the benefits to the employing organisation. There is need to develop a more systematic approach to the evaluation of aggression management programmes that go beyond 'customer satisfaction' to allow organisations and their staff to make informed decisions as to the effectiveness of individual training packages.

An important step forward in terms of conducting training evaluation is not only to gather reliable and valid evidence but to enable such evidence to be translated into useable guidance regarding the content design and delivery of aggression management training.

The author has adopted realistic evaluation (Pawson and Tilley 1997) as an approach to his research into the effectiveness of aggression management programmes. This approach, which he will discuss, sees outcomes as arising from mechanisms acting in contexts. The question then becomes not whether an intervention worked, rather what worked, for whom, in what circumstances. This innovative approach to evaluation has its basis in the social sciences and recognises that violence and aggression toward clinical staff is enacted within a social context requiring a local response.

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Sexual Harassment in the Health Sector: Empowering Women Health Workers & Creating gender just Workplaces

Workshop

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Introduction

In 1997, the Supreme Court of India passed a landmark judgment commonly referred to as the Vishaka judgment to be followed by all establishments in dealing with prevention and redress of sexual harassment. The judgment defines sexual harassment of women at workplaces for the first time and recognizes it as a violation of human rights. The Supreme Court's definition of sexual harassment includes "such unwelcome sexually determined behavior (whether directly or by implication) as physical contact and advances; a demand or request for sexual favors; sexually colored remarks; showing pornography; any other unwelcome physical, verbal or non verbal conduct of sexual nature" (6).

Background

The guidelines shift the onus for ensuring employees' safety and gender equality to the employer and institutions, whether in the government or the private sector, making them responsible for implementing both preventive and remedial measures to make the workplace safe for women. The guidelines suggest preventive measures, which include organizations make public in appropriate ways and express prohibition of sexual harassment in the workplace, amend conduct service rules to include sexual harassment as an offence, and raise awareness of appropriate disciplinary measures that will be taken against the offender. In terms of remedial measures the guidelines make it mandatory for employers to set up a complaints committee headed by a woman, for at least half its members to be women along with a third party representative.

In the context of the health sector, although the level of violence against healthcare workers is largely undocumented, evidence from developed country settings highlights the prevalence of sexual harassment in the health sector, the power imbalances and vulnerable work conditions for female workers that perpetuate this harassment. Studies conducted in medical schools in US on sexual harassment indicate that incidents were deflected away from the problem of sexual harassment by re-framing the problem as one of women's sensitivity as well as re-victimized the women by blaming their sensitivity or finding some other reason to justify such harassment (2). The scenario in India is of no difference. While sexual harassment at workplace is an unspoken reality; there is hardly any reporting of the implementation of the guidelines in the health sector. In the study: Sexual Harassment in the Workplace: Experiences of Women in the Health Sector few respondents (20 out of 135) were aware of the Supreme Court Guidelines on Sexual Harassment and none had heard of a complaints committee for redress of complaints (1). Further evidence drawn from the few reported cases suggests that women seldom report sexual harassment and that where harassment is reported, quick action is not taken, complaints committees are inappropriately constituted, and even when judgments are made in favor of the woman, action is rarely taken against the perpetrator (3, 4, 5).

This write up takes forward the qualitative research findings reflecting health workers experiences on sexual harassment in Kolkata hospitals and reflects on the author's experiences of conducting training programs in different nursing institutes in Kolkata, India. These training had been initiated with the objective of ensuring women's access to safe and gender just workplaces. The focus has been on creating awareness on the issue, the relevant guidelines, of the inappropriateness of sexual harassment, rights of women workers and skill building of women workers towards seeking redress.

The Denial

Private hospitals were completely non responsive to dialogue for training and denied the need. Sporadic government hospitals accepted the offer but without any cost implication on their part. This was not surprising as during the research the authorities had professed absolute ignorance about the guidelines and dismissed the need for implementation.

“Sexual harassment does not occur here. We do not need any training”
Managing Director of private hospital

Many of those in authority felt such instances occur in lieu of benefits and held the women liable for the harassment. Very often women workers themselves tend to regard sexual harassment as normal and share the sentiments of authorities that onus of prevention is on them (1). This is similar to the thinking prevalent in other kinds of workplaces where authorities have dismissed the need for implementation of the guidelines by saying sexual harassment cannot happen in their workplaces. Some of the reasons attributed are employees being from 'good families', 'highly educated' and sharing 'family like relationships in the workplace' (5).

The principals of nursing institutes were more responsive but for them to give their consent the training had to be positioned as part of a larger curriculum on laws for women. There was however a tacit understanding that the training would focus on sexual harassment at workplace and the relevant guidelines. These institutes are only for women and also have an all women faculty.

Session Description

The training sessions were conducted in 4 different nursing colleges in the city, both government and private. Three of these institutes were affiliated to private hospitals while one was affiliated to a government hospital. The training sessions were conducted mostly amongst Bachelor nursing students in the age group of 20 - 23 years. The teaching faculty did not intervene with the module neither were they present during the training sessions. They took feedback from the students after the training and expressed their satisfaction with the process. This attitude of the faculty of the nurses training institute was in complete contrast to the indifference expressed by hospital authorities towards initiating training on the issue.

The sessions design after the icebreaker focused on encouraging the participants to speak about their experiences of sexual harassment. There were requested to discuss their experiences in small groups and then present it to the larger group. The participants were remarkably forthright in sharing their experiences of sexual harassment at workplace. The experiences narrated by participants illustrate that these young women students had experienced a range of harassment while working as trainees in the hospitals but none were aware of the guidelines on sexual harassment. The experiences described by the participants were painful to hear and brought to light vulnerabilities of women workers. For the participants it was an emotional outpouring and had moments of both tear and laughter. The experiences described by participants follow the classification provided by the Supreme Court Guidelines. Some of the incidents described include:

- One of the juniors was taken to the OPD by one of the senior students when she complained of cough and cold. The doctor took her behind the screen and palpated her breasts (4th year student nurse).
- An anesthetist wrote a poem on the vagina and recited it in front of us (a 3rd year student nurse).
- In orthopedic ward when one nurse was massaging one of the male patients, another patient commented 'get as much fun the as possible' (2nd year student nurse).

