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Australian nurses' perceptions about workplace violence management, strategies and support services

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Abstract

Aims: This study ascertained nurses' perceptions about workplace violence management, strategies and support services.

Background: Nurses regularly encounter verbal and physical violence in their workplace. Workplace violence has long-term consequences on nurses' personal lives and professional work ability. However, more needs to be known about nurses' perceptions of violence management and interventions used.

Methods: Ninety-eight nurses from a regional public hospital in Queensland, Australia, completed a survey about workplace violence. Nurses worked in the Emergency Department, Intensive Care Unit or Mental Health Department.

Results: Ninety-five per cent of nurses stated that all violence should be reported, but 18% would take no action, and 22% would not complete an incident from. Perceptions and preferred responses differed for verbal and physical violence. Low-level interventions and aggression management training were preferred by nurses. Nearly all nurses felt that they should be involved in the development of workplace violence policies.

Conclusions: Nurses rate aggression management training highly, and they desire more input into violence policies. The under-reporting of violent incidents remains an issue for future management.

Implications for nursing management: Understanding nurses' perceptions of workplace violence management enables the identification of gaps when applying policy and adopting practical approaches to reduce the incidence and severity of workplace violence.

KEYWORDS
Australia, nursing, organization and administration, supervisory, workplace violence

1 | BACKGROUND

Nurses experience workplace violence on a regular basis (Farrell et al., 2006; Hodge & Marshall, 2007; Lyneham, 2000; Pich et al., 2011). The WHO (2021) states that up to 38% will experience physical violence and many more will face verbal aggression, which leads to 'immense financial loss in the health sector'. Workplace violence has long-term consequences on nurses' personal lives and professional work abilities. Workplace violence can change a nurse from being a health care provider to a health care patient (Rosen, 2013).

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The professional consequences of workplace violence include a decrease in a nurse's ability to offer effective patient care and an increased risk of making errors (Farrell et al., 2006; Gacki-Smith et al., 2009; Henderson, 2003; Hodge & Marshall, 2007; Hutchinson et al., 2013; Jackson et al., 2002; Jones & Lyneham, 2001). Violence leads to the loss of experienced nurses from the workforce and difficulty in attracting nurses into the health care system (Rosen, 2013).

1.1 | Definition of workplace violence

In this study, workplace violence refers to verbal and physical violence towards nurses, which is a Customer/Client (Type II) violence category according to the Injury Prevention Research Center (2001), where the perpetrator has a legitimate relationship with the business and becomes violent while being served by the company. This is also known as 'vertical violence' in the literature. Violence and aggression are defined as any incident that puts a health care worker at risk, and includes verbal and physical abuse, threatening behaviour, assault by a patient, family member, friend, or member of the public or any type of behaviour that may cause health care workers to fear for their safety (Ayranci, 2005). This study focuses specifically on vertical violence because it is the most prevalent type of workplace violence in health care settings (Alexy & Hutchins, 2006). Vertical violence occurs between care recipients and health professionals, while horizontal or lateral violence occurs between health care professionals.

1.2 | Violence towards nurses in Australia

Nationally, the fourth highest amount of work-related harassment and bullying is found among 'health and welfare support' professions, resulting in at least 60 worker compensation claims per 100 million hours worked (Safe Work Australia, 2021). This costs at least $10,600 per claim and averages 7.7 weeks absence from work. Importantly, these figures count only the officially processed work cover claims, and not the many incidents which do not make it to either the reporting or compensation stage. Pich and Roche (2020) conducted a large study ($n = 3{,}416$) in the state of New South Wales which revealed that nearly half of nurses and midwives experienced violence from patients and visitors in the previous week and more than 75% of respondents had experienced some form of violence in the previous 6 months—sometimes up to 20 episodes of violence in half a year.

