Workplace Violence: Differences in perceptions of nursing work between those exposed and those not exposed – a cross sector analysis.

Desley Hegney, RN, PhD
Alice Lee Centre for Nursing Studies, The National University of Singapore and The University of Queensland, University of Queensland and Blue Care Research and Practice Development Centre, Queensland
Address: Block E3A, Level 3, Engineering Drive 1, Singapore 117574
Email: nurdgh@nus.edu.sg
Telephone: +65 65163109
Fax: + 65 67767135

Anthony Tuckett, RN, MA, PhD
The University of Queensland, University of Queensland and Blue Care Research and Practice Development Centre, Queensland 4064
Address: PO Box 1539 Milton BC Queensland 4064
Email: a.tuckett@uq.edu.au
Telephone: +61 7 3720 5405
Fax: + 61 7 3720 5332

Deborah Parker, RN, BA, MSocSci, PhD
The University of Queensland, University of Queensland and Blue Care Research and Practice Development Centre, Queensland 4064
Address: PO Box 1539 Milton BC Queensland 4064
Email: deborah.parker@uq.edu.au
Telephone: +61 7 3377 3310
Fax: + 61 7 3720 5332

Robert M Eley, BSc(Hons), MSc, PhD
The University of Southern Queensland, Centre for Rural and Remote Area Health, Queensland, Australia, Queensland 4350
Address: West Street Toowoomba Queensland 4350
Email: eleyr@usq.edu.au
Telephone: +61 4631 5477
Fax: +61 4631 5452

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Corresponding Author:
Desley Hegney, RN, PhD
Alice Lee Centre for Nursing Studies, The National University of Singapore and The University of Queensland, University of Queensland and Blue Care Research and Practice Development Centre, Queensland
Address: Block E3A, Level 3, Engineering Drive 1, Singapore 117574
Email: nurdgh@nus.edu.sg
Telephone: +65 65163109
Fax: + 65 67767135

ABSTRACT

Nurses are at high risk of incurring workplace violence during their working life. This paper reports the findings on a cross sectional, descriptive, self-report, postal survey in 2007. A stratified random sample of 3,000 of the 29,789 members of the Queensland Nurses Union employed in the public, private and aged care sectors resulted in 1192 responses (39.7%). This paper reports the differences: between those nurses who experienced workplace violence and those who did not; across employment sectors. The incidence of workplace violence is highest in public sector nursing. Patients/clients/residents were the major perpetrators of workplace violence and the existence of a workplace policy did not decrease levels of workplace violence. Nurses providing clinical care in the private and aged care sectors experienced more workplace violence than more senior nurses. While workplace violence was associated with high work stress, teamwork and a supportive workplace mitigated workplace violence. The perception of workplace safety was inversely related to workplace violence. With the exception of public sector nursing, nurses reported an inverse relationship with workplace violence and morale.

Keywords
Workplace violence, policy, nurses, safety, stress, teamwork

INTRODUCTION

In 2007, a study of members of the Queensland Nurses' Union (QNU) was undertaken to identify what factors impact upon nursing work in Queensland and how satisfied nurses were with their work. The participants were registered (RNs), enrolled nurses (ENs) and assistants in nursing (AINs). In Queensland, the work of registered and enrolled nurses is regulated by the Queensland Nursing Council. Assistants in nursing (also known as carers, personal care attendants) are unregulated providers of nursing care. The work of AINs and ENs is directly or indirectly supervised by RNs. Approximately 80% of ENs and RNs are members of the industrial union – the QNU. With no workforce numbers collected on AINs, the percentage of membership is unknown.

Study respondents were asked to indicate if they had experienced workplace violence (defined as: aggression and/or workplace harassment/bullying) within the last three months. Those indicating workplace violence were then asked five further questions: the source/s of the violence (clients/patients, visitors/relatives, other nurses, nursing management, other management, doctors, allied health professionals, others); if their workplace had a policy for dealing with aggressive behaviour of other staff (defined as nurses, management, doctors, allied health professionals) and, if answering 'yes' the adequacy of this policy (never or very seldom, seldom, sometimes, mostly, always or nearly always); if the workplace has a policy for dealing with aggressive behaviour of patients/clients/visitors and, if answering 'yes' the adequacy of this policy (never or very seldom, seldom, sometimes, mostly, always or nearly always).