The perpetrators include doctors, non medical staff, administrative staff, patients and patient party. Analysis of the range of experiences narrated by them indicates that the behavior is targeted especially at the young and plays on their vulnerability. The reluctance of the participants to make a formal complaint is strengthened by the fact that sharing with the immediate supervisors has met with little response. In fact the participants reported that the general perception amongst seniors is that young nurses are only interested in 'catching doctors': You all (young nurses) come to the wards to catch doctors - Senior nurse, government hospital

These sharing sessions were followed by a discussion on the issue in the context of the guidelines and the strategies that may be adopted by women workers while seeking redress. Clarity on the issue is necessary as very often experiences of sexual harassment are dismissed as mere harassment and thereby not considered either within the purview of the guidelines or the complaints committee. Towards this the module focused on the findings of the research conducted by the author.

While the women workers were forthright regarding their experiences of sexual harassment at workplace, they did not have any information about the guidelines, nor did they have the skill and the knowledge required to seek redress. The strategies suggested by the participants included those in which the onus was on them, e.g. not going near the doctor (harasser), or ignoring the harassment. Some reasons given by the participants include:

- 'We must protect ourselves as much as we can, complaining is not an option as we have to complete our studies by being in this situation only'. (4th year student nurse).
- 'The woman should adjust, keep quiet or leave the job according to the situation' (3rd year student nurse).

The women are aware of the repercussions involved and therefore irrespective of the nature of harassment hesitate to complain. They are aware of the reality and stated that 'before complaining her (the harassed women) should assess how much importance or guidance the authorities are going to give her'. Complaints even when made are not always looked into as per the Supreme Court Guidelines. In one instance the chairperson tried to conclude the complaint on basis of documents provided by the management in the first meeting itself (5). Women workers in such instances need training on how to document the complaint, information on strategies too be adopted while seeking redress, a clear idea of their rights, information about different groups who can provide support etc.

Conclusion

These sessions substantiate that sexual harassment is a continuing reality, an experience to which young nursing students are initiated from very beginning of their training. Simultaneously they are initiated to a culture which silently and tacitly condones the harasser and refuses to enforce the preventive or redress mechanisms spelled out by law. This same culture by constantly reminding young women students that they are accountable for the harassment ensures an environment where complaints are never made.

Finally for creation of a safe and equal work environment, it is necessary that training on the issue and guidelines is incorporated in the curriculum on a systemic & sustainable basis. Along with training of young students, training of supervisors and those responsible for inquiry of complaints is necessary. Further to training, authorities must build confidence among women workers that complaints made will be treated impartially and confidentially.

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Staff Resistance to Restraint Reduction: Identifying and Overcoming Barriers

Poster

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Abstract

Professional organizations, regulating agencies, and hospital administrators have taken a strong stance on restraint reduction policies. When implementing a restraint reduction initiative, it is important to identify the barriers to restraint reduction, such as concern for personal safety, lack of knowledge about and practice using alternate de-escalation skills, and fear of disrupting the therapeutic milieu by using a variety of de-escalation methods.

Education aimed to reduce the use of restraints needs to do more than simply provide information. It is important to acknowledge the emotional response of the nursing staff and the culture of the current practice. A variety of educational strategies, including role-playing, and case studies will help identify attitudes, beliefs, and behaviors that are congruent with reducing the use of restraints. If the ultimate goal of restraint reduction is philosophical change, it will eventually lead to a new culture of practice.

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Student nurses' self-confidence and performance of managing patient aggression after attending training courses

Paper

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Keywords:

Aggression, nursing student, self-confidence, de-escalation performance

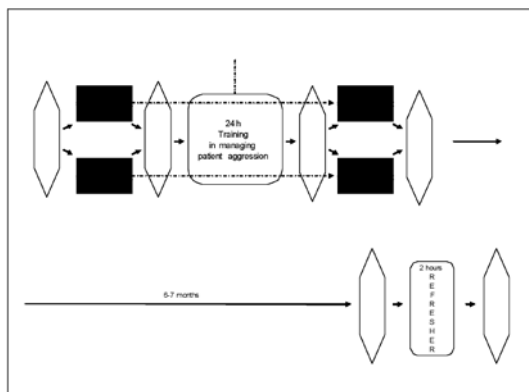
Introduction

The central task of vocational training is to prepare and qualify for the challenges of a profession. Therefore training in managing patient aggression should be normal part of nursing education. This is still not the case [1-3] although nursing students express particular needs and problems [4]. Training programmes should be delivered in respect to the target group and the target setting [2]. Thus we tailored a training programme in accordance to the special needs of nursing students [4] and based on the best available evidence of training issues [5]. The resulting training programme was tested in its impact on nursing students' self-confidence and performance in managing patient aggression. The benefit of enhanced self-confidence in managing patient aggression could be seen as an important source of exoneration and as an antecedent of improved performance [6]. Several investigations have demonstrated improved self-confidence after training when measured by Confidence in Coping with Patient Aggression Scale [7-9]. No clear evidence exists that trainings in aggression management lead to a significant better performance of the staff in managing patient aggression [10]. Therefore, the hypotheses of this investigation was that a successful training programme leads to enhanced self-confidence [9] and improved performance in managing the aggressive behaviour [6].

The objective of the study was to test whether nursing students of different educational levels have different self-confidence levels and to what extent a training programme would enhance student nurses' confidence. A further aim was to ascertain whether or not the performance of de-escalation an aggressive situation will improve after training.

Methods

Six groups of students (n=104) at different stages in their nursing education (10th to the 28th month of nursing education) completed Thackrey's Confidence in Coping with Patient Aggression Scale [9] at six time points. Initially a baseline test was carried out before any intervention (t1), then after being personally confronted with an aggressive simulation patient (t2). The next measurements took place at the end of the training programme but before being confronted with a further novel aggressive situation (t3) and after performance in this situation (t4). A medium term effect was investigated a half year later by assessing confidence before (t5) and after a refresher course (t6) (Box 1).