In Queensland, where this study is situated, a few publications have reported on workplace violence in the Emergency Department (Cabilan et al., 2021; Partridge & Affleck, 2017) or differences between sectors of employment (public, private and aged care), although not in fine detail about differences in violence incidence between wards (Hegney et al., 2003, 2006, 2010). Dafny and Beccaria (2020) found that vertical violence seems to be increasing, with nurses reporting frequent incidents of verbal and physical violence, sometimes on a daily basis.

1.3 | The research gaps

While violence against nurses has been established in the literature, two important gaps are addressed by this study: First, there is minimal research on workplace violence in regional hospitals towards nurses in Australia, and second, there needs to be more consideration of nurses' perceptions on workplace violence management.

1.4 | Workplace management strategies to address violence

Several management strategies have been used to address workplace violence towards nurses. The main interventions for managing aggressive behaviours in acute care settings include staff training programmes that aim to promote communication skills and the use of de-escalation techniques (Dafny & Muller, 2021; Ramacciati, Ceccagnoli, Addey, Lumini, et al., 2016; Small et al., 2020) so nurses can respond to unpredictable environments and implement immediate interventions for their safety. Khan et al. (2021) suggested that staff training should be more interactive, practical and less theoretical and include real-life scenarios. Behaviour management training and de-escalation techniques can mitigate a violence incident (de la Fuente et al., 2019) if used when the patient is in the pre-assaultive phase (Small et al., 2020). Furthermore, Khan et al. (2021) suggested that de-escalation techniques significantly improved overall staff satisfaction and confidence in coping with violent patients. Similarly, de la Fuente et al. (2019) found that behaviour management training improves the nurses' confidence in dealing with aggressive patients.

Early interventions such as sedation or chemical restraints (Cabilan et al., 2020; Dafny & Muller, 2021) and mechanical restraints (Kynoch et al., 2011) can also improve the management of violent incidents, in addition to the presence of security guards (Ramacciati, Ceccagnoli, Addey, Lumini, et al., 2016), alarms, CCTV monitoring, safe refuges and access controls (Queensland Health, 2016). Identified challenges to workplace violence management include poor resourcing for training and inconsistent training models (Queensland Health, 2016). Strategies that address the risk of workplace violence include improving reporting procedures (to be more user-friendly), providing alternatives for staff support and encouraging cultural change that reduces tolerance towards workplace violence across the institution (Queensland Health, 2016). Furthermore, it has been found that when staff have autonomy and ownership of management programmes, they are more likely to be engaged with them (Tillott, Walsh, & Moxham, 2013)—a principle which was picked up by Queensland Health (2016) and Salmon et al. (2021). Cabilan et al. (2020) found that nurses were supportive of, and engaged with, a violence risk assessment tool that could trigger an alert system and enable them to manage workplace violence effectively. Safety committees and advisory boards can assess safety issues and suggest interventions to prevent workplace violence (Small et al., 2020). After a violent incident, nurses may attend a debriefing session that provides feedback on strategies to prevent future incidents in a

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supportive environment and may include follow-up support, including referral to a psychologist (Small et al., 2020).

1.5 | Purpose

This study sought to explore nurses' responses to violence in a regional workplace and their perception of the strategies and support mechanisms for managing workplace violence.

2 | METHODS

Violence towards nurses is a complex problem that involves differing individual experiences. However, the range of nurses' perceptions needs to be understood so that the problem can be adequately addressed.

2.1 | Study design

A mixed-method study was conducted, and data were collected using a questionnaire which consisted of both closed and open-ended questions. The items included 12 items regarding management of verbal and 12 items regarding the management of physical violence, and 30 items regarding strategies, support, workload and autonomy in the workplace (4 items regarding management strategies, 6 items regarding available services and 13 items regarding personal support services for nurses in the hospital, 4 items regarding workload and 3 regarding autonomy at work). In total, there were 54 items.