In the current literature, workplace violence is describe within the parameters of physical or verbal assault or physical and non-physical violence.[1 2] The definition used for this study complies and is taken as physical or verbal violence which includes harassment.[3] The source of workplace violence is primarily from patients or their relatives [3-10] however, there is also a large proportion of workplace violence (known as horizontal violence) from other health care professionals, particularly nurses.[11-14]

There is debate about the actual incidence of workplace violence towards nurses. This debate exists because of under-reporting and lack of consistency in the definition of workplace violence. However, there is international agreement that nurses are at high risk of incurring workplace violence during their working life, regardless of the context in which they work.[15-20]

Employers are obliged to provide a safe place of work [15, 21, 22] and there have been attempts to address the issue of workplace violence. Various initiatives have come from government (legislation, zero tolerance policies), organisations (policies/procedures, environmental design, education of workers), and industrial bodies (zero tolerance).[11, 15, 17, 19, 20] Most programs, however, have focused on the individual rather than the climate of workplace violence (in the community as well as the organisation).[7, 9, 10, 12, 23] While large scale evaluations have not been carried out on the major initiatives to reduce workplace violence, research suggests that strategies such as organisation policies and procedures, the 'Zero Tolerance' policy and workplace training have been unsuccessful [8, 19, 21, 23-26] or have given the wrong message [5, 23, 25] and that rather than declining, reports of workplace violence have increased. This apparent increase in workplace violence reporting may be the result of a greater knowledge by workers of workplace violence and a decrease in under-reporting rather than an increase per se in workplace violence itself.[3, 23]

The consequences of workplace violence include physical (personal injury, physical health) and psychosocial outcomes (post traumatic stress disorder, anxiety, fear, helplessness, substance abuse, relationship problems, sick leave,) for the individual nurse [1, 4, 9-12, 14, 18, 24, 27-32] as well as costly implications (poor staff retention, property damage, poor attendance rates, workers compensation costs, decreased productivity) for employers of nurses. [1, 5, 12, 14, 18, 27, 33] Workplace violence and its outcomes also have an impact on the quality of care delivered to patients/clients/residents. [5, 16, 27, 31]

At a time of nursing shortages, considerable attention has focused on the effects of workplace violence on workforce recruitment and retention. [4, 14, 29, 32] Variables linked to lack of job satisfaction such as workload, poor skill mix, poor communication between staff, poor management support and low morale have all been found to impact the incidence of workplace violence. [2, 3, 14-16, 20, 29, 34] Further, nurses who find themselves short staffed, forced to rush care, increase the dissatisfaction of patients and their families on the care they receive so increasing the likelihood of workplace violence. [20] Compounding the issue is the lack of funding available for health care, thus increasing waiting times for services and increasing the frustration of patients and their relatives. This frustration is often then directed at the providers of health care (particularly nurses) [5, 10, 15, 30] who are often attempting to provide care in a financially strained environment.

The results of the analysis of workplace violence data from two similar studies (2001, 2004) into the incidence of workplace violence amongst Queensland nurses have been published previously. [3] This paper reports on the results of a similar study to those conducted in 2001 and 2004 [35, 36] that was undertaken in 2007 which asked the same questions about exposure to workplace violence and policies in place to deal with this. The focus of this paper, not reported previously, is the analysis of these 2007 data from the perspective of those nurses who reported experiencing workplace violence in the previous three months compared with those who did not. Similar to the previous studies, the data are also analysed according to the context of practice (in this case the sector of employment – public sector (acute hospitals and community nursing), private sector (acute hospitals and domicillary nursing) and aged care [public and private]).

METHOD

Aim of the study

The overall aim of the 2007 study was to ascertain the factors impacting nursing work and to compare the 2007 data with the data collected in 2001 and 2004. The results of this analysis would then inform the strategic planning of the QNU.

The specific aims of this paper are to ascertain if there are any differences between:

- Those nurses who report exposure to workplace violence compared to those who do not and to report on these differences; and
- To ascertain if these perceptions differ across employment sectors.
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Research design

This cross sectional study is a descriptive, self-report, postal survey of members of the QNU undertaken in October and November 2007.

Sample design

The study was stratified to enable determination of differences across the sectors of nursing. To achieve this goal data were gathered using a mail-out over three nursing sectors (public acute plus community; private acute, aged care [public and private]). There were 29,789 members in the QNU database in 2007. Of these, 69.5% were from the public sector, 15.9% from the private sector and 14.6% aged care. To ensure adequate levels of precision in estimating key measures a total of 3000 questionnaires were distributed to 1000 randomly selected nurses in each sector. There were 1192 responses constituting a response rate of 39.7%.

Survey Instrument

The questionnaire utilised in this study was almost identical to that used in 2001 and 2004 surveys of QNU members. Only minor changes were incorporated to the original questionnaires. Piloting of the instrument was unwarranted because the data collection process was unchanged from that used for the previous studies. The few items modified or added to were pre-tested by independent experts.

The questionnaire containing 75 questions was divided into eight sections – 'Your Current Employment, Your Working Hours, Your Responsibilities Outside Work, Your Professional Development, Perceptions of Work and Nursing Work, the Nursing Work Index, About You and, You and Nursing Work'. The 12 questions reported herein fell in the sections on Your Working Conditions and Perceptions of Work and Nursing Work. Answers to the questions were categorical nominal (yes or no; n=3), continuous interval from Never to Always (n = 2) or continuous interval from Extremely True to Extremely False (n = 6). A free choice of offered options was available for one question.