Box 1: Research design

Before the training was administered one of two different standardized situations were displayed by simulation patients (either situation A or situation B). After completing the training each member of a group was confronted with a novel aggressive situation for which the student had not been specifically trained. All encounters were videotaped and 156 videotaped sequences of nursing students managing aggressive situations were investigated. Five DVDs including 30-32 clips which were randomly selected were distributed to three experienced de-escalation trainers. The student performance on each DVD was rated independently by the three de-escalation experts from three German speaking countries. The expert raters did not know whether a video was captured before or after training. Performance rating was conducted using the Managing Aggressive Behaviour Scale (MABS) a 6-item scale (see Table 2) combined with a 5-point Likert scale ranging from “strongly agree” to “strongly disagree”. The scale has shown good internal consistency in several tests (Cronbach’s alpha from 0.84 to 0.88) and acceptable test-retest reliability (Pearson’s r 0.81 und Interrater reliability (ICC 3.0.70–0.91). The training course was developed to fulfil four requirements. Firstly to ensure that the best evidence and summarized guideline issues were implemented [5] and elements of a tested and well acknowledged training programme were used [11-13]. Secondly the development of declarative, procedural and conditional knowledge was promoted by drawing on current educational theories [14]. Thirdly the training was administered in accordance with high standards as described by the Universities’ and Colleges’ Staff Development Agency (UCoSDA) [15]. Fourthly the training consisted of contents, aims, and methods (Table 1) aiming to ameliorate students’ problem solving capacities and their resource enhancement [4, 8].

Educational aims

PREVENTION

A-01 considers finding out potential causes of aggression as being important

A-02 considers defusing risks of aggression as being important

ASSESSMENT OF OCCURRENCE

B-01 recognizes a tense situation and takes a calming influence

B-02 is aware of the fact that a patient could be right concerning the cause of his arousal

B-03 does not take aggressive situations personally

B-04 interprets an aggressive situation by examining whether nursing interventions failed

Methods and contents

Lecture: Def inition of aggression [18], current theories and their limitations with an emphasis on social interactionist approach and less useful but popular applications of theories of aggression [5, 19-24], assault cycle [25], and legal issues of Germany[26].

Working in groups: Sharing of own experiences on aggression [27].

Educational aims	Methods and contents
B-05 interprets an aggressive situation by examining gaps in the safety culture of the ward/institution	Work in groups and lecture: Coping with perceived aggression, post-trauma support. [25, 28, 29], attribution theory [30, 31], the "Just World Hypothesis" [32], and safety culture [25, 33].
B-06 interprets an aggressive situation by examining the nursing intervention practice	
B-07 interprets an aggressive situation by examining own behaviour	
B-08 interprets an aggressive situation by using current theories of aggression and pathology	
B-09 communicates with the patient in a calm manner	Skill training: Self-awareness, verbal, para-verbal and nonverbal communication skills, body language [34-36], non-physical de-escalation [19, 25, 37], physical de-escalation e.g. danger zones/spatial safety zones, non-provocative intervention, safe posture, several variations of non-provocative release of wrist-grabbing, cloths-grabbing, hair-grabbing, escaping encirclement, choking, and biting. [38, 39].
B-10 communicates with the patient in a respectful manner	
B-11 communicates with the patient in a solution oriented way	Training with simulation patients [40].
DEALING WITH THE PATIENT	
C-01 remains calm	Training with simulation patients [40].
C-02 tries to look at the situation from the patient's point of view	
C-03 gives signals of esteem to the patient	Training with simulation patients [40].
C-04 behaves respectfully towards the patient	
C-05 behaves respectfully towards her-/himself	Training with simulation patients [40].
C-06 remains appropriately self-critical	
C-07 is willing to accept a compromise	Training with simulation patients [40].
C-08 provides the aggressive patient with the same amount of care and nursing than others patients get	
C-09 considers the patient's given or not given abilities for future actions	Training with simulation patients [40].
C-10 gives the opportunity to vent one's anger (i.e. to grumble about s.th. without insulting or hurting s.o./s.th.)	
C-11 tries to identify reasons and motives for the behaviour of the patient	Training with simulation patients [40].
C-12 tries to remove the trigger of aggression and shows in case of impossibility the unchangeable framework requirements	
C-13 shapes the further procedure considering the given institutional safety culture, patient rights, and own rights	Training with simulation patients [40].
C-14 looks for help without any feeling of embarrassment	
C-15 is able to deflect assaults and to escape dangerous situations.	Training with simulation patients [40].
C-16 behaves clearly and without aggression	
C-17 is able to verbalize her/his own concerns and points of interest	Training with simulation patients [40].
C-18 behaves in a self-confident manner	
C-19 behaves assertively	Training with simulation patients [40].
COPING AND AFTERCARE	
D-01 considers strategies of coping a vital issue	Training with simulation patients [40].
D-02 involves members of the team to echo and underline the importance and indispensability of the own message/issue	

Educational aims

D-03 involves other team members to emphasize the importance and indispensability of the needs of other learners, team members and beginners

D-04 approaches vocational and social peers to get assistance in coping with the situation

D-05 talks about depressing emotions concerning patient aggression/sexual harassment

Table 1: Aims, methods and content of the training unit

Results

Irrespective of educational levels all six groups of students showed similar low baseline scores of self-confidence (2.3 – 2.4 on a scale ranging from 1 to 5). After the trainings a significant enhancement of students' self-reported confidence was found in each group (3.5 – 3.9, $p < .001$ on the paired samples t-test). The total means of self-confidence in dealing with patient aggression remained the same before and after encountering an aggressive situation (2.4 in t1 and t2, 3.7 in t3 and t4) which suggests that the self-assessment is a realistic appraisal. The enhanced confidence persisted over half a year (3.5) and was fortified by a refresher course (3.8). After the training programme the students demonstrated a significant performance enhancement on all items of the Managing Aggression Behaviour Scale ($p < .001$, paired samples t-test) (Table 2).