2.2 | Questionnaire development

A tailored survey instrument was created for this research. To do this, a pilot questionnaire was developed, which was then revised into the final survey questionnaire. The draft questionnaire was based upon the research questions and on a combination of relevant questions adopted from two survey questionnaires by the University of Southeren Queensland (2010) and International Labour Office (2003). All the survey questions were checked for face and content validity. Face validity is the extent to which a question seems to measure what it claims to measure, based on close reading and study of the question. Content validity is the extent to which a question reflects a specific domain of content, the body of knowledge or a particular set of tasks. Validity was continually assessed as a part of the process of developing the questions and creating multi-item scales. Items were referenced back to the core concepts being measured, and feedback sought from six research nurses who were knowledgeable in this topic. All the questions were checked for reliability and internal consistency through a pilot study with a sample of 13 nurses, who also checked that the questions were clearly worded. The final anonymous questionnaire was also checked for reliability and validity. Data were then collected, screened and analysed.

2.3 | Study setting

The location of the study was a regional public hospital: one of 12 Queensland public hospitals that contain an Emergency Department (ED), Intensive Care Unit (ICU) and Mental Health Department (MHD). The selection of this hospital allowed data to be gathered at one place and time in a single institution.

2.4 | Participants

Participants included enrolled nurses, registered nurses, clinical nurses, head nurses and nurse unit managers working in emergency, intensive care or mental health. The rationale for including clinical nurses and management, such as head nurses and nurse unit managers, in the target population for this survey was because all these nurses in Queensland are involved in direct patient care. The target population was 193 nurses, all of whom worked in these three departments. The total number of respondents was 98 nurses, and the total response rate was 50.78%. The 98 participants consisted of 26 nurses from the ED, 16 nurses from the ICU and 56 nurses from the MHD. The demographic profile of participants is provided in Table 1.

TABLE 1 Demographic profile of the nurses

Demographic profile	Number ($n = 98$)	Distribution
Age		
22–35 years	32	33%
36–50 years	41	43%
51–68 years	23	24%
Gender		
Male	37	38%
Female	61	62%
Level of education		
Diploma in nursing	8	8%
Bachelor's degree	59	60%
Master's degree	26	27%
Other: Associate degree, certificate of nursing	5	5%
Years of work experience		
1–5 years	24	25%
6–15 years	39	41%
16–43 years	33	34%

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2.5 | Data collection

The survey was distributed during a 4-week period between 28 October 2014 and 28 November 2014. Nurses participated in the survey by answering either an online survey or a printed survey. The printed surveys were returned to a secure box in each department. The survey contained three sections: (1) demographic data and workplace data (as seen in Table 1 above); (2) perceptions of nurses regarding verbal and physical violence and (3) support during verbal and physical violence incidences, available services, personal support services, workload and autonomy at work. The perceptions of the nurses were measured by using a Likert-type scale that ranged from 1 to 5, where 1 = *Strongly Disagree*, 2 = *Disagree*, 3 = *Neutral*, 4 = *Agree* and 5 = *Strongly Agree*.

2.6 | Data analysis

The quantitative data were analysed using the IBM SPSS Statistics version 21 software. The Likert-type questions were re-coded into three categories: *disagree* (1 or 2), *neutral* (3) and *agree* (4 or 5). Descriptive statistics were calculated and included frequency counts and percentages. Respondents were able to decline answering any question, so some items have fewer responses. The dataset was visually checked for missing data and random responding prior to analysis. There was no evidence of random responding, and a conservative tolerance of 5% missing data was set. All data remained under this tolerance level. Missing data were not pro-rated nor were included in analysis.

2.7 | Ethical approval

Ethical approval was obtained from the Human Research Ethics Committee of the Queensland Health Department (HREC/14/QTDD/6) and from the Human Research Ethics Committee of the University of Southern Queensland (H13REA249) prior the study being conducted.

3 | RESULTS

3.1 | Management of workplace violence

The survey contained 12 statements (Table 2) regarding the methods nurses use to manage aspects of verbal violence and physical violence in their workplace.