Procedure

The researchers were provided with coded listing of QNU members. From these, using random numbers, 1000 participants were selected from each of the three sectors, resulting in a total sample of 3000. The survey, along with a Plain Language Statement and Reply Paid envelope was mailed to these participants by the QNU. Three weeks after the first mail out, a reminder was sent to non-respondents. The research team had no access to names or

addresses of the membership. The participants were provided with a reply paid envelope in which to return the questionnaire directly to the research team. At no time has the QNU access to any identifiable data. Data on completed questionnaires were scanned into the software program Verity TeleForm (v9.0 Verity Inc, Sunnyvale, CA, USA) and exported after clearing into SPSS.

Data Analysis

Analyses were undertaken using SPSS Version 15. 5. Data are nominal and non parametric and comparisons were undertaken on an item-by-item basis. Comparisons were undertaken within and across sectors by cross tabulations. Differences assessed by chi-squared testing with an alpha level of 0.05 required for significance.

Limitations of the study

The results reported in this paper apply to nurses who were financial member of the QNU in October and November 2007. Non-response bias was a potential limitation to the study. Checks where made against the QNU database regarding the distributions of sector of employment, sex, age and job designation. No differences were determined for sex or age or job. However if QNU membership is taken into consideration, a limitation of this sampling method is under-representation of nurses in the public sector while there is an over-representation of nurses from the private and aged care sectors.

Ethics

The study was approved by the Human Research and Ethics Committees of the University of Queensland, Brisbane and the University of Southern Queensland, Toowoomba, Australia.

RESULTS

Levels of workplace violence

Respondents were asked if they had experienced workplace violence in the last three months. Of the 1143 respondents to this question 522 (45.7%) indicated "yes". There are significant sector effects with less violence experienced in the private acute 35.8% of 360 respondents than in the public acute (53.4%, n=309) and aged care (49.7%; n = 348) sectors (χ^2 = 23.723, df =2, p<.001).

Sources of workplace violence

Those who said "yes" to the previous question were asked to identify the perpetrators of the violence from a list (Table 1). Respondents could identify more than one perpetrator. Clients/patients/residents were the greatest source of violence. There were highly significant effects across sectors in sources of that violence. "Clients/patients/residents", "other management", "visitors/relatives" and "other nurses" were less likely to be the source of workplace violence in the private sector and "doctors" the least in the aged care sector.

Demographics and workplace violence experience

There were no significant differences in reported workplace violence with nurses' sex (χ^2 = .571, df = 1, p = .45) or age (χ^2 = 7.987, df=5, p=.157). Nor was their any difference associated with job level (AIN, EN, RN) in public employment (χ^2 =16.840, df = 11, p = .113). However, there were statistically significant differences with the level of nurse in private employment (χ^2 =16.297, df = 8, p=.039) with those nurses employed as AINs and ENs more likely to report experiencing workplace violence than any level of RN. These results were the same for the public acute and private acute sectors. There were insufficient numbers of aged care nurses throughout the job range in public employment for analysis, however comparison of AIN with RN1 in the private aged care indicated that AIN were more likely to report violence than RN1 (57.4%, n = 66 versus 43.2%, n = 32) (χ^2 =3.610, df = 1, p=.057

Knowledge of workplace policy and adequacy of this policy for workplace violence from other staff

There was no difference in the known existence of a policy for managing workplace violence by staff between those that said that they had experienced workplace violence (83.3%) and those that had not (86.0%, χ^2 = 1.881, df =2, p=.390). Nor was there any sector effect (χ^2 = 4.551, df = 4, p = .337). However, within sectors there was a significant effect with 8.9% fewer aged care nurses who had experienced violence knowing if there was a policy in place and 6% more not knowing if there was a policy than among the aged care nurses who have not experienced violence (Table 2).

Table 2 here

Of those who did experience workplace violence 39.3% stated that their workplace policy for violence from other staff was "never, very seldom or seldom" adequate. This compared to 7.2% of those who didn't experience violence. There were no differences among sectors (χ^2 = 12.542, df = 10, p=.250), however, within all sectors there were large differences between those who answered "yes" and "no". The perceived adequacy of policy by those who had experienced workplace violence was much smaller (Table 3).

Table 3 here

Workplace policy and the adequacy of this for workplace violence by patients/clients/residents

Similar results were seen for the existence of workplace violence policy by clients/ patients/ residents/ visitors. Overall there was no difference between those who did and didn't experience violence (χ^2 = 1.487, df 2, p=.475) nor sector effect for those that did experience violence (χ^2 = 8.947, df = 4, p=.062). Within sectors there was a difference for aged care (χ^2 = 9.697, df = 2, p = .008) but not for the public (χ^2 = 8.080, df = 2, p=.018) or private (χ^2 = 1.131, df = 2, p = .568) acute sectors. In aged care only 74.7% of nurses who reported this source of violence knew of a policy compared to 86.6% of those who reported no violence.