Students' behaviour towards the client	Pre-test mean	Post-test mean	Difference	P-values*
1. Valuing the client	3.18	3.94	0.76	< .001
2. Reducing fear	2.46	3.56	1.1	< .001
3. Inquiring about client's queries and anxiety	2.28	3.45	1.17	< .001
4. Providing guidance to the client	2.55	3.42	0.87	< .001
5. Working out possible agreements	2.43	3.55	1.12	< .001
6. Risky (R)	2.77	3.52	0.75	< .001
Total mean	2.61	3.57	0.96	< .001

Note: (R) denotes item recoded in direction of best-practice

* paired samples t-test

Table 2: Pre and post test performance of students

Comparing identical situations (type A or B) managed by untrained and trained students it becomes visible that trained students were more able to show significantly better performance. In situation A the MABS scores increased from 2.4 (untrained) to 3.6 (trained), $p < .001$, and in situation B from 2.9 (untrained) to 3.5 (trained), $p < .001$.

Discussion

This investigation provides evidence that a training programme in aggression management can positively affect students' self-confidence. Interestingly, the baseline mean of confidence of the students in this study corresponds to the results of similar investigations [7-9, 16] which indicates

consistency in the different groups at different time points when no intervention is conducted. This suggests that enhancement does not occur by itself, and that the positive development reported here is strongly correlated to the educational measure.

Self-confidence is considered to be an antecedent of successful performance [6]. Bandura mentions a “marked difference between possessing knowledge and skill and being able to use them well under taxing conditions” [6]. People with a high sense of efficacy visualize success scenarios that provide positive guidance and support for performance.

A good level of enhanced performance is reached when trainees possess compilation [17] skills. This means that a trainee is not merely able to reproduce learned skills in well-known uses but generalizes skills to situations not specifically trained. As Kraiger showed, compilation can be inferred from evidence such as plateaus in the rate of increase of desired behaviours and decrease in the frequency of undesired behaviours. This becomes visible in performance. These requirements were fulfilled by the research design and are visible in enhanced values of MABS. Thus this investigation provides some evidence that competency in de-escalating could be significantly enhanced by training courses.

Conclusion

Positive development of self-confidence is strongly correlated to the training course and enhancement does not occur by itself. Self-confidence and performance in de-escalating aggressive situations improves significantly after attending a training course.

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The Development of Crisis Negotiation in Forensic Mental Health - Staff training and policies to deal with extreme violence in the workplace

Workshop

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Abstract

Crisis incidents occur within Forensic Mental Health settings, and as such staff within psychiatric services is often attempting to manage, are witnesses to, and may also be the victims of extremely violent acts. Such incidents (although not exclusively) would include barricades, weapon use, roof top protests and hostage situations.

In 2005, a joint project between Partnerships in Care and Merseycare NHS Trust was established to develop a comprehensive training pack to develop the competencies of it's most junior staff to deal with these violent incidents. This training pack utilised consultant practitioners and academics, and was also developed in conjunction with the Crisis Negotiation Unit at the FBI.

Within Partnerships in Care, the Crisis Negotiation training has been delivered, and currently there are twenty-eight trained staff across three secure hospitals within the North West of England. The training looks at the history of hostage negotiation and the methods used. It focuses on the different types of hostage taking, the impact on the hostage and the role of the negotiator within this. It also focuses on the characteristics of a good negotiator, the tactics used, and the strategy for successful negotiations using the Behavioural Change Stairway Model (Vecchi, Van Hasselt and Romano, 2005).

The training also examines how the negotiation process may have to be adapted specifically to be effective with those patients in crisis who have mental disorders. As part of this training, extensive role-plays and an assessment process are incorporated. The training lasts for five days.

Additional training has also been developed to teach all staff 'What to do if held against your will'. Victim behaviour can often seriously impact upon the resolution of a crisis situation, and therefore this training looks at informing staff of the key issues if taken hostage. This includes a limited insight in to the negotiation process and suggested ways to react. This also includes understanding psychological responses to being a hostage, such as 'Stockholm Syndrome' where a hostage may begin to develop positive feelings towards the hostage taker. The final section examines what may potentially happen to a hostage, psychologically, after the incident. This training lasts for approximately one hour. Detailed and comprehensive policies have been developed to ensure the successful management of these examples of extreme violence within the workplace. These policies include detailed role definitions and expectations of differing grades of staff for the duration of the crisis.

This workshop will give attendees the opportunity to examine some of the main psychological strategies used in crisis negotiation, and it's adaptations for those perpetrators who have mental disorders. They will get the opportunity to experience some of the practical elements to the two training courses outlined above. They will get an overview of policy development within this area and an opportunity to explore the application of this work to their own workplaces.

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The relationship between workplace violence and professional boundaries - exploring the impact on client care

Paper

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Keywords:

professional boundaries, workplace bullying, power, ostracism and alliances

Introduction

Professional boundary crossings and violations occur along a continuum of over and under involvement with clients. The literature discusses a variety of reasons as to why these crossings and violations occur including stressful work environments, poor staff patient ratio and personal distress. This paper explores how the experience of workplace bullying can influence the decisions that clinician's make which may result in professional boundary crossing or violations.

Main paper

Professional boundaries have been defined by Peterson (1992) as the "limits which protect the space between the professional's power and the patient's vulnerability". According to Campbel et al, (2005) and Gutheil, (2005) health professional are responsible to delineate and maintain professional boundaries. In order to do this health professionals need to be aware of their own needs and attend to transference and counter transference issues that emerge in their therapeutic relationship with clients. When extra intra and inter personal stress is experienced through workplace bullying and violence it may be that the health professional is less able to identify, examine and attend to safe professional boundaries. Thus, the risk of them crossing or violating professional boundaries increases.

Over involved boundary crossings and violations can include favouritism, inappropriate touch and giving and receiving gifts. Under involved crossings or violations include, avoiding clients, talking in derogatory terms about clients, neglect and physical and or sexual abuse has been reported in the literature.