3.1.1 | Nurse management of verbal violence

Table 2 outlines the nurses' perceptions towards the management of violence. Few nurses agreed with the option of taking no action in response to a verbal abuse incident (18%, $n = 95$), and few wished they could transfer to another position (16%, 95). Low-level interventions were preferred, such as asking the person to stop (96%, $n = 97$) and taking to colleagues (90%, $n = 97$), over high-level or formal interventions, such as seeking counselling (56%, $n = 94$), completing a compensation claim (32%, $n = 95$) or pursuing prosecution (27%, $n = 93$). Thus, they otherwise expressed agreement with the majority of the statements about possible techniques for managing verbal violence such as asking the offender to stop, talking to friends/family for support, talking to a colleague for advice, seeking counselling, trying to defend themselves, completing an incident form, reporting to a senior staff member and reporting to hospital security.

3.1.2 | Nurse management of physical violence

Table 3 shows the nurses' agreement on how to manage physical violence. Nurses generally either supported or did not disagree with the listed management options when it came to physical violence. They

TABLE 2 Nurses' perceptions towards the management of verbal violence

Management of verbal violence	*n*	Agree	Neutral	Disagree
Ask the person to stop	97	96%	1%	3%
Talk to colleague for advice	97	90%	6%	4%
Report to a senior staff member	97	88%	6%	6%
Complete an incident form	96	78%	9%	14%
Talk to friends/family for support	95	77%	13%	11%
Try to defend themselves	95	70%	76%	6%
Report to hospital security	94	61%	20%	19%
Seek counseling	94	56%	27%	17%
Complete a compensation claim	95	32%	38%	31%
Pursue prosecution	93	27%	32%	42%
Take no action	95	18%	8%	74%
Transfer to another position	95	16%	38%	45%

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TABLE 3 Nurses' perceptions towards the management of physical violence

Management of physical violence	n	Agree (%)	Neutral (%)	Disagree (%)
Report to a senior staff member	97	95%	4%	1%
Ask the person to stop	97	93%	6%	1%
Talk to colleague for advice	97	93%	4%	3%
Complete an incident form	96	91%	6%	3%
Try to defend themselves	95	90%	8%	2%
Report to hospital security	94	84%	12%	4%
Talk to friends/family for support	95	80%	11%	10%
Seek counselling	94	68%	20%	12%
Complete a compensation claim	95	59%	25%	16%
Pursue prosecution	93	52%	27%	21%
Transfer to another position	95	23%	32%	45%
Take no action	95	6%	6%	88%

disagreed with taking no action (disagreement of 88%, $n = 95$) and transferring to another position (disagreement of 45%, $n = 93$). If the nurse was unable to verbally negotiate with the person, they indicated that they would then try to defend themselves (90%, $n = 97$) and call security (84%, $n = 94$). They also preferred to engage in a discussion about the incident with a colleague (93%, $n = 97$) and to complete an incident form (91%, $n = 96$). They were twice as likely to consider formal prosecution for physical violence over verbal violence (52% versus 27%, $n = 93$). The more formal options such as seeking counselling, completing a compensation claim and pursuing prosecution were rated lower than the more immediate options of talking with colleagues, senior staff and the violent person.

3.2 | General management strategies of workplace violence

The perceptions of nurses about general workplace management strategies were ascertained by responses on statements addressing:

- management strategies
- available services to nurses
- personal support services for nurses in hospital support
- workload in department
- autonomy at work

The survey contained 30 statements concerning these subthemes. Respondents' agreement and disagreement for each statement are presented in Table 4.

3.2.1 | Management strategies

Over half the nurses thought that the hospital should be involved in reporting violence to police (61%, $n = 95$), and most were aware of workplace violence policies (86%, $n = 97$) and believed every instance of violence should be reported (95%, $n = 97$). Nurses also expressed high agreement with the statement that the hospital should involve nurses in developing workplace violence policies (96%, $n = 97$).