Among all nurses there were sectors differences in the perceptions of the adequacy of the policy for violence perpetrated by patients/clients/residents/families (χ^2 = 52.745, df =10, p<.001). The main effect was in the private acute sector where respondents perceived that policies were more adequate. However, when only those who experienced violence were compared there were no sector differences (χ^2 = 9.703, df = 10, p = .467) and 29.2% of this cohort stated that policy was "never, very seldom or seldom" adequate compared to 8.5% for

those who didn't experience violence. Within each sector there were significant effects with the adequacy of the policy being perceived to be far less in those who had experienced violence (see Table 4).

Table 4 here

Further analysis of perceptions of nursing and nursing work was undertaken comparing responses of nurses who had and had not experienced violence in the past three months both across and within sectors.

Nursing work is emotionally challenging

There were no sector differences (χ^2 = 9.618, df = 10, p = .475) among the "yes" cohort of nurses where 81.2% said the job was "extremely" or "quite" emotionally challenging. This figure compared to 67.9% for those nurse who reported no experienced violence. Among these "no" respondents there were sectors differences (χ^2 28.764, df 12, p = .004) with 77.1% of the aged case sector considering the job to be emotionally challenging compared to 63.9% and 63.5% for the public and private acute sectors, respectively. Within sectors there were also highly significant differences between "yes" and "no" respondents for both acute sectors (Table 5).

Table 5 here

Work stress is high

Over 80% of the "yes" cohort considered work stress to be "extremely" or "quite" high compared to 65% in the "no" group. Across sectors there were differences in both the "yes" (χ^2 = 23.663, df = 12, p = .023) and "no" group (χ^2 = 39.918, df 12, p<.001) with aged care sector respondents perceiving the highest levels of work stress in both instances. Within each sector the perceived stress was significantly higher among those who said "yes". (Table 6)

Table 6 here

Workplace lacks teamwork and support from colleagues.

There were no sector differences (χ^2 = 12.885, df = 12, p = .377) in perception of teamwork and support for "yes" respondents and overall 32% of these nurses thought that teamwork was extremely or quite lacking. Among those nurses who said "no" to violence the

equivalent figure was 15.6%. However in this “no” group there with highly significant sector difference (χ^2 = 40.732, df 12, p<.001) with more aged care sector nurses agreeing with the statement compared to the acute sectors Within sectors there were significant effects between “yes” and “no” respondents in the private acute and aged care sectors with the teamwork perceived to be more lacking among the nurses who had experienced work place violence (public acute χ^2 = 10.828, df = 6, p = .094, private acute χ^2 = 31.543 df = 6, p < .001, aged care χ^2 = 19.295, df = 6, p = .004).

Workplace is safe

Among nurses who had experienced violence only 43% considered their workplace to be extremely safe or quite safe. There were no sector differences (χ^2 = 25.329, df = 12, p = .013) in this group with the public sector nurses considering their work sector to be less safe than the two other sectors. Among nurses who had not experienced workplace violence 63.2% thought it to be extremely safe or quite safe and there were sectors differences (χ^2 = 27.466, df 12, p=.007) with the lowest perception of safely also in the public acute sector. Within sectors both the public acute and aged care sectors showed differences in perceptions between the “yes” and “no” groups (Table 7)

Table 7 here

Nursing staff morale.

Among nurses who had experienced violence only 10.3% considered nursing staff morale to be extremely or quite good (Table 8). There were sector differences (χ^2 = 25.651, df = 12, p < .012) with public sector nurses considering their workplace morale to be the highest. In comparison 30.2% of nurses who had not experienced violence considered morale to be “extremely” or “quite” good and there were no differences among sectors (χ^2 = 17.509, df = 12, p < .131). Highly significant effects were found within each sector in morale. Those who had experienced workplace violence were more likely to consider morale to be poorer than those and had not (public acute χ^2 = 30.784, df = 6, p < .001, private acute χ^2 = 38.245 df = 6, p < .001, aged care χ^2 = 34.085, df = 6, p < .001).

Table 8 here

Morale is improving or deteriorating

Among nurses who had experienced workplace violence 50% considered staff morale to be deteriorating "extremely" or "slightly (Table 9) and more aged care nurses noted "extreme" deterioration (χ^2 = 24.521, df = 12, p < .017). In contrast among nurses who had not experienced workplace violence only 28.6% considered morale to be deteriorating "extremely" or "quite". However, there was also a significant effect for the "no" cohort (χ^2 = 30.183, df = 12, p=.003) with the largest perceived deterioration in the aged care sector.

Table 9 here

Within sectors there were significant differences between those who had and had not experienced violence (public acuteχ^2 = 17.317, df = 6, p = . 008; private acute χ^2 = 36.665, df = 6, p < .001; aged care χ^2 = 26.560, df = 6, p < .001). In each case those who had experienced violence considered the morale to be deteriorating more than those who had not.