The presenter will incorporate stories from her PhD and examples from the one to one work she does with nurses who have crossed or violated professional boundaries to discuss the overt and covert ways in which workplace bullying influences nurses to become over or under involved in client care. For example one way that nurses can become over involved with patients is when they experience ostracism from colleagues. The experience of feeling isolated and ostracised by one's professional group may lead to an individual seeking solace and support from another group, such as patients. This is highlighted in the following statement from a nurse who was the recipient of bullying from colleagues which was witnessed by patients:

...mothers would tell me things that validated my own feelings to help me get over it and realise that this wasn't just me ...patients would say to me 'it looks like it's a bit stressful for you'. I felt embarrassed, I felt like crying and I felt like complaining about the other nurse to that patient. (Isobel)

The importance of health professionals developing and maintaining self awareness, resilience and internal and external support mechanisms is discussed in this presentation. The role of organisations in supporting staff through education, training, supervision and where necessary, counselling, is also highlighted.

Conclusion

Using stories from nurses who have crossed and violated professional boundaries the presenter has examined the role of workplace bullying as an important factor which influences the decision making of nurses. Recognising the relationship between workplace bullying and professional boundary crossings and violations is an important step towards managing this emerging organisational issue. In order to maintain safe professional boundaries for the client and health professionals it is important that organisations offer a supportive, blame free culture which addresses issues of workplace violence as they emerge.

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The Therapeutic Management of Violence & Aggression Training

Paper

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Abstract

Background

In 2002 Cardiff & Vale NHS Trust took the decision to review its Violence & Aggression training. This review took place in light of national changes and some well publicised incidents where mental health patients had died in or following a period of restraint. Following this review the decision was taken to radically change the way the 'Therapeutic Management of Violence & Aggression Training' was delivered and managed in its Mental Health Settings. As a result an external company (React UK Ltd) was given the opportunity of training a small select group of clinically based nurses as trainers in the management of violence & aggression. These trainers would, in turn, train all clinically based staff. Historically violence and aggression training in mental health hospitals in the UK was taught using pain based techniques that originated in the prison service.

Spirit of the Model

It was clear from the outset that all involved wished to make fundamental changes in the culture of the hospital regarding ways of managing potentially violent situations. Trainers had a desire to change staff focus from one of crisis management to one of early recognition of potential situations and utilisation of effective de-escalation techniques. Previous training had taken a 'one size fits all' approach. The new model would set out to individualise responses using a gradient of response. For example, a low level approach for Service users that present less of a risk to others moving through a variety of approaches & techniques to service users that are potentially much more volatile.

Difficulties

Understandably some staff were cautious or resistive regarding the changes. The trust had already removed its seclusion facilities and some staff felt their safety may potentially have been compromised by more changes.

Benefits

However, annual training and clinical input from the Violence & Aggression trainers has served to reduce/allay the anxieties of staff. Clinical staff are encouraged to liaise with the trainers regarding aspects of the model in order that it remains progressive in its outlook and any problem areas can be quickly addressed. Trainers are available to areas as a resource of information/advice when dealing with difficult situations. Interestingly, there has also been a reduction in the number of violent incidents occurring in clinical areas since the training was introduced in 2003. On going developments: Having been actively involved in the National Audit of Violence for Adult Services (2005) & the National Audit of Violence for Older Peoples Services (2007), the Trust has sought to embrace their recommendations as quickly as possible. This helped identify training needs & a specialist course for Older Peoples Services was introduced in May 2007. Indeed by actively embracing guidelines set out by the National Institute for Clinical Excellence (NICE) and the All Wales Passport (Welsh Assembly Government) Cardiff & Vales training has become a Beacon Site within Wales.

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Violence in the Education of Nurses

Poster

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Abstract

Introduction

The nursing profession is composed mostly of female population which is, because of the nature of work, exposed to different types of violence. Researches which have been done demonstrate physical, verbal and sexual violence on nurses. Violence in the education of nurses begins to spread especially in the countries with presence of dominancy of doctors and low potential of nursing profile. It is prohibited right on further education to nurses, using free days, changing shifts, having paid leaves during studies and also they are not paid more after getting higher level of education.

Aim

The aim of the paper is to show in which aspects of education violence under nursing profession is conceived.

Methods and material

The research sites included several hospitals and also colleges for nurses. The sample is derived from nurses-students, with working experience of minimum five years and working on different shifts in the different departments. The research respected ethical principles about informal approval and privacy of inquiry.

Results

The results will be presented on the Conference.

Conclusions

Education is important for strengthening of nursing, strengthening profession and autonomy in nursing. Professional associations and syndicates should protect the right of nurses to study and this problem should be discussed in public. Education is important for strengthening of nursing, strengthening profession and autonomy in nursing. With education nurses are more informed about their rights, and they are strengthening their positions in working environment.

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Violence in the house of healing: Recognition and response to violence in healthcare

Paper

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Abstract

Society can no longer consider healthcare institutions as sacred ground, immune from acts of violence. Hospitals, once revered as healing institutions, have become battlefields where angels of mercy fear to tread. Workplace violence has become a significant public health concern of epidemic proportion with implications for healthcare providers, healthcare consumers, and society at large. The alarming number of violent acts compels us to increase worker and employer awareness of risk factors for violence in healthcare settings and to provide educational strategies for recognizing and reducing exposure. Nurses, who are both victims and perpetrators of violence, frequently do not recognize the full continuum and broad definition of workplace violence. The purpose of this study is to identify the types and frequency of violent behaviors reported by nurses within a community based, academic healthcare network. This study is unique as it examines and correlates the nurses' understanding of the definition of workplace violence in relationship to the violence they have experienced in the hospital setting. Nurses' perceived ability to handle violence is also correlated to their perception of victimization.

The hypotheses for this study are: Nurses do not consistently recognize workplace violence and are not prepared to handle violence in the hospital setting. Nurses define workplace violence in terms of physical injuries and do not recognize other, more common, insidious forms of violence including verbal abuse and stalking.