3.2.2 | Available services for nurses

Nurses indicated that the hospital should provide consultation after an incident (94%, $n = 96$), that the hospital should allow use of medication to calm aggressive patients (90%, $n = 94$) and, to a lesser extent, that the hospital should allow the use of mechanical restraints (74%, $n = 96$). Nurses were in high agreement about the need for hospitals to be proactive in reducing violence by encouraging training on violence management (99%, $n = 96$) and allowing access to policies addressing workplace violence (99%, $n = 96$).

3.2.3 | Support services in hospital

Nurses were in high agreement that all hospital services should support nurses through opportunities for education and training to address violence (96–7%, $n = 96$), provide resources for resolving problems (95%, $n = 94$) and encourage new ideas to deal with violence (95%, $n = 95$). Nurses were in high agreement that clear guidance was needed on how to deal with violence (94%, $n = 94$), that nurses should work under safe conditions (97%, $n = 97$) and they should feel safe in their work environment (95%, $n = 94$). They also recognized that the needs of the department required consideration (96%, $n = 95$). High agreement was found for personal support services that allowed nurses to manage patient care adequately and effectively (95%, $n = 95$), to empower nurses to sharing information and feedback (93%, $n = 94$) and to receive support from colleagues and supervisors after an incident (94%, $n = 93$).

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TABLE 4 Nurses' perceptions towards management strategies, available services, support services, workload and autonomy in the workplace

Management strategies, available services, support services, workload, and autonomy	*n*	Agree (%)	Neutral (%)	Disagree (%)
Management strategies				
Hospital has workplace violence policies	97	86%	9%	5%
Hospital should involve nurses in developing workplace violence policies	97	96%	3%	1%
Nurses should report violence in each instance	97	95%	3%	2%
Hospital should report violence to police in each instance	95	61%	27%	12%
Available services to nurses				
Hospital should provide training on violence management	97	96%	2%	2%
Hospital should provide consultation after an incident	96	94%	5%	1%
Hospital should allow using of medication	94	90%	10%	1%
Hospital should allow using mechanical restraint	96	74%	18%	8%
Hospital should encourage nurses to attend aggression management training	96	99%	0%	1%
Hospital should allow access to policies addressing workplace violence	96	99%	0%	1%
Personal support services for nurses in hospital				
Should provide opportunities for education	96	96%	3%	1%
Should ensure nurses work under safe conditions	97	97%	1%	2%
Should provide training to address violence	96	97%	2%	1%
Should allow nurses to manage patient care adequately and effectively	95	95%	4%	1%
Should encourage new ideas to deal with violence	95	95%	4%	1%
Should allow sharing information and feedback	94	93%	6%	1%
Should provide resources for resolving problems	94	95%	4%	1%
Should show clear guidance about violence	94	94%	5%	1%
Should assess the needs of the department	95	96%	3%	1%
Should facilitate support from colleagues after an incident	94	94%	5%	1%
Should provide support from supervisors after an incident	93	94%	5%	1%
Should empower nurses to accomplish work in an effective manner	94	94%	5%	1%
Should allow nurses to feel safe in their work environment	94	95%	4%	1%
Workload in my department				
Negatively affects my ability to manage patient care	96	61%	19%	20%
Contributes to violence towards nurses	94	61%	19%	20%
Nurses do not have sufficient time to complete their work	94	60%	18%	22%
There is a process in place that deals with workload issues	95	44%	29%	27%
Autonomy at work				
Nurses have the ability to make necessary decisions related to patient care	96	63%	21%	16%
Nurses' autonomy contributes to reducing workplace violence	95	62%	25%	13%
Nurses are satisfied with their authority to manage violence at work	95	32%	26%	42%

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3.2.4 | Workload in departments

Nurses somewhat agreed that the heavy workload in their departments affected both their performance (60%, $n = 94$) and the overall levels of violence in the workplace (61%, $n = 94$). Nurses were ambivalent about the processes that are in place for dealing with workload issues (44%, $n = 95$). However, nurses tended to think that workload negatively affected their ability to manage patient care (61%, $n = 96$).