DISCUSSION

Levels and sources of workplace violence

While nursing is recognised as a high risk occupation, the international data do not provide a consistent view of the incidence of workplace violence among nurses because no one study has used a consistent definition of workplace violence. Where there have been attempts to quantify the extent of workplace violence among nurses it appears that the incidence of workplace violence is rising [3, 37]. There are many causes postulated for this increasing level of workplace violence including:

a) The focus on workplace violence (for example the 'Zero Tolerance policy) has raised the awareness of nurses and they are more likely to report workplace violence.[3, 37] However, elsewhere nurses continue to under-report workplace violence. [6, 13, 17, 32, 34]. The main cause of under-reporting violence nurses receive from patients/clients/residents, is accepting it as normal in their nursing work [6, 26, 29, 34]. Other reasons for under-reporting incidences of workplace violence include: poor or unknown reporting mechanisms [17, 34]; fear of reprisals by senior management [6, 34]; lack of time or unwillingness to complete the necessary paperwork [6, 17]; a belief that

no action will be taken [17, 25]; an increase in victimisation from bullies within the workplace (particularly if they are subject to horizontal violence) [11, 17, 25]; and their gender (male). [38]

b) The society in which we live has increasingly become more violent and/or more tolerant of violence.[23]

c) Within many workplaces there is a climate which encourages workplace violence.[7, 9, 11]

The results of the 2007 study show a lower incidence of workplace violence than a previous Australian study [20]. Furthermore, the data do indicate that there is no net increase in workplace violence in the members of the Queensland Nurses Union who have responded to this survey in 2001, 2004 and 2007. Rather, it appears that levels of workplace violence have decreased from a higher level in 2004. However the results clearly show that the levels of violence are still high and require greater attention. While the 2007 findings appear to be inconsistent with reports of rising incidents of workplace violence internationally, the international increase could be the result of other factors (as aforementioned) rather than an actual increase in violence.

Similar to many previous studies into the sources of workplace violence, the major source of workplace violence was from patients/clients/residents. [3, 5-8, 18, 22, 24, 30-33, 39]

Policies for the control of workplace violence from other staff and patients/relatives

The majority of the respondents here noted a policy in place to prevent and/or manage workplace violence from other staff and/or from patients/relatives. This is consistent with international best practice which suggests workplaces should have policy for the prevention and management of workplace violence. [15, 17, 30] It is therefore consistent that those respondents who had experienced workplace violence within the last three months were more likely to believe that their workplace policy was ineffective.

Of interest is the finding that awareness of policy did not differ between those who had and had not experienced workplace violence. This suggests that policies do exist and it is not the absence of policy that is a causal factor to violence. This conclusion is inconsistent with

previous statements which have linked the presence of policies with decreased levels of workplace violence and lower levels of reporting. [8, 11, 19, 24]

A major finding here is that in the public sector, with its single overarching corporate policy, the incidence of workplace violence is highest. This finding suggests that it may not be the presence or absence of a policy on workplace violence which decreases workplace violence. Rather, it is the local work climate (or context) in which the policy is put into place which has a greater effect. [11] Many contend that the existence of a policy is insufficient and that there needs to be a multi-focal approach to successfully address workplace violence. [5, 6, 19, 22]

Demographics of nurses and workplace violence

While there has been a focus on organisational initiatives, there is also a large body of work that links the individual characteristics of nurses (e.g. age, experience in nursing, gender, personality traits) to their level of experienced workplace violence. [2, 20, 22, 29, 31] This study reported here did not measure the personality traits of nurses and analysis of the demographic data of the participants did not find any significant association between gender, age of the nurse, experience of the nurse and their reports of workplace violence. [24, 31, 33] Findings on the job level of nurses were inconsistent between the sectors, with no difference in experience of workplace violence and level of nurse in the public sector. However, in the private and aged care sectors, those nurses who provide the most clinical care (RN level 1, ENs and AINs) experienced more workplace violence than more senior RNs.[3]

The emotionally challenging nature of nursing work and work stress

Similar to our previous studies, this study found that nurses perceive nursing work to be emotionally challenging.[40] The findings also suggest that those nurses who find nursing most emotionally challenging are more likely to report higher levels of workplace violence. Similarly, those nurses who reported high levels of work stress were also those who reported workplace violence. While there have been no studies which have linked perceptions of the emotionally challenging nature of nursing work to workplace violence, there have been previous studies which have linked work stress and workplace violence. [10, 12, 22] However, it

is unclear if the work stress is created by the workplace violence or if the high level of stress is caused by other factors (such as insufficient staff, high workload) and that this stress then increases the incidence of workplace violence. [4, 6, 10, 12, 14] Regardless, those environments with greater levels of work stress also experience greater levels of workplace violence.