The research design for this study includes a confidential, self-report questionnaire based upon literature review of related topics including workplace violence, violence against nurses, nursing culture, medical hierarchy, stress, and nurse retention. Nursing staff are asked to respond regarding perceived victimization, ability to handle violence, the types of violent behaviors experienced, frequency, the source, nursing staff physical and emotional responses, and formal actions taken to report the event. Demographic data including gender, ethnicity, years working in nursing, and educational level attained are collected and correlated with the frequency and types of violence reported in the questionnaires. Qualitative data is also collected and analyzed for the nurses' understanding of the definition of violence correlated to perception of victimization.

Research findings support the hypotheses as 88.9% of the respondents report experiencing workplace violence, 71.0% do not recognize themselves as victims, and 56.6% do not feel prepared to handle violence in the workplace. Respondents also report the alarming rate of 11.3% considered leaving the nursing profession, 3.7% experienced physical illness, and 66.4% experienced emotional stress. Based upon these findings, a violence prevention and workplace safety program was developed for the host healthcare network with implications for the discipline of nursing and the global healthcare community.

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Violence in the public ambulatory services of health care

Poster

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Abstract

The aim of this exploratory and qualitative paper is to analyse the violence that threatens the users of the public ambulatory services of health care. It was tried to show the institutional significance of the violence and its mechanisms. This paper was done in hospitals and in ambulatory units of Sao Paulo City in 2008. It was composed by interviews, which had semi structured plot and these were recorded, with health professionals. In this paper, the everlastingness of violence, in its concealed and dissimulated forms, was verified. In general, the patients have shown low self esteem related to the quality of care; the professionals, in their turn, didn't use to treat well the patients; this was showing, at most of the time, that they were obligated to do the service and they didn't like it. The discrimination of drugs and alcohol addicted was seen; this made clear the lack of orientation of the health professionals. Regarding the women, that were raped and victims of domestic violence, this work realized the feeling of compassion of the health professionals. According the users, the violence was demonstrated mainly in the delay of the attending, in the lack of attention and in the mistreat. There is also an indulgence and silence of some users due to the fear of not being attended. Other users have justified the bad attending due to the high quantity of people at the public health services. It was concluded that the attending must not support itself by subject perception of this event. It must be supported by the competence and right qualification of the administrative technical staff who consider, without discrimination, any and all client profile. The institution must offer workshops like psychodrama as opportunity for the health workers of reflection about their attending.

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Work place violence project: Mauritian Participation

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Introduction

Workplace violence - be it physical or psychological - has become a global problem crossing borders, work settings and occupational groups. It affects the dignity of people and is a source of inequality, discrimination, stigmatization and conflict at the workplace. All categories of workers are affected but the health sector is at major risk. To address this issue SANNAM in collaboration with ICN initiated a three year project on workplace violence in five SADC countries, Mauritius, Lesotho, Zanzibar, Swaziland and Botswana.

Project structure

The workplace violence is a three year project funded by Norwegian Nurses organization and NORAD coordinated by SADC AIDS Network for Nurses and Midwives. SANNAM is a nurse's organization with the objectives of creating a safe environment for nurses especially in the fight of AIDS in the SADC region. The professional content is from International Council of Nurses-ICN. The project targets five participating countries. (Lesotho, Zanzibar, Swaziland, Mauritius and Botswana.) In 2006, Mauritius and Botswana hosted the 1st training workshop where Zanzibar, Swaziland and Lesotho participated.

Each country has a trained National Representative who is responsible of coordinating training workshop in their respective country and the implementation of activities. In 2007, Swaziland and Lesotho hosted the 2nd training workshop where Mauritius, Zanzibar and Botswana participated. This year 2008 the final gathering will be held in Zanzibar where all the five countries will be together, share country experience and reflect on the way forward.

Objectives

- To provide nurses and midwives with knowledge and understanding of workplace related abuse, sexual harassment and violence.
- To empower Nurses and Midwives to more effectively cope with violence.
- To establish sustainable policies, procedures and services at health care institutions to cope with and reduce incidents of violence.

Mauritius background

Mauritius is a small island in the Indian Ocean with a population of 1.2 million. The inhabitants are from different ethnic groups (Creole, Hindus, Muslims, Chinese and white people. Our Resources are mainly sugar cane, textile and tourism industry. Mauritius was a British colony. In 1968, it become independent and in 1998, a Republic. Education and Health are free of charge and the level of literacy of the population is very high. Mauritius is a nice place, surrounded by sea with beautiful beaches but unfortunately, the country is facing a great problem that of intravenous drug users.

This has contributed in a rise in HIV infection and also a shift in the mode of transmission from hetero sexual to blood transmission. Example sharing of needles among the users. Mauritius is the only island in the Indian Ocean with a high prevalence of HIV and that is a considered burden on our health personnel.

Methodology

Mauritian participation

Mauritius has been very lucky to be among the five chosen countries. A five day training workshop was organized in 2006 by Dr Mireille Kingma, ICN consultant in Mauritius. 30 Mauritian participants from eleven health institutions were trained with the objective to implement workplace violence projects at their site of work. A training manual designed by WHO-ICN-ILO-PSI was used as tool to equip them with appropriate skills. Each representative has the responsibility of disseminating information on how to reduce violence through proper communication, counseling, to ensure support to victims and develop skills to face this challenge.

Situation analysis in health setting

A situation analysis showed that though being a small island, the prevalence of violence is similar to other countries. Despite the high level of literacy of the inhabitants, violence is present in both urban and rural areas. In the urban areas, it is on the increase due to some vulnerability associated with some groups of risk behaviours (drug abuse, heavy alcohol consumption, prostitution and increase mobility of people.) Risk assessment showed that nurses were at special risk while working alone, in contact with people with special vulnerabilities, frustrations and while working in emergencies especially on the week end and period of festivities.

Working alone, inexperienced and young, is very risky. (Example a young nurse was badly assaulted in a psychiatric ward by a criminal psychiatric patient because the nurse was not used to this ward and was not accepted by the patient.) Contact with specially vulnerable people also contributes to violence. For example a female nurse who was five months pregnant was aggressed by an alcoholic patient while she was working in an Emergency unit. Unfortunately she lost her baby.