3.2.5 | Autonomy at work

Over half the nurses agreed that they had the autonomy to make necessary decisions related to patient care (63%, $n = 96$) or decisions about the management of violent patients (62%, $n = 95$). Only a third were satisfied with their authority to manage violence at work (32%, $n = 95$).

4 | DISCUSSION

When dealing with both verbal and physical violence, nearly all nurses indicated that they would ask the person to stop, talk with a colleague or report the incident to a senior staff member. Security services were most likely to be called for physical violence rather than verbal violence (84% vs. 61%). While some nurses sought formal counselling more for physical than verbal violence (68% vs. 56%), they generally showed a preference to talk to a colleague, family or friends. Security services are considered effective in mitigating violent incidents (Ramacciati, Ceccagnoli, Addey, Lumini, et al., 2016). This trend of not resorting to formal support reflects the literature, for example, Arnetz and Arnetz (2001). Conversely, Ramacciati et al. (2018) found that nurses perceived no protection from their managers and supervisors.

Despite nearly all respondents agreeing that any violence should be reported (95%), nurses indicated that they were less likely to complete an incident form if the violence were verbal rather than physical (78% vs. 91%) and similarly for taking no action at all (18% vs. 6%). These findings of under-reporting of workplace violence are present in many studies (Clements et al., 2005; Ferns, 2002; Hegney et al., 2010; Jones & Lyneham, 2001; Lyneham, 2000; Shoghi et al., 2008; Talas et al., 2011), with a specific set of reasons posited which include: Nurses believing policies are not effective, nor enacted, and that consequences for offenders were not enforced. Queensland Health (2016) similarly observed under-reporting of violence, and the reasons they provided were that there was a perception that verbal violence is less serious than physical violence, that there was a lack of faith in the effectiveness of the reporting process and possibly there was too much complexity involved in formal reporting. Similarly, Dafny and Beccaria (2020) found that nurses perceived that 'nothing will be done' if a report is made, and they indicated a lack of understanding about how to complete an incident report correctly or a lack of time and heavy workload that hindered the reporting of an incident (alongside a long reporting process and unfriendly reporting procedures). The perception of 'nothing will be done' was also found in the Ramacciati et al. (2018, p. 24) study when one of the nurses stated, 'You get the feeling that no one in healthcare management cares if nurses are attacked!!!'. Kim et al. (2019) found that organizational response is crucial in the association between workplace violence and depressive symptoms of the person reporting the violence, and if the organization did not respond the person felt unprotected and felt additional stress from the denial of their problem.

In this study, the nurses were least likely to complete a compensation form, pursue prosecution or transfer to another position for both types of violence, which additionally suggests some level of tolerance and normalization of workplace violence, something also observed by Queensland Health (2016). Salmon et al. (2021) point to the need for effective incidence reporting as a key focus of future activities. Ramacciati et al. (2021) discovered that 67% of participants who used technology, such as a free smartphone app for reporting violent incidents, found it was easy to use, saved time, simplified reporting and facilitated the reporting system.

Nearly all nurses (96%) agreed on the value of aggression management training as a means for helping them manage workplace violence. Nurses agreed that there should be continued availability of medical restraint (90%) and, to a lesser extent, mechanical restraint (74%) as options available to them, but they preferred these options less than skill training. Given this, nurses felt that sharing new ideas (95%) and generally obtaining opportunities for education (96%) were valuable in addressing issues of violence, and nearly all agreed (99%) that the hospital should encourage nurses to attend aggression management training.