Teamwork and support within the workplace

A supportive team within the workplace has been found to mitigate workplace violence. [14, 23] Similarly, working within a team which is unsupportive and where the nurse may experience harassment and bullying has been associated with high levels of workplace violence. [14, 29] This study has found that nurses who perceive high levels of teamwork and support within their workplace are less likely to have experienced workplace violence.

Safety of the Workplace

The findings of the 2007 study reflect those of our previous study and Spector et al's study which found the perceived degree of workplace safety was inversely related to the incidence of reported workplace violence. [3, 9] Additionally, the public sector nurses (who experienced the highest level of violence) were more likely to believe their workplace was unsafe. This finding has also been noted by other authors who believe that those nurses who perceive the workplace to be unsafe are more likely to have experienced workplace violence. [2, 22, 30, 39]

Morale

Nurses in this study who experienced workplace violence were more likely to believe that morale was low and decreasing. The effect of workplace violence on morale has previously been identified. [4, 11, 16, 27] These researchers linked low morale to the experience of workplace violence. However here, public sector nurses (who had the highest levels of workplace violence) had the highest perceptions of workplace morale.

Arguably, whether the incidence is one percent or seventy percent, the long-term consequences for the individual, the profession and the employer are well documented and supported by the findings of this study. [15, 29] The personal costs are demonstrated by the high levels of levels of workplace stress, the lack of feeling supported and/or being a member of a team, perceptions of an unsafe workplace and lower perceptions of morale within the workplace.

The impact of workplace violence on the profession of nursing is large. Previous studies have shown that exposure to workplace violence can influence how a student would perceive their future career. [4, 13] The aforementioned factors also impact on the profession if both experienced and inexperienced nurses continue to exit the profession because employers do not provide a physical and emotional safe place in which to work. [18]

The context of practice

The higher level of workplace violence from patients/families in this study in the public sector is consistent with the view that 'state government workplaces are more likely to experience workplace violence from patients/families'.[7] Elsewhere in Australia and here, nurses in private hospitals were less likely to be exposed to workplace violence than nurses in the public sector. [20] However, it is apparent that there are differences in the incidence of workplace violence *within* a sector. For example, not all nurses working for the state government (public sector) believed policies were effective despite working under the same policy. This would reflect local differences impacting on the implementation of the policy. Peek-Asa and colleagues found when evaluating the implementation of a standard policy across workplaces that implementation differed (i.e. larger hospitals were more likely to have implemented more aspects of the policy than smaller hospitals). [8] Similar to our previous studies, these data highlight the challenges of nurses employed in the aged care sector. Data revealed regardless of exposure to workplace violence, nurses in the aged care sector are more likely to highlight the emotional challenges of this work and continue to perceive morale to be deteriorating. In these cases, exposure to high levels of workplace violence merely exacerbates job dissatisfaction. [40]

From an organisational perspective, this study clearly shows the impact of the local context on the reported exposure to nurses to workplace violence. It appears that nurses employed in the public sector, the majority of which perceive their policies to be adequate, have a greater exposure to workplace violence than nurses in the other sectors. Employers must continue to focus on prevention and management at the local level. A 'one size fits all' policy which may not take into consideration local nuisances is insufficient to address this major workplace issue. Results suggest that workplace violence impacts on factors which influence job satisfaction and therefore while workplace violence factors remain unaddressed there will continue to be unnecessary attrition from the nursing workforce. [41]

CONCLUSION

This study reveals that there was no net increase in workplace violence in the members of the Queensland Nurses Union (Australia) who responded to a self-port postal survey in 2001, 2004 and 2007. Rather, it appears that levels of workplace violence in fact decreased from a higher level in 2004. Nevertheless, results clearly suggest that the levels of violence are still high and require greater attention. Exposure to workplace violence has implications for individual nurses, the profession and the employer. Although the data demonstrate consistencies and inconsistencies with other studies and do not provide any clearer picture on the incidence of workplace violence among the nursing workforce, a caveat is required: a focus on measuring accurately the incidence risks taking away from the need to control the problem.

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Table 1 Sources of workplace violence by sector

	Public acute	**Private acute**	**Aged care**
Number of nurses	**144**	**231**	**175**
Number of perpetrators	**313**	**365**	**355**
Identity of perpetrators	Percentage of responses		
Clients/patients/residents**	35.5%	20.0%	36.3%
Other nurses*	21.4%	14.2%	21.7%
Visitors/relatives**	24.3%	11.8%	17.7%
Nursing management	14.1%	10.7%	15.2%
Doctors**	10.9%	12.6%	2.0%
Other staff	4.5%	2.2%	8.7%
Other management*	2.2%	.5%	4.5%
Allied health professionals	2.2%	.8%	.3%
Other	1.0%	.5%	.6%