Strategies adopted

- Meeting with Ministry of Health to support the project: The Ministry of Health welcomes this project in a positive way. A Violence Committee was set up at the ministerial level with the objective to develop strategies in order to reduce violence in health care settings. Letters of support from the Ministry were sent to each health institution with a view to provide assistance to this project.
- Situation analysis in each institution: Representative of the eleven institutions had to make a survey to have an idea of the impact of violence in their working area and develop means of interventions. Meetings held in all regions with stakeholders including doctors and management.
- Regular visit and feedback: Ongoing regular visit in all institutions to encourage reporting and follow up. Feed back from each representative. Meeting with administrators of hospitals to have an overview of the situation.
- Workshops for higher officials: Workshops are organized every six months for higher officials in order to share information about the extent of violence and on other strategies to adopt if need be.
- Support from police and security officers: Police and Security Officers are invited in our awareness session to talk to our health personnel about skills to adopt in case of violence.
- Sensitizations programmes: In all institutions nursing personnel and other health care workers are being sensitized regularly. Each institution is allocated a seed grant to implement activities and to report the outcome

- Capacity building for representatives of work place violence: The National Representative has the responsibility to mount regular workshops for all the representatives, give them appropriate training and share the project progress.
- Hotline: A hotline service is available at the seat of the National Nursing Association.
- Display of posters in health care settings: Attractive posters are displayed in all institutions to educate and help both patients and staff to develop a sense of responsibility and mutual respect with a view to create a safe working environment.
- Development and distribution of pamphlets: Pamphlets are distributed to give proper information to patients and relatives concerning procedures in hospitals. (Example: Why a patient has to wait when referring to another doctor?)
- Introduction of violence record book: A Record Book for Violence has been introduced in each health institution. This will help to compile data concerning the frequency of violence.
- Involvement of media members to mainstream this campaign: Establishment of a good alliance with media is very important as it can contribute significantly in a positive way to help the community adopting a changing in behaviour towards health personnel. Media can market the importance of creating a good working environment for better customer care. This will be a win - win situation.
- Awareness sessions in schools, colleges: Sensitization of school children and students is very fruitful as they are the future clients and parents. They can act as ambassadors towards their relatives and help them to recognize the value of the health personnel and also adopt a safe behaviour in hospital premises.
- Working with religious bodies: Religious bodies play an important role in the prevention of violence at the workplace. They are very influential and can counsel the community about the importance of respecting the hospital premises. Religious bodies are in contact with a significant audience and can make them realize the work which is being performed by health personnel and also understand their constraints.

Contents of training for health care workers at hospital level

- Understanding types of violence: Physical, verbal, psychological, bullying/mobbing, harassment, assault/attack, threat.
- Risk Assessment: Analyzing available information, identifying situation at special risk.
- Situations at Special Risk: Working alone, working in contact with public, working with object of value, working in an environment increasingly “open” to violence, working in conditions of special vulnerability.
- Interventions: Developing a human-centered workplace, issuing a clear policy statement
- Individual focused: Training, assistance and counseling, wellbeing promotion.
- Organizational intervention: Staffing, management style, information and communication, work practices, job design, working time.
- Environmental intervention: Physical environment, workplace design.
- After The Event Interventions: Response plans, reporting and recording, medical treatment, debriefing, counselling, management support, representation and legal aids, grievances procedures, rehabilitation

The way forward

Enlarged community needed: The Media, Research and educational Institutions, Specialists in workplace violence/Consumers/Patients/advocacy groups, professional organizations, the Police and criminal justice professionals, NGOs active in the area of workplace violence, Health and Safety, Human right and Gender promotion are needed to support and participate in the initiations to combat workplace violence

Solidarity

Emphasis is laid on solidarity among all health personnel. There is a need to support each other in this battle.

Partnership

Workplace violence is not an isolated individual problem, partnership is essential.

A holistic approach should be developed and promoted to address this problem at the roots involving all parties concerned and takes into account the cultural, gender- dimension of the problem

Conclusion

Violence is very destructive, it hurts ones self esteem and dignity. Mauritius is sparing no effort to combat this problem through a multi-sectoral approach with the blessing of this project.

Together we survive, united we overcome

Reference

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Workplace bullying is the solution, so what's the problem?

Workshop

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Abstract

This workshop invites participants to respond to the statement: 'Workplace bullying is the solution so what's the problem?' A number of action methods will be used throughout the workshop to assist participants gain a greater awareness and understanding of the intrapersonal, interpersonal and systemic factors that influence workplace bullying. Specifically the workshop will focus on the experience of shame in workplace bullying. The facilitator will explore how shame experienced by an individual (or group) may create such an internal disturbance that workplace bullying becomes a solution to manage the individual or group distress.

The facilitator will share stories and findings from her PhD which examined the experience of shame in nursing. As the stories emerge in the workshop participants will gain insights into the intrapersonal conflict of perpetrator/recipient roles and how those internal tensions are played out in 'bullying behavior'. The facilitator has been running the workshop in Australia for over two years.

Shame is a concept that has been extensively theorized within the social sciences as important in the development of individual identity, self esteem and role performance. Yet the concept of shame in relation to workplace behaviors has generally been overlooked. Understanding the influence of shame in the workplace as it relates to workplace bullying is important for two reasons: first it may offer new insights about professional identity; and second it may help professions to understand how certain behaviours reported in the literature such as intimidation, humiliation, silence and ostracism are part of some workplace cultures that then become central to the professional identity of that workplace. If workplace bullying is indeed a solution to the experience of shame then it is important to look at managing shame in the workplace. The strategies and interventions discussed and demonstrated in the workshop can be used by educators and trainers in their respective roles.