This finding matches the Queensland Health (2016) report which similarly called for training, especially training models which showed consistency with each other, and they promoted the need for appropriate teaching resources to be made available to staff. Cabilan et al. (2021) found that staff education and training are critical in preventing workplace violence and should be done regularly, and they suggested de-escalation techniques, self-defence, mental health intervention and risk assessment. Jakobsson et al. (2021) suggested it was important to identify the most likely incidents occurring at the wards and then create strategies to suit these, such as risk assessments, education, evaluation, reflection and scenario-training related to those incidents. Queensland Health (2016) generally stated the need for adequate funding be allocated to the prevention of violence, since this underfunding and lessening of the importance of violence was identified as contributing to the problem. Spelten et al. (2020) assessed the effectiveness of organizational interventions to minimize workplace violence and found that interventions at all stages of violence should include post-event interventions because these interventions can deter perpetrators, support personnel and minimize recurrence of workplace violence incidents.

Nurses perceived the roles of workload and autonomy as less of an influence on the reduction and management of violence, with nurses indicating workload as a contributor to violent outcomes

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(61%), probably because of reduced ability to engage in timely care (60%). The sense that having greater autonomy to make decisions about care would somewhat reduce the level of violence at work (Tillott, Walsh, & Moxham, 2013). Nurses were very keen to be involved in developing workplace violence policies (96%). The contributing factors of workplace violence emerge across the hospital system, so a reform of the system needs to incorporate multiple points of action if it is to improve workplace violence, including gaining input and insight from nurses (Salmon et al., 2021). Unfortunately, Jakobsson et al. (2021) found that ward managers have limited opportunities to ensure that nurses are working in a safe environment, so senior management need to take responsibility. Similar, Ramacciati, Ceccagnoli, Addey, Giusti, et al. (2016) suggested that it is the responsibility of both the hospital administration and nursing management to reduce workplace violence, and further research and implementing strategies are required to overcome the extensive workplace violence towards nurses.

5 | LIMITATIONS

This study was conducted in a single hospital, so factors related to this hospital which are unknown to the authors may have influenced the ratings and outcomes of the survey that may not be present in other hospitals, nor other regions of Australia and internationally. However, the literature does indicate that the issue of workplace violence is prevalent internationally and that management of violence is reasonably uniform across Australia and other similarly developed countries, albeit with varying degrees of support, training and legal intervention (Spelten et al., 2020). Another limitation of this study is that it applies to a hospital setting and may not be transferrable to residential and community nursing care settings, albeit with these venues often having similar policies in place, as directed by the national regulatory body which governs all nursing activities.

6 | CONCLUSION

This study has found that nurses have strong agreement on the main methods of how best to prevent violence, including asking the person to stop, consulting with other staff and reporting to senior staff. They were least likely to pursue prosecution, seek formal counselling or fill in a compensation claim. In terms of strategies and services, nurses agreed that appropriate aggression management training and education was important, as well as using medication options, but mechanical restraint being least preferred. Nurses wanted input into workplace violence policies and felt dissatisfaction with their authority to manage violence at work.

IMPLICATIONS FOR NURSING MANAGEMENT

This study contributes to the body of nursing knowledge by providing a more thorough understanding of perceptions of nursing staff about workplace violence and what management strategies, support and services are rated most positively. Reducing workplace violence has the potential to improve the quality of life for nurses in their work environment, the health care they provide and overall patient wellbeing. In addition, decreasing violence towards nurses has the potential to improve nurse retention rates in the health system and reduce cost from lost time and injury.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

AUTHOR CONTRIBUTIONS

HAD designed the study and acquired and analysed the data. HAD, GB and AM interpreted the data and wrote the manuscript.

ETHICS STATEMENT

Ethical approval was obtained from the Human Research Ethics Committee of the Queensland Health Department (HREC/14/QTDD/6) and from the Human Research Ethics Committee of the University of Southern Queensland (H13REA249) prior the study being conducted.

DATA AVAILABILITY STATEMENT

no data available

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