* p<.01, ** p< .001

Table 2 Workplace policy for violence by other staff: sector analysis

		Sector					
Existence of Policy		**Public**		**Private**		**Aged care**	
		No	**Yes**	**No**	**Yes**	**No**	**Yes**
No policy	Count	3	11	7	2	2	7
	% within	2.2%	7.1%	3.1%	1.6%	1.2%	4.1%
Yes, policy	Count	114	125	188	107	160	143
	% within	82.0%	80.6%	83.2%	85.6%	93.0%	84.1%
Don't know	Count	22	19	31	16	10	20
	% within	15.8%	12.3%	13.7%	12.8%	5.8%	11.8%
Total	Count	139	155	226	125	172	170
	% within	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		χ^2 = 4.440, df = 2, p=.109		χ^2 =.810, df = 2, p = .667		χ^2 = 7.053, df = 2, p = .029	

Table 3 Perceptions of the adequacy of the workplace policy by previous exposure of violence (YES) or no violence (NO) in the last three months: by sector.

Adequacy of Policy		Public		Private		Aged Care	
		No	Yes	No	Yes	No	Yes
Never/ Very seldom	Count	3	30	2	22	5	29
	% within	2.7%	23.3%	1.1%	20.8%	3.2%	19.9%
Seldom	Count	5	27	9	20	8	22
	% within	4.4%	20.9%	4.7%	18.9%	5.1%	15.1%
Sometimes	Count	27	31	27	24	26	51
	% within	23.9%	24.0%	14.2%	22.6%	16.6%	34.9%
Mostly	Count	45	20	64	24	70	26
	% within	39.8%	15.5%	33.7%	22.6%	44.6%	17.8%
Always	Count	13	6	33	2	36	9
	% within	11.5%	4.7%	17.4%	1.9%	22.9%	6.2%
Don't know	Count	20	15	55	14	12	9
	% within	17.7%	11.6%	28.9%	13.2%	7.6%	6.2%
Total	Count	113	129	190	106	157	146
	% within	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		$\chi^2 = 49.559$, df = 5, $p < .001$		$\chi^2 = 73.063$, df = 5 $p < .001$		$\chi^2 = 68.077$, df = 5, $p < .001$	

Table 4 Adequacy of the policy for control of workplace violence from patients/clients/residents/families by sector and by previous exposure of violence (YES) or no violence (NO) in the last three months.

Adequacy of Policy		Public		Private		Aged Care	
		No	Yes	No	Yes	No	Yes
Never/Very seldom	Count	3	15	1	10	5	17
	% within	2.7%	11.6%	.6%	11.4%	3.4%	12.4%
Seldom	Count	4	22	11	14	12	25
	% within	3.6%	17.1%	6.5%	15.9%	8.1%	18.2%
Sometimes	Count	36	33	19	27	31	49
	% within	32.1%	25.6%	11.2%	30.7%	20.8%	35.8%
Mostly	Count	41	34	57	21	64	32
	% within	36.6%	26.4%	33.7%	23.9%	43.0%	23.4%
Always	Count	14	11	40	6	32	10
	% within	12.5%	8.5%	23.7%	6.8%	21.5%	7.3%
Don't know	Count	14	14	41	10	5	4
	% within	12.5%	10.9%	24.3%	11.4%	3.4%	2.9%
Total	Count	112	129	169	88	149	137
	% within	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		$\chi^2 = 20.508$, df = 5, $p = .001$		$\chi^2 = 49.047$, df = 5, $p < 001$		$\chi^2 = 37.026$, df = 5, $p < .001$	

Table 5 Nursing work is emotionally challenging: by exposure to workplace violence by sector and by previous exposure of violence (YES) or no violence (NO) in the last three months.

Workplace challenging		**Public**		**Private**		**Aged Care**	
		No	**Yes**	**No**	**Yes**	**No**	**Yes**
Extremely	Count	29	54	40	36	51	69
	% within	21.2%	35.5%	18.0%	29.8%	30.5%	40.8%
Quite	Count	59	71	100	63	77	69
	% within	43.1%	46.7%	45.0%	52.1%	46.1%	40.8%
Slightly	Count	35	20	49	19	30	25
	% within	25.5%	13.2%	22.1%	15.7%	18.0%	14.8%
Neither	Count	2	3	15	1	2	1
	% within	1.5%	2.0%	6.8%	.8%	1.2%	.6%
Slightly	Count	8	1	9	0	1	2
	% within	5.8%	.7%	4.1%	.0%	.6%	1.2%
Quite	Count	4	3	8	2	4	3
	% within	2.9%	2.0%	3.6%	1.7%	2.4%	1.8%
Extremely	Count	0	0	1	0	2	0
	% within	.0%	.0%	.5%	.0%	1.2%	.0%
Total	Count	139	152	222	121	169	170
	% within	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Workplace unchallenging		χ^2 = 17.785, df = 5, p = .003		χ^2 = 19.659 df = 6, p = .003		χ^2 = 6.391, df = 6, p = .381	

Table 6 Perceptions of work stress by sector and by previous exposure of violence (YES) or no violence (NO) in the last three months

Work stress is high		**Public**		**Private**		**Aged**	
		No	**Yes**	**No**	**Yes**	**No**	**Yes**
Extremely	Count	30	62	54	56	78	94
	% within	21.6%	40.8%	24.3%	46.7%	45.9%	55.3%
Quite	Count	51	57	83	42	55	52
	% within	36.7%	37.5%	37.4%	35.0%	32.4%	30.6%
Slightly	Count	43	27	57	19	29	15
	% within	30.9%	17.8%	25.7%	15.8%	17.1%	8.8%
Neither	Count	7	4	13	1	2	4
	% within	5.0%	2.6%	5.9%	.8%	1.2%	2.4%
Slightly	Count	3	2	9	0	4	0
	% within	2.2%	1.3%	4.1%	.0%	2.4%	.0%
Quite	Count	5	0	4	2	2	3
	% within	3.6%	.0%	1.8%	1.7%	1.2%	1.8%
Extremely	Count	0	0	2	0	0	2
	% within	0	0	.9%	.0%	.0%	1.2%
Total	Count	139	152	222	121	169	170
	% within	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Work stress is low		$\chi2$ = 20.599, df = 5, $p < .001$		$\chi2$ = 26.360 df = 6, $p < .001$		χ^2 = 12.894, df = 6, p = .045	

Table 7 Perceptions of safety of the workplace by sector and by previous exposure of violence (YES) or no violence (NO) in the last three months

Workplace is safe		**Public**		**Private**		**aged**	
		No	**Yes**	**No**	**Yes**	**No**	**Yes**
Extremely	Count	8	1	34	9	38	18
	% within	5.8%	.7%	15.3%	7.4%	22.8%	10.7%
Quite	Count	65	50	103	48	86	66
	% within	46.8%	32.9%	46.4%	39.7%	51.5%	39.1%
Slightly	Count	25	28	29	21	15	23
	% within	18.0%	18.4%	13.1%	17.4%	9.0%	13.6%
Neither	Count	13	17	18	10	11	22
	% within	9.4%	11.2%	8.1%	8.3%	6.6%	13.0%
Slightly	Count	14	24	20	12	7	18
	% within	10.1%	15.8%	9.0%	9.9%	4.2%	10.7%
Quite	Count	12	21	14	15	10	14
	% within	8.6%	13.8%	6.3%	12.4%	6.0%	8.3%
Extremely	Count	2	11	4	6	0	8
	% within	1.4%	7.2%	1.8%	5.0%	.0%	4.7%
Total	Count	139	152	222	121	169	170
	% within	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		χ^2 = 18.878, df = 6, p = .004		χ^2 = 11.856 df = 6, p = .065		χ^2 = 28.621, df = 6, p < .001	
Workplace is unsafe							

Table 8 Perceptions of the morale of the workplace among nurses who had experienced violence in the previous three months: sector analysis

Staff morale is good		Type of workplace			Total
		Public	Private	Aged Care	
Extremely	Count	2	2	1	5
	% within workplace	1.2%	1.6%	.6%	1.1%
Quite	Count	12	13	17	42
	% within workplace	7.4%	10.4%	9.9%	9.2%
Slightly	Count	41	18	25	84
	% within workplace	25.3%	14.4%	14.5%	18.3%
Neither	Count	7	11	12	30
	% within workplace	4.3%	8.8%	7.0%	6.5%
Slightly	Count	33	17	15	65
	% within workplace	20.4%	13.6%	8.7%	14.2%
Quite	Count	34	36	47	117
	% within workplace	21.0%	28.8%	27.3%	25.5%
Extremely	Count	33	28	55	116
	% within workplace	20.4%	22.4%	32.0%	25.3%
Total	Count	162	125	172	459
	% within workplace	100.0%	100.0%	100.0%	100.0%
Staff morale is poor					

Table 9 Perceptions of the movement of morale in the workplace among nurses who had experienced violence in the previous three months: sector analysis

		Type of workplace			Total
Staff morale deteriorating		Public	Private	Aged Care	
Extremely	Count	29	29	56	114
	% within workplace	17.9%	23.2%	32.6%	24.8%
Quite	Count	36	35	47	118
	% within workplace	22.2%	28.0%	27.3%	25.7%
Slightly	Count	42	28	21	91
	% within workplace	25.9%	22.4%	12.2%	19.8%
Neither	Count	19	7	19	45
	% within workplace	11.7%	5.6%	11.0%	9.8%
Slightly	Count	11	12	11	34
	% within workplace	6.8%	9.6%	6.4%	7.4%
Quite	Count	19	9	11	39
	% within workplace	11.7%	7.2%	6.4%	8.5%
Extremely	Count	6	5	7	18
	% within workplace	3.7%	4.0%	4.1%	3.9%
Total	Count	162	125	172	459
	% within workplace	100.0%	100.0%	100.0%	100.0%
Staff morale improving					