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Workplace Violence: A Multidisciplinary approach to nursing education

Poster

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Abstract

With the global increase of workplace violence in the health care setting it is imperative to increase awareness/knowledge for those working in health care. The images and definitions of work place violence greatly vary in part because of global diversity. Cultural and religious beliefs may shadow acceptable behaviors which for thousands of health care professionals can mean the difference between safe and unsafe work environments. According to the United States Department of Justice, Bureau of Justice statistics 913,000 health care workers were victims of violent assaults from 1993-1999. Of these, 429,000 were nurses. The rising incidence of work place violence in the health care setting has caused many nursing organizations to take action. Task forces, surveys, handouts, workshops and training sessions have been implemented. Nurses are in a very inimitable position because violence, whether physical or verbal, has the potential to arise not only between nurse and patient, but also between patients, visitors and other professionals. Nurses identifying and defusing potential acts of violence provide for a safer work environment, as well as improved outcomes in patient safety. Ensuring these improved outcomes greatly depends on new nurses understanding what work place violence is, who is at risk, where the violence occurs, what the risk factors are, and how to de-escalate aggressive behaviors. Increasing awareness/knowledge in nurses begins in nursing school. The purpose of this education is to create safer work environments by educating student nurses of the risk factors for workplace violence, improve skills and attitudes, and provide strategies for prevention and avoidance, before they enter the work force.

To address this issue a multidisciplinary approach was used to incorporate education on workplace violence into nursing curriculum. A two hour class, developed in collaboration with a retired New York City Police lieutenant, addresses eight objectives. Senior level nursing students participate in this class of instruction which is included as part of their leadership course. Class covers topic content, allows time for open discussion as well as questions and answers, and demonstration/return demonstration of safety techniques. A pre-test identifies knowledge base and a post-test identifies knowledge gained. Using a Lickert Scale students are given the opportunity to evaluate class objectives, class content, strategies utilized, and class presenter. Students verbalize appreciation and understanding for the training, and are grateful for the tactics learned.

Globally, violence in the health care setting is a significant concern to all health care workers and their employers. In the United States the Department of Health and Human Services, Office of Disease Prevention and Health Promotion, recognizes workplace violence as an increasing national concern, and in their Healthy People 2010 initiative two health objectives were included to focus on improving safety standards in the workplace. In Australia, the Australian Institute of Criminology rated the "health industry as the most violent workplace in the country" (Zinn, 2001). Since violence cannot be eradicated measures can be taken to minimize risk. Utilizing teamwork and collaboration education on workplace violence can be incorporated into the curriculum of

nursing students worldwide. New nurses pledge to devote themselves to the welfare of all those in their care, but to what expense? Educating new nurses minimizes risk by increasing their awareness for potential problems and creating safer work environments.

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Work-Related Violence in Forensic Psychiatry Compared with the Results in Irish Health Care Settings

Paper

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Keywords:

SOVES, work-related aggression and violence, forensic

Introduction and background

Aim of the study was to compare findings between studies of work-related violence within forensic care service in Finland with those of non forensic services in Ireland. Comparisons included findings in relation to the frequencies, impact, reporting, support, and training in both sites.

Methods

The study populations included all nurses of one forensic psychiatric hospital in Finland ($n=415$) compared with all nurses within one Irish regional health authority (sample $n=7863$). 222 nurses in each site responded yielding response rates of 55% in Finland and 70% in Ireland. Both study locations utilised the SOVES (Survey of Violence Experienced by Staff) questionnaire which was developed for the Irish study (McKenna 2004) and replicated in the Finnish study. The internal reliability of the questionnaire was 0.877-.917 in the Irish study and 0.87 in Finnish study suggesting a high degree of internal reliability. Violence was defined in the questionnaire as:

- Verbal aggression: Abusive or offensive language, personally derogatory remarks, profanity or obscene comments.
- Threats: Warnings of intent to injure, harassment, physical intimidation, threat with a weapon.
- Physical assault: Slapping, pinching, pushing, shoving, spitting, kicking, use of a weapon.

Results

The extent of verbal abuse encountered by staff in both locations was similar. However forensic staff were almost twice as likely to be threatened and more than twice as likely to be physically assaulted. Occurrences of all manifestations of violence were significantly underreported in both locations.

Despite encountering significantly more threats and physical assaults, staff in the forensic service reported less emotional distress and less time off work subsequent to occurrences. This is an interesting finding considering that the rate of injury was similar in both locations subsequent to physical assaults.

Respondents in both locations primarily relied on colleagues and managers for support following occurrences. Forensic nurses utilised their manager with twice the frequency of the non forensic nurses, and were more aware of the formal support structures available to them.

Respondents in both locations rated their necessity for training in the management of work related violence as essential for their current work assignment. Forensic nurses had received significantly more training and had higher levels of confidence in the use of verbal and physical interventions. This is an interesting finding considering the difference in time off work subsequent to physical assaults.

Discussion and conclusion

The comparison of a similar number of nurses, in diverse clinical settings, using the same instrument suggests that the frequency, response, and impact of occurrences of work related aggression differs between settings. This is worthy of consideration in the context of 'one size fits all' approaches and supports the notion that organisations need to adopt service specific rather than generic responses.

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Announcement

**The Second International Conference
on Workplace Violence in the Health Sector
will be held on the 27th till the 29th of October 2010
at Amsterdam, the Netherlands**

The call for abstracts will be issued in August 2009

Please reserve these important dates in your agenda

Looking forward to seeing you in Amsterdam in 2010



Together, Creating a Safe Work Environment

Violence is a global phenomenon and can have major negative effects on the health care sector. The first International Conference on Workplace Violence in the Health Sector held from the 22nd till the 24th of October in Amsterdam, the Netherlands, offered a platform to address the topic from a comprehensive perspective with a broad range of sub-themes such as the nature and epidemiology, gender, legal/ethical, and economical aspects, policy, as well as scientific/theoretical and practical issues like staff training.

These conference proceedings reflect the work and projects of practitioners, researchers, and policy makers from many countries all over the globe. Together we aim to reduce work place violence and to render the health sector a safer place for all concerned.

This book furnishes the reader with a wealth of information, ideas, and contacts and will be welcomed by persons confronted directly or indirectly with the issue of workplace violence. It is the hope and desire of the conference organizers that the concepts, interventions, and solutions presented and discussed in Amsterdam will radiate beyond the conference and through their implementation will facilitate Creating a Safe Work Environment.

Dr. Ian Needham

Dr. Mireille Kingma

Prof. Dr. Linda O'Brien-Pallas

Mr. Kevin McKenna

Mr. Rick Tucker

Mr. Nico Oud